COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

DENVER, COLORADO PUBLIC MEETING TRANSCRIPT
September 22-23, 2014

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DAY 1: SEPTEMBER 22, 2014

Chairman Sanders: [Session 1 - 00:00:01] …Abuse and Neglect Fatalities hearing in Denver. I'm David Sanders, the Chair of the Commission, and I'm just going to do a couple of brief remarks to introduce the hearing today and then we will introduce the remaining Commissioners and begin our testimony.

So the Commission is a 12-member Commission that was appointed by the President and by Congress. And our goal is to produce a report that includes recommendations on how to reduce or eliminate the child abuse and neglect fatalities. And last year there were over 1,600 child abuse and neglect fatalities in the country, and obviously a horrendous issue that we are examining in detail over the next year and a half, and have the direction from Congress to produce a report that will improve the condition for children in this country.

We have been instructed by Congress to hold hearings across the country to learn what is working and what is not working. So we will hear, in Denver, from local officials and from national experts who will give us a sense of the work here in Colorado, as well as some of the latest research nationally.

For presenters, we are all concerned with reducing abuse and neglect, but our task is specifically to reduce child fatalities. So we will thank all of you for your testimony and ask that you really focus on what we can learn and what we can do to improve the conditions related to fatalities.

We'll also ask you to adhere to the timelines that you've been provided. There will be a timekeeper who will hold up time remaining for you, and it is a hard stop when she holds up the timer that says "Stop."

For audience members, we want to thank you for being here. I know we have a number of people who have joined us on the phone, and we have a number of people here in the room. Thank you for your interest and thank you for being here. There won't be an opportunity to have a dialog with the audience as this really is for the Commissioners, but we do welcome your written testimony and we would certainly welcome any comments that you have in writing through our website.

So let me move to having each of the Commissioners introduce themselves. Why don't we start at the far end on the right with Commissioner Petit?

Commissioner Petit: [Session 1 - 00:02:39] I'm Michael Petit with the Every Child Matters Education Fund, formerly with the Child Welfare League of America, and prior to that Commissioner of Maine's Department of Health and Human Services.

Commissioner Martin: [Session 1 - 00:02:50] Good morning, my name is Patricia Martin and I'm the Presiding Judge of the Child Protection Division in Chicago, Cooke County. I'm also former President of the National Council of Juvenile and Family Court Judges. It's a delight to be here.

Commissioner Dreyfus: [Session 1 - 00:03:05] Good morning, my name is Susan Dreyfus. I'm CEO of the Alliance for Children and Families, former Secretary of Washington State

Department of Social and Health Services, and Administrator of Children and Family Services for the state of Wisconsin.

Commissioner Covington: [Session 1 - 00:03:18] Good morning, I'm Teri Covington. I'm the Executive Director of the National Center for Child Fatality Review, and we support states in the development of their child fatality processes. I had, prior to that [*inaudible, recording skipped*] to the state of Michigan for doing the same thing for the state of Michigan.

Commissioner Rubin: [Session 1 - 00:03:40] Good morning, my name is Dr. David Rubin; I'm a general pediatrician and the Co-Director of our Policy Lab at the Children's Hospital of Philadelphia.

Commissioner Rodriguez: [Session 1 - 00:03:50] Good morning, I'm Jennifer Rodriguez. I'm a lawyer and the Executive Director of the Youth Law Center in San Francisco, and we are a national public interest and advocacy organization. Prior to that, I was a fostered youth organizer and a legislative manager for the California Youth Connection, a foster youth advocacy organization in California.

Commissioner Zimmerman: [Session 1 - 00:04:13] Good morning, my name is Marilyn Zimmerman, and I am an enrolled member of the Ft. Peck Assiniboine and Sioux Tribes. I currently serve as the Director of the National Native Children's Trauma Center at the University of Montana.

Commissioner Ayoub: [Session 1 - 00:04:28] I'm Amy Ayoub from Las Vegas, Nevada. I'm the owner of The Zen Speaker, a presentation skills coaching company. I'm a child advocate, and I'm a sex trafficking survivor.

Chairman Sanders: [Session 1 - 00:04:40] And we have two Commissioners on the telephone, Commissioner Wade Horn and Commissioner Bud Cramer, and one of our Commissioners had a last-minute emergency and is unable to attend.

I'm David Sanders, the Chair of the Commission and I'm an Executive Vice President at Casey Family Programs, a foundation that provides support to vulnerable children, and prior to that the Director of Child Welfare Services for Los Angeles County. So we're going to go ahead and get started with our first presenters. We have a parent and youth presenter. The parent is Toni Miner and the youth presenter is Daryle Conquering Bear. You can come on up to the table, and we look forward to your testimony.

We will start with you, Ms. Miner.

Toni Miner [Session 1 - 00:05:32] Good morning. I'm Toni Miner, and I am a family advocate in Jefferson County, Colorado. Prior to that, I was a parent partner who supported families

that were going through child welfare cases. I would like thank Dr. Sanders and the Commissioners for allowing me to be here to speak today.

I would like to share some insights that I have gained through my life experiences and through my work experiences here in Colorado. I have been a parent partner, a family advocate, a trainer, a collaborator on so many different things. I also sit on the Title IV-E Waiver Oversight Committee here in Colorado as the parent voice.

I am going to give you five recommendations today, and I believe that this will help to eliminate child fatalities, and I urge you to act on them.

One is to make prevention a priority.

Two is to use a supportive and not a punitive approach when dealing with families, and to realign child welfare dollars to strengthen and keep families together. We need to partner with parents to work with the families and we need to ensure that parent voices are required in policy and procedures for funding.

Now I'm going to tell you a little bit about my story. I am a recovering meth addict. I have almost 13 years of being clean off of meth. Prior to that, I used meth every day for six years. I have two adult daughters that, unfortunately, had to live through my meth abuse. Now when I finally got clean they didn't have any trauma assessment or any trauma treatment in place. So rather than looking at my girls as being traumatized because of the choices that I had made, they looked at them as being a bad product from a bad person. So they, unfortunately, have followed in my footsteps.

I would also like to recognize my mother who is here today, Gloria, who aside from my two daughters she was the one person that I hurt the most through my drug abuse. She and I didn't know if we could ever repair our relationship, and today she is my biggest advocate, my biggest cheerleader. She watches my kids for me while I work, and I don't think I could make it without her.

So here I am today, and I am raising my two grandkids that are 10 and 5, and I have a son who is 12. And they are the light of my life. And like I said, unfortunately both of my daughters decided to follow in my footsteps, and I needed to break the cycle so I took on my grandchildren. I am bound and determined to make sure that they do not live through what my daughters lived through.

So with my work as a parent partner and an advocate, I want to help create opportunities for other families to find their voice, to give them hope so that they can see that light at the end of the tunnel. I sit on the juvenile justice subcommittee in Jefferson County and a Communities of Excellence Committee. We have got a human trafficking subcommittee that I

sit on in Jefferson County and I also am on the Domestic Violence and Child Protection Services Coordinating Council with the state.

I'm also a crossing guard at my kids' school, and they think that it is the greatest thing, how someone who made so many bad choices and I put my daughters in very dangerous situations, that now I'm all about protecting my kids and the kids at my children's school. My son always told me when he was little and we would go to the store, "Mom, go out and stop that car." And I'm going, "You know, son, I can't do that, I don't have my green vest on, so I can't go out and stop the cars." So he gets that now.

I also sit on a Birth Parent Advisory Committee with Casey Family Programs. We, over the last year, have been working very, very hard on system reforms. We have developed recommendations for improving child welfare policies and practices to help eliminate child abuse and neglect fatalities. I know that you all, when you were in Michigan, were able to meet my colleague, Nancy Vivoda, and that she had shared the flyer with you. I hope you found it very useful. We have been working very, very hard on that, and all of us on the BPAC have, one way or another, been involved with the child welfare system, and so this is very, very close to our hearts. I also belong to the Birth Parent National Network with the National Alliance for Children's Trust and Prevention Funds, and we are working to educate policymakers about the need to reform the child welfare system.

Now I would like to go a little bit more into detail, and I'm going to read off my paper because I don't want to miss anything from my recommendations to you all. So I am here today because I want to talk more about these five recommendations that I believe will help eliminate child abuse and neglect fatalities.

One, make prevention a priority. We need to invest significant funding and resources and yet we don't do that. What I see as a parent is that whenever funding is tight, the first thing to go is the money that helps the parents. Prevention is always the first service to be cut. This must not happen. We need to protect all children who are at risk from potential child abuse and neglect fatalities. The Child Abuse and Prevention Treatment Act Title II funding needs to be carefully reviewed, as it is consistently underfunded. I know that from speaking with colleagues that it has not been raised from $42 million to keep up with the growth of the United States.

We also need to use a supportive and not a punitive approach to help families at risk safely keep their children at home. We need to engage families at risk as early as possible, using a supportive approach to help them keep their children safely at home and help them build protective factors.

For example, parents need to hear that everyone has frustrations and problems, and that it is okay for them to reach out for help without it creating more problems for them. Parents get isolated and think that they are the only ones feeling overwhelmed, but they are too ashamed

to ask for help. I know that in my own situation I felt very siloed and I felt very ashamed of the choices that I was making, and I was also terrified that if I asked for help they were going to come take my children from me, when all I wanted was someone to help me learn to be a better mom. There was not one moment in my life that went by that I did not love my children, and that I did not have their best interests at heart; I just did not know how to properly care for them or protect them.

Speaking from my own experiences, families at risk respond best to supportive and strength-based approaches. I really appreciated the support and trust that I received from my child welfare worker and my probation officer when I finally got clean. They both believed that I could change and become the strong, resilient, and healthy parent that I am today. The culture in the child welfare system does not always support this kind of strength-based work, and that needs to become the normal way of working.

Not all children are able to stay safely home with their families, and I'm living proof of that, and that is why I have my grandchildren. But whenever possible, we have got to figure out a way for these kiddos to go into kinship care. I can tell you my little grandson has got PTSD, and he is kind of a hard kid sometimes. But because I'm his grandma I'm there for him, and I love him, and I'm not going to turn my back on him. I think if he was in a foster home, they would have a lot harder time dealing with him.

And we have got to realign the child welfare dollars for more flexibility, as in the IV-E Waiver. We need to partner with the parents to work with other families during or after involvement with the child welfare and court systems. We need more parent partner programs; we need family advocates; we need parents that have been through the system to go out and support these families to show them that there is light at the end of the tunnel, and to show them that we are living proof that it can be done. We also need to ensure that parent voices are required in funding and policies.

I wish to commend all of you for the work that you are doing, and if we implement these recommendations and invest in families, the sky is the limit in what we and they can achieve. I strongly urge you to implement these recommendations to help families be strong and healthy so that all children at risk are protected from potential death due to child abuse and neglect. Thank you, and I welcome any questions that you may have.

Chairman **Sanders: [Session 1 - 00:14:51**] Thank you very much, Ms. Miner. We have Diego Conde who also is going to speak, and he has arrived. So why don't we move to Mr. Conquering Bear and then to Mr. Conde.

Daryle Conquering Bear Crow: [Session 1 - 00:15:10] Good morning, Commissioner Sanders and the rest of the Commission panel. It is an honor, and I am very humble to be invited to the table to speak about this important issue involving not just my community of American

Indians but the community of the foster youth and the prevention and what are we going to do to our families to keep them strong and whole?

Commissioner Rodriguez, California Youth Connections is an amazing organization, and to model off of them in Colorado and throughout the United States is an amazing thing to do, so I thank you.

Commissioner Zimmerman, I thank you for being up there and being a Native American Indian representation. It's not very often we see American Indians represented at these national meetings, so I thank you and I know our Creator is blessing you with many blessings, so thank you.

My name is Daryle Conquering Bear Crow. I come from Pine Ridge, South Dakota, the second worst poverty city in America. Yet we forget about them, and we worry about metropolitan cities. I am an American Indian. I am an American citizen, but why do we forget about American Indians? We have the Indian Child Welfare Act that was enacted 39 years ago. I stop at a stop sign. I give a security guard an I.D. I follow the federal law, yet we get to follow the Indian Child Welfare Act. Why did I have to be ripped away from culture? Why was I in a state of Colorado state foster care system? When that law, 39 years ago, stated to keep me connected to my culture, to keep me connected to my family.

Why bring up the Indian Child Welfare Act? It was supposed to be a preventative law to help keep our Indian children together, to keep them connected to their culture. There was a time in my life that suicide was a question, that drugs was the answer, that alcohol was it. Why? We're the forgettable citizens of the United States of America. Yeah, we're given dollars, we have the BIA. You give us federal dollars. It's not enough.

Casey Family Programs does very little for an Indian Child Welfare Unit they have, yet we commend them for a lot. Yeah, I speak the truth, and that's what you want to hear. It may hurt, but it really does hurt those kids like me.

We talked about this issue 10 years ago. We're here again 10 years later talking about it. People have goals, organizations have goals. No underage [*inaudible*] set by 2017. What about that 20-20 goal? Are you really going to reach those goals?

I sit on various boards and commissions, some national boards, and we talk about it every time. What are we doing for our youth? What are we doing for them? Many of us are dying, use suicide. We give out a grant, a $2 million grant for the whole United States to provide to 565 tribes. Those are preventative dollars. 565 tribes. What are they going to do with $2 million when you have separated all that?

I look at my story. Someone today is going to commit suicide. Someone today on a reservation is going to die. A little baby is going to go into foster care. That baby is going to go into foster

care, and who knows by the age of 10 if he'll be alive? Culture means a lot. When I went to Hawaii … it takes a family. In Native American communities, it does take a village to raise a kid. We strip them away from that community, we expect them to go in a state foster care system. They go in there, we strip away their culture, and it goes on and on. If you think about it, it takes me back years and years ago to a historical trauma, to school board days. Walking into this building and you see Daryle Conquering Bear Crow on your program, you expect to see somebody with two braids, long hair. No, this is what the state foster care system did. You're not allowed to have long hair. We're going to change your identity, we're going to change your look. It's not a story of mine, but those of my brothers and sisters, 476 of them in foster care, thousands of them in foster care.

Preventative dollars will work. Channeling that money from fancy organizations will work and getting them on boards will work. But that is just the top layer of the problem. When we go into actual reservations, when the Commission and panel goes to a reservation and not just an urban city, then we will get to the problems and get to hear from what it really is. It took me six hours to get here from Pine Ridge to speak about this problem. I relocated to Denver. Why not go to one of those reservations? One huge recommendation, go to a reservation. Hear what it is for American Indians to be in foster care, to have a parent speak to you about their kid dying in care, or what the preventative steps might be.

Yeah, we heard that more dollars would be added to it. We all know with sequestration and the cuts that are happening in budgets BIA is the first thing to go. How do we hear their systems will be better? We've been asking that question for the last 39 years, 10 years since I've been doing advocacy work. Having youth come is one thing, having them be active in the talks is another.

Again, I ask you, by the end of the day 1,026 kids are going to be entering into foster care. Of those, 10 of them might be American Indian. How are we going to keep them connected to their culture? How are we going to keep them from going through the child abuse that we've taken them away from? How are we going to help them break the cycle?

Let me reiterate, I ask you to go to a reservation and hold a panel presentation like this. Thank you.

Chairman Sanders: [Session 1 - 00:22:33] Thank you, Mr. Conquering Bear. Mr. Conde?

Diego Conde: [Session 1 - 00:22:39] Good morning, Commissioners, I appreciate you guys having me here today. I'm honored and grateful. My name is Diego Conde, I'm 19 years old. I spent five years in Colorado's foster care system.

My mom came to the U.S. when I was about 3 years old, so I've been in Colorado most of my life. I went through a lot of adversity with my mother being sick and dying from cancer. Unfortunately, going through 4 to 5 different foster homes, I realized a lot of abuse and

neglect, a lot of kids from different ethnicities losing hope and spirit to move on with their lives, which is a really small chapter. I've experienced everything from my foster brothers trying to commit suicide, to them being willing to sell drugs to be able to make a living for themselves. I started working at the early age of 14, taking a two-hour bus ride from Aurora all the way to Westminster to work at a local pub, just to make a living for not only myself but my foster brothers that needed food, clothing, and even hygiene things, which was very unfortunate.

A lot that I've realized and I recommend to you guys, Commissioners, with all the power that you can do, is being able to give foster kids and foster parents positive affirmations and a better environment where they are able to flourish, because what I really realized is that it is hard being a foster parent. It's hard being in foster care. But that doesn't mean that we can't try and impose order and keep succeeding in life by pushing harder and meeting those metrics and those objectives and initiatives. What I really realized is a lot of kids in foster care have this sense of wanting to belong, wanting to do greater things, but a lot of them have difficulty with being normal in school and attending extracurricular activities. For example, I was in AP and IE classes, and in order to take AP exams there is a cost to it, and it was difficult. I had to go through several steps to finally get funding to take that exam to get college credit.

Another thing I realized is a lot of Latino children are losing their heritage and their culture because they're not with Latino and Hispanic families, which is an increasing population. We've noticed, even with Daryle having trouble with Native American culture, it is really being able to provide a curriculum for foster parents and youth that is interactive so that they are able to understand one another, whether it is African American, Caucasian, Asian, or Pacific Islander, or Latinos. It's really important to have those steps and processes set up and in place, and a strong foundation where we are able to communicate more efficiently.

For example, I have kind of been working on having foster parents, GALs, and counselors work together with a system in place, kind of like a platform where they are able to get the same information at the same time, because that is really important. A lot of problems are created throughout child welfare is miscommunication. Not everybody is on the same page, everybody has their own ideas, their own goals or their own initiatives, but nobody is really taking the time to listen to each other's stories. It could be one or two minutes, it could be five minutes to an hour. It is just really taking the time to really listen, concentrate, and have that silence and that special time with somebody that can truly get them on a better and stronger path. I know, for myself, not a lot of people were listening to me when I was going through a lot of adversity, especially when I had surveillance at my home. I thought that was a little bit of an invasion of privacy, and I still don't understand today why there had to be surveillance and why we had to use call monitors to call my foster dad. It was really interesting, but now that I look back at it, it made me who I am today, and that is why I continue to do advocacy work because I see the strong passion in myself and other advocates and leaders, like us, that come here today. Like today, it was about an hour just to get up here all the way from the Tech

Center because of traffic. You know, I love doing stuff like this because I could see the flare and the passions I could pass on to future generations and future leaders.

One of my ending notes is that I don't know if you guys ever heard about Earl Nightingale. A lot of what he was talking about is the people between who are successful and not successful are the people that envision who they become. So if you envision that you're going to be successful and that you are going to achieve something, you see that, you picture it. And that is what we have got to tell our foster parents and our foster children, is that you envision yourself doing great things, successful things. You want to be a lawyer? Be a lawyer. You want to be a singer? Be a singer. You need to get people to follow their passions. That is what has productivity, that is what creates greater things, and on top of that it just produces more effort and more results.

So thank you.

Chairman Sanders: [Session 1 - 00:28:04] Thank you, and thanks to all three of our panelists. Any questions from the Commissioners, or comments? Commissioner Ayoub.

Commissioner Ayoub: [Session 1 - 00:28:13] Ms. Miner, thank you so much for being here. As someone in recovery, I congratulate you and commend you for what you are doing with your life, and therefore the life of your children, grandchildren, and everyone else's grandchildren.

You talked about the importance of prevention. You were wonderful to give us five specific things, so could you get even more specific and talk a little bit maybe on one or two suggestions on the preventative side, and especially if you have something around the drug abuse area.

Miner: [Session 1 - 00:28:50] So in my experience, folks, unless they are truly ready to get clean, they are not going to. You cannot force someone into sobriety. It took me being raided twice and getting pregnant with my third child before I went, "Whoa. Something needs to change here." When parents really want that, for folks to come in and to be more partnering with them.

You know, I had a caseworker at the time that came in and partnered with me; he did not judge me. He was like, "So you know, you've got some issues. What can we do to help you?" and I was like, "Whoa. Wait a minute. You want to help me? You want to help me keep my kids and you want to help me get sober?" And he was like, "Yeah, I really want to be here for you and help you do this." So I think that human services partnering with folks is one big issue, and the other one is we need parent partners. We need whatever you want to call them, recovery coaches, family advocates. We need people that have been through the system to be able to walk alongside these families that are going through similar situations,

because we get it. We feel it. And it also helps the parents go, "Wow. This person really knows."

You know, when I go out and I meet with families now it is not until I really start sharing more and more of my story with them that they even actually realize that I do get it, because they look at me and go, "Yeah, right. You didn't use meth." And I'm like, "No, really, I did." And then as I start sharing more with them, then they're like, "Wow. She really does know." So they start opening up more with me. And we can help call them on their stuff because people are going to lie. You know, I tell my kids all the time that lying is a "using behavior." This is what I tell my adult daughters. We really need that partnership, and we really need to try to get these families as early as we can.

I can say that families are not going to want to call for help and go, "I'm at the point where I want to beat my child," because they are terrified that by their child being at risk for that abuse, that social services is going to come in, yank the child out of the home, tell the parents how horrible they are, and they're not going to get the help that they need. We need to ensure these families that we're going to go in and partner with them and say, "What can I give you to be a better parent? What do you need in your life?" Parents aren't used to hearing that. They are used to people coming in saying, "This is what is wrong with you, this is what you need to do." They don't learn any self-efficacy so that when human services is gone they are lost because they don't have that person standing over them cracking the whip saying, "This is what needs to be done for you." And every family is different, we have to remember that. We are all individuals, and what worked for me may not work for the next person.

We need to also listen to the families. I went and spoke to the judges and magistrates in Jefferson County about two years ago, and they asked what was the one thing that I had to say to them. And I said, "I realize that you have a very full docket, but you have to look at us as individuals. You have to look at us like we are all people. I'm not a case number. I'm not another case for you. I'm a mom. I'm a grandma that really cares about my kids. Take the time to get to know them, the parents and the youth. The youth know what they want. And the parents know what they want, and maybe they just need to learn different ways to keep themselves and their kids safe."

Does that answer it for you?

Commissioner Ayoub: [Session 1 - 00:32:59] Absolutely. Thank you so much.

Miner: [Session 1 - 00:33:00] Thank you.

Chairman Sanders: [Session 1 - 00:33:01] Thank you. Commissioner Martin, then we'll close with Commissioner Zimmerman.

Commissioner Martin: [Session 1 - 00:33:07] Very well. First of all, thank you to each of the panelists. Each of your stories was inspiring and very, very heartfelt, and I believe each of the Commissioners felt your story as well as the pain that goes with them.

My question is directed to the two gentlemen. Both of you emphasize culture and how important culture is for youth, whether in foster care, in state courts, or tribal courts. And I guess I don't know how to say this delicately so I'll just put it out there. Have you seen that recognizing culture or appreciating and embracing, giving, allowing culture to develop reduce the abuse and neglect fatalities?

So in other words, you mentioned Mr. Conquering Bear Crow, that after ICWA , and so I want to know on your reservation, the reservations you are familiar with, have you seen a reduction of the fatalities after the institution of ICWA or the establishment of ICWA? Have you seen a reduction of the fatalities when culture is embraced and offered?

Conquering Bear Crow: [Session 1 - 00:34:17] Thank you, Commissioner, and that is a great question. Being a consultant and an advisory committee member to the National Resource Center for Tribes that was granted a national grant, I got to go to the Ft. Belknap tribe and Port Gamble, who were given title IV-E grants, and given money to run their own tribal services. Over the past two years, we've seen some reduction of some of those foster care cases and abuse fatalities. But we go back to an incident that everyone knows of in 2011 or pretty earlier of the Red Lake tribe and the abuse and stuff that has happened there. Why? You say we have title IV-E and people in tribes are given that. Some tribes are given opportunities for that, but they can't match dollars to dollars to that, let's just be realistic with that. The state and the federal requirements are that hard. The Navajo Nation is going to be one of those tribes we look to, and with the great Navajo code talkers and everything like that we will see how successful title IV-E will be with that.

On my reservation, no, there is no positive remarks that I can give. But for those tribes that have title IV-E, and who have fought for those, and who are implementing their own tribal services, there is some positive coming out of that. But we need to focus on those tribes that won't be able to match dollars to dollars, and how we will be able to give them preventative dollars without requiring them to give it back to us.

Conde: [Session 1 - 00:35:50] With the Latino and Hispanic culture, you could see a lot. It is really family oriented, so a lot of these families just don't know what it means to truly be a family. Whether it is going to watch a movie together or whether it is sitting down at the dinner table. Throughout my experience, I never sat down with my foster parents. I was really sitting down with my foster brothers and we were kind of like our own little family. And I just encourage you, Commissioners, to think that family is the most powerful thing out there. It changes your heart, it changes your mind, and it changes your soul. So I really believe once we get a system in place where we are able to track down metrics of how interactions between families get better, whether it is communication, whether it is problem-solving

skills, or whether it is, "Hey, have you mentioned school and how great they are doing?" I've known a lot of parents that don't really check up on grades and it is very unfortunate. But once we get parents and youth more active and willing to communicate with each other and break that sense of it is taboo to talk to each other because we come from different experiences, and we're different ages, and different cultures, that's when we will finally get a lot more positive results throughout this nation.

Chairman Sanders: [Session 1 - 00:37:11] Commissioner Zimmerman?

Commissioner Zimmerman: [Session 1 - 00:37:15] Yes, thank you. Thank you all for your testimony, and I want to thank you especially, Daryle, for coming and representing American Indian and Alaska Native foster parents and children in this venue.

Have you, in your work with the National Resource Center for Tribes, had any indication that culture or ceremony, I'll put it that way, has improved the lives of foster children, reducing the risk for abuse, neglect, and death?

Conquering Bear Crow: [Session 1 - 00:37:47] Great question, Commissioner Zimmerman. I'd like to provide an example. In prisons and state penitentiaries they use sweat lodges. They use sweats. Non-natives and natives go through that, and when they exit care they come out, they are wanting sweats, they are wanting to do ceremonial activities, and they change for the better. But in the state foster care system, they are not allowed to attend ceremonies. It's a different type of medicine for them. They are not used to that. What we give them is psychotropic medication, when all they really probably needed is ceremonial sweat, some sage to smear down, and some cultural remedies. And so when we have the Sweetwater Grass Grant that is out there for the Pine Ridge Reservation, they build sweats, they build that lodge, they build that hut, whatever they use, and they have weekly sweats. And to see that happening with our youth right now, and to see it happening at all, there is some change but it is not significant. And once we allow our Native American kids, American Indian and Alaska Native kids to actually attend cultural ceremonies, we will probably see a change. But that comes from the ACYF in allowing our American Indian and Alaska Native kids to attend ceremonial stuff, attend a sage, to see a medicine man without going through a background check. We all know there is federal law that mandates for that, but when you enter a kid in foster care they are going to be traumatic, they are going to be emotional. Don't give them psychotropic medications; they really need ceremonial stuff. Thank you.

Commissioner Zimmerman: [Session 1 - 00:39:27] Thank you, and I want to say that I imagine that your Tiospaye is very proud of you today. Thank you.

Chairman Sanders: [Session 1 - 00:39:41] Thanks to all three of you for very moving testimony. Good way to start the day. Thank you very much.

Our next two are Julie Krow, who is the director of the Office of Children, Youth and Families for the Colorado Department of Human Services and Dr. Larry Wolk, who is the executive director and chief medical officer for the Colorado Department of Public Health and Environment. And each will have about eight minutes to present, and then we will have some time for questions.

Ms. Krow, are you starting?

Julie Krow: [Session 1 - 00:40:18] Thank you. Good morning. My name is Julie Krow, I'm the director of the Office of Children, Youth and Families for the Colorado Department of Human Services and the incoming president of NAPCWA. My office oversees the Division of Child Welfare, the Division of Youth Corrections, and the domestic violence programs for the state of Colorado. I'm joined by Dr. Larry Wolk, executive director and chief medical officer of the Colorado Department of Public Health and Environment. On behalf of our teams, we are honored to support you in your efforts to develop a national strategy for eliminating child fatalities.

Today you will hear about the governor's Child Welfare Master Plan, learn about some of our prevention programs, and hear about how we collaborate to respond to and quantify child abuse and neglect fatalities. We will end with recommendations about how the federal government can support states to make improvements.

The media has focused on struggles of child welfare in many states. I started my job in September of 2011, just as a high-profile investigative media series began to examine child fatalities in Colorado. It was heartbreaking for all of us to hear about children who suffered abuse and neglect and the impact those losses had on the people that cared about them. As the series unfolded, we worked with members of the community and members of the legislature to create an opportunity to transform our child welfare system. Through our governor's Child Welfare Master Plan we were able to seek nearly 30 million new dollars of funding for initiatives aimed in preventing child abuse and neglect. We funded SafeCare Colorado for families that were screened out of the child welfare system or who would benefit from prevention services. SafeCare is an evidence-based practice, which provides in-home parenting skills, home safety, and health education. Building parenting skills at the front end through public school education or through programs like our voluntary SafeCare program is critical to preventing child abuse, neglect, and fatalities. We worked with Dr. David Olds to augment our Nurse-Family Partnerships Program to better serve clients in the child welfare system. Our Office of Early Childhood implemented a Colorado community response program, which offers voluntary family-focused services and parent education. We provided additional funding through core services for in-home family preservation, and we promulgated rules in Colorado to spend child welfare funding more flexibly on non-opened child welfare cases.

We also worked with the Colorado Department of Public Health and Environment and members of the legislature to pass House Bill 1117 to align many of our state's child abuse prevention services by moving them from the Colorado Department of Public Health and Environment to the Colorado Department of Human Services. We moved the Tony Grampsas Youth Services Program, the Nurse Home Visitor Program, the Family Resource Center Program, the Colorado Children's Trust Fund and its board, and the Maternal and Infant Early Childhood Visiting Program to the Human Services Office of Early Childhood and into child welfare.

Colorado was awarded a federal IV-E waiver to test innovative, front-end approaches to safely reduce congregate care, promote permanency, and better identify at entry children and families affected by trauma. We requested funding to implement a statewide child abuse and neglect reporting hotline. This is significant in Colorado because we are a state-supervised, county administered state. Our new hotline will go live in January and will integrate with the state's child welfare information system to link call recordings directly into our SACWIS system. This will allow us to have data that we need to continuously make quality improvements.

In 2014, every county was trained in enhanced screening. An enhanced screening guide was also added to our SACWIS system. We standardized the use of RED teams to ensure consistent screening, practice, and that each referral was properly assessed and assigned. We took a team of state, county, and community partners to several states to learn about their hotlines in efforts to engage the public. During this trip, we learned that in New York the public was much more engaged than they were in Colorado and more likely to report child abuse and neglect. In order to understand this, we hired a contractor to conduct a public opinion survey regarding why Coloradans were hesitant to report child abuse and neglect.

As a result of that research, we invested $1.8 million in a statewide public awareness campaign, which will coincide with the launch of our hotline, and beginning in April, in recognition of Child Abuse and Neglect Awareness Month, Colorado will host one of the most robust, ongoing public awareness campaigns in the entire country. As part of this effort, we will work with Dr. Larry Wolk and his team to weave in key prevention messages. We partnered with the Kempe Center to completely overhaul our Child Welfare Training Academy, and we sought to improve the efficiency of caseworkers by distributing more than 1,050 mobile technology devices to county child welfare staff.

Throughout the increased media attention, we looked for ways to increase transparency and public engagement, reinforcing the message that we in child welfare can't do this alone; we need our community partners to help keep kids safe. So we rolled out a new public-facing website, which we called the Colorado Department of Human Services Community Performance Center. This website pulls data straight from our SACWIS system, making it available by state, county, and judicial district. There have been more than 4,500 visits to the site just since we rolled it out in April.

Now I will talk a little bit about child fatalities and reviews. In 2011, the legislative changes were made to provide CDHS with statutory authority for an improved child fatalities review process, funding one additional staff position to conduct these reviews and establish an enhanced criteria for incidents which should be reviewed.

In 2012, we added the review of near-fatal and egregious incidents to the responsibilities of our child fatality review team. I think that we are one of the only states that reviews near-fatal and egregious incidents. We also included reporting and public disclosure requirements. This aligned Colorado statute with the federal requirements of CAPTA.

We further refined the child fatality reporting statute to allow for the release of a child's name, date of birth, and date of death. In 2013 we revised the criteria for qualifying for a full review by the child fatality review team, lengthening the time considered for previous involvement from two years to three years, and removing some exceptions related to previous involvement. We also outlined in statute interagency collaboration. As a result, both my agency, the Department of Human Services, and Dr. Wolk's agency have staff members assigned to sit on each other's fatality review teams. While we have two different processes for children who are both known and unknown to the system, we share information and make joint, annual recommendations.

I was asked to provide some recommendations about how the federal government can support states to improve our system. First, fatalities cannot be prevented by one system alone. This should be a shared community responsibility. We need partners at the federal level to do everything possible to encourage partnerships, teaming, data sharing, and flexible funding between Medicaid, public health, education, law enforcement, domestic violence programs, and child welfare.

Caseworkers are expected to be all things to all families. They need to know if a child is medically stable, injured, critically ill, or even if they are taking the right psychotropic medication. We need to ensure children on their caseloads are doing well educationally. Funding integrated teams of experts such as a caseworker, nurse, and educational expert might be a better way to approach a case or even prevent a fatality. In order to do this, it would be helpful if Medicaid would routinely pick up the cost to send nurses out with caseworkers to visit families who have at-risk young children, especially since we know that most of our fatalities occur in the very youngest children.

One promising practice may be to fund parenting skills education throughout our public school system. If children involved in the child welfare system were presumptively eligible for high-quality, early childhood education, they might be safer. This could also be extended to children in kinship, foster, or adoptive homes.

Colorado has improved the way we measure safety and risk and how we identify and review fatalities and egregious incidents. However, it is still difficult to compare our data with that of other states because of varying definitions and timelines. This can be challenging to understand which practices are working best.

Chairman Sanders: [Session 1 - 00:51:01] Ms. Krow, I'm going to have to ask you to wind down. Go ahead with your last couple of recommendations, then we'll have to wind down.

Krow: [Session 1 - 00:51:11] Okay, so we support the reauthorization of CAPTA, and APHA and NAPCWA, as president of those two organizations, we support federal finance reform. We believe this is good for kids but will also assure a continued federal and state partnership in child welfare.

We support all efforts to support data, both internally and across state lines. One project that APHA and NAPCWA supported was the National Electronic Interstate Compact Enterprise, and we would like to see other data-sharing efforts like that across the country. And to keep children safe, we need SACWIS systems that are interoperable with Medicaid, public health, education, and law enforcement.

I hope these recommendations were helpful, and I will now turn it over to Dr. Larry Wolk.

Chairman Sanders: [Session 1 - 00:52:16] Thank you. Dr. Wolk?

Dr. Larry Wolk: [Session 1 - 00:52:19] Thank you, and good morning. I'm Dr. Larry Wolk. In addition to being the chief medical officer and executive director of the Department of Public Health and Environment, I'm also a pediatrician.

Twenty years ago, I founded a nonprofit safety-net organization for kids called The Rocky Mountain Youth Clinics, and so I can tell you first-hand that child maltreatment is a public health issue. I will condense to try and get you caught up and see if we can then answer a few questions, because you are going to hear from really who I consider the experts a little bit later on today. Lindsey Myers from our department is well versed on the subject.

The media often focuses on the child welfare system when discussing child abuse and neglect, and child maltreatment is more than just a child welfare issue. We also consider, at the Department of Public Health, that these types of issues should not be addressed in silos, that we have to take a broad-based approach, and you have already heard, I think, from the panel of three before us, that preventive strategies can be and are showing hope as a successful way for the Department of Public Health to be a part of the solution by making sure we address all social determinants of health. We have a very active Health Equity Commission, we are experts in collecting and analyzing data to better understand the child maltreatment problem, among others. Identifying factors at multiple levels of the social ecology that put children at higher risk for maltreatment, develop and test prevention strategies, and assure

widespread adoption of evidence-based practices. We really have to stay objective and evidence-based and shun or try and avoid some of the political pressures that might push us one way or the other.

So much of our work on the issue is through the Child Fatality Prevention System, which you have some materials on, and you will hear quite a bit more about. The system comprises 48 local child fatality review teams and a 46-member state review team. Members of these teams are experts in the fields of child abuse prevention, pediatrics, family law, death investigation, motor vehicle safety, and sudden, unexpected infant death. Really, the variety of the disciplines involved and the depth of expertise provided by the team results in a very comprehensive review process, allowing for a broad analysis of both contributory and preventive factors of child deaths.

According to our system, child maltreatment caused and/or contributed to the deaths of 230 children in Colorado between 2008 and 2012. And again, you have more information in your packet contained in the year 2014 Annual Report.

We have a little bit of definitional misalignment, I'll say, because we work closely with CDHS to make sure we can reconcile all of those 230, and we get pretty close. We get to about 70 percent of those being substantiated of the 230 that were reported over those five years, but the remaining 30 percent were either not reported to county Departments of Human Services or the incident did not meet the statutory definition for substantiated maltreatment. And again, Lindsey Myers will talk to you later today and can provide you a little bit more information on that, and there is also more information in your packet.

The Child Fatality Prevention Act requires the Child Fatality Prevention System State Review Team to collaborate with the CDHS Child Fatality Review Team to make joint recommendations for the prevention of child fatalities due to child maltreatment. In just this past July in our legislative reports, we had two that we endorsed. One is to incorporate the infant safe sleep education and how to address safety concerns related to infant safe sleep practices, and then the second is to continue to provide dedicated resources for the implementation of Colorado's child welfare plan, entitled Keeping Kids Safe and Families Healthy 2.0, which really has a very heavy prevention focus for families with young children in every county here in Colorado.

Lastly, I would mention our Essentials for Childhood grant. We are very fortunate, here in Colorado, that the CDC selected us to be only one of five states to be part of this project to promote the types of relationships and environments that help children grow up to be healthy and productive citizens so that they can build stronger and safer families and communities for their children. Again, taking this broader-based social determinants of health approach and going outside of maybe the traditional child welfare and even public health systems to engage, through a collective impact process, all of the community partners that are involved in helping us raise kids in our community.

You will also hear more about that today, but we are using a very structured process to develop and implement strategies to promote healthy families and relationships. And the reason why it is so exciting to me and to us is it really brings in nontraditional health care organizations, entities, and leaders in the community rather than just focusing on health and social welfare organizations.

As to our single recommendation, then, for the federal government, we would like to see an increase in funding for primary prevention. I think you have heard that already, but I'll say it again. The Essentials for Childhood project that we are starting to embark on really is, again, something that is exciting, something that comes to us through federal partner support, and we would love to see a program like that really take off and really receive some additional support.

So thank you for the opportunity to provide some comments.

Chairman Sanders: [Session 1 - 00:58:55] Thank you, Dr. Wolk. Actually, I know probably everybody has at least one question, so let me start with Commissioner Rubin.

Commissioner Rubin: [Session 1 - 00:59:07] Thanks to the both of you for testifying. You know, it gives me great pleasure to come to Colorado. I think for a long time, for those of us outside who follow public health and child welfare, not to say that Colorado always gets it right, but you have one of the most thoughtful systems in terms of integrating across a number of different levels, so thanks to both of you.

I'm going to ask a little bit of a tougher question that you probably haven't prepared for, Dr. Wolk, and Ms. Krow you can comment on as well. I'm glad to see that you mentioned leveraging the Medicaid funds in terms of integrating nursing services. My observation, based on a number of the meetings that we've had, is that often the response and the relationship to public health and Medicaid is initiated on the child protective services side as they seek to respond to challenges they are having in their system. Less often is a public health approach initiated on the public health side—realizing that many of the kids that are dying are not yet known to child welfare, to identify children who are at risk and to perform some level of well-being checks on those kids.

For example, most of these kids are on Medicaid. And from personal experience, I have seen Medicaid claims that document multiple injuries to young infants that are at the claims level. And the question I have for you guys is, what would it take for Medicaid to take a little bit more primary responsibility of identifying potential at-risk infants and toddlers early in their life and not necessarily initiating a child welfare report, but beginning to initiate a community response to make sure the kid is okay? Very concretely.

Dr. Wolk: [Session 1 - 01:00:50] Thank you, Commissioner. I don't disagree, and one of the nice things that we have been building here is our health information technology system. We do have the All Payer Claims Database, which Medicaid is now a part of, as well as our Health Information Exchange. We have two in the state, a larger one and the state-designated one, called CORHIO, where every hospital system now in the state is contributing data to. So it wouldn't take much, and having most recently come from being the CEO at CORHIO, I can tell you we are on the doorstep of now starting to develop the analytics with both the All Payer Claims Database as well as with the state's HIE to start culling that information so that we can identify these kids much sooner, even sooner than when claims are presented, because if you can get it from electronic health record information that is submitted to the Health Information Exchange, even practitioners who might be, let's say, reluctant to report or identify, we at least then have the ability to look at the clinical information and make that decision ourselves and be more preemptive.

It is a little different for me, because generally speaking the three of us go everywhere together, HCPF, which is Medicaid, myself—the Department of Public Health, and the Department of Human Services. So in spite of the fact that we don't have, let's say, an overall health authority like some states do, we act as if we do, and the three of us are generally very well aligned.

Commissioner Rubin: [Session 1 - 01:02:36] Well thank you for that comment. For all the public health folks who will testify today, I ask you the same question. To think about what an initiated response would look like and where Medicaid could be brought to the table, so I thank you for all your comments.

Chairman Sanders: [Session 1 - 01:02:52] Commissioner Covington?

Commissioner Covington: [Session 1 - 01:02:56] Hello. Thank you very much for your comments. I have a couple of questions for Director Krow. You talked about how the governor's master plan is promulgating flexible funding. Can you talk a little bit about what that is and what you think some federal lessons could be around that?

Krow: [Session 1 - 01:03:20] Sure. We passed something called Program Area Three that allows us to spend our child welfare dollars for prevention or at-risk of abuse or neglect. We still have to follow the same rules that follow the funding stream, but we did pass state legislation that allows us to spend dollars earlier, and we made modifications to our SACWIS system so that we can track the impacts of that spending. And so for instance, screened-out referrals who didn't meet the criteria to be screened in can receive SafeCare or other in-home family preservation services. And this is very new, we just started doing this this year, so we don't yet have data related to the impact, but we are hopeful for this strategy.

Commissioner Covington: [Session 1 - 01:04:13] My other question was you talked about how a number of programs that had formerly been in public health were moved over to DHS.

I'm wondering how you think that is going to be helpful or why you thought that was help, because a lot of those are traditionally public health programs—home visiting and other sort of primary prevention programs. We have been doing a lot of talking at the Commission about ways to integrate across agency systems, and I'm curious about why that happened and where you feel that is going.

Dr. Wolk: [Session 1 - 01:04:46] Yeah, I can start by saying I think what we are trying to do is find those areas of population health that align more closely with either DHS or with HCPF. This was before my time so I can't take credit for it, but I think it really is sort of to get that closer alignment or that better alignment.

Krow: [Session 1 - 01:05:15] I will say that we wanted to create a really robust Office of Early Childhood. So you will hear, I think, from Mary Anne Snyder later on the agenda, but we believe that having a nurse home visitor program that was aligned with our Office of Early Childhood and our Child Welfare Department might help us make sure that more children, to your point, Commissioner Rubin, were seen earlier on if they were entering our system or even at risk. And then having our Family Resource Center engaged and thinking about prevention in a different way, even thinking about prevention of fatalities. The Colorado Children's Trust Fund and the Maternal and Infant Early Childhood Home Visiting Program, just trying to think about how do we create prevention services before children get to the child welfare system? So that is some of our strategy, but we have worked more and more closely with public health and with Medicaid over the last couple of years and we are proud of what we have done.

Chairman Sanders: [Session 1 - 01:06:26] Commissioner Dreyfus?

Commissioner Dreyfus: [Session 1 - 01:06:29] Thank you very much, and Commissioner Sanders, as we have gone around the country we keep asking states, "Do you have a plan for reducing child abuse and neglect fatalities?" and I have to say this is pretty darn close. So congratulations. You have a lot of great things in there, and if you put it all together it is a pretty comprehensive way in which you are thinking about this.

Just very quickly, you didn't talk about this, but I would like to hear about the multidisciplinary nature of investigations. You talk about how you now are doing the egregious, the near-fatal as well as the fatalities in terms of the multidisciplinary review, but one of the things we are hearing a lot around the country is the differing levels of integrated work going on between law enforcement, child welfare, and other critical partners in the investigation phase of those incidents.

I was just wondering if you could speak to that.

Krow: [Session 1 - 01:07:24] Sure. We are a state-supervised, county-administered system with 64 counties, and we recently reviewed the memorandums of understanding that counties

have with their local law enforcement. We did find that that's an area we can improve upon. Some had very robust, integrated teams and were working closely hand-in-hand with law enforcement; others might have been working closely with law enforcement but hadn't updated their MOU for many, many years. Some had strained relationships, at best, with local law enforcement. So we know that is incredibly important. We would like to improve upon integrated teaming.

One thing that I would love to see, and I know that some other states have this, is a SACWIS system that would flag us if there was a new arrest or a new visit to a home by law enforcement, so that we knew right away. And I love the idea of having integrated teams that could go out both with law enforcement and with nurses, because we strongly believe that caseworkers could miss medical concerns of very young children, and having a nurse as part of the team would be very helpful.

Chairman Sanders: [Session 1 - 01:08:51] Commissioner Martin?

Commissioner Martin: [Session 1 - 01:08:53] Thank you very much for your information, and I do congratulate you on the work that you are doing here in Colorado. It does sound very, very promising.

I have two questions, and remember I'm coming from the juvenile systems, the court systems, so my questions are kind of based there or stem from there. When you have a family that you are working with in efforts to provide preventive care and you feel that the preventive care is not progressing, is there some mechanism that is in place to bring it to the attention of the court? Do you understand my question?

Krow: [Session 1 - 01:09:27] Yes. So I think the question was if we have prevention services in place, what is the mechanism to bring it to court? And yes, we have really worked on expanding our communication. That is part of the reason that we brought some of the preventative services over from public health with Dr. Wolk's support, so that there was that better communication between early childhood, between our public health prevention program, and between child welfare. We also rolled out online mandatory reporter training across the entire state just in the last couple of months. It is an amazing training, and it is built for nurses or for public health practitioners, and for school officials. So we have different modules, and people can take this training online and they can print out a certificate when they are done. So part of our effort is not only more closely aligning our programs but improving our training for mandatory reporters.

Commissioner Martin: [Session 1 - 01:10:31] So I would ask you to really focus on that. I think we are all involved in trying to prevent fatalities for children and abuse and neglect, but I think it is also imperative that we make certain that we have the legal standards provided for to come into court and not bring all the kids into court when we think there is an issue going on.

My second question really pertains to what I understand my families to do, and that is typically that they don't go to one pediatrician. They don't go to one clinic for medical care, particularly if there is some intentional abuse or harm going on. They typically rely on emergency rooms for medical care. So does your system kind of take that into account? Are you able to then connect families or connect Johnny Jones from one emergency room to the next throughout your system?

Dr. Wolk: [Session 1 - 01:11:23] Like I said, we are on the doorstep of that because we have spent the past several years getting every hospital in the state to now connect to the state health information exchange. One of the greatest challenges is the unique patient identifier and making sure that John Smith, is John Smith, is John Smith. So there are like 14 different elements that go into that, to make sure that we can make sure we are dealing with the same John Smith. Like I said, I think within the next six months or less we will start looking at the analytics to create the registries that then allow us to create the alerts so that these patients that move all about, for whatever reason, and obviously specifically for you all's interest, I think we will make this very exciting and really mandatory for all health care providers, because we have several thousand physician offices who have connected to the HIE, as well.

Chairman Sanders: [Session 1 - 01:12:38] Commissioner Petit.

Commissioner Petit: [Session 1 - 01:12:43] Thank you. We have been hearing, over the last few months, and we are hearing here today a lot of discussion about postmortem fatalities review process. We are also hearing a lot about prevention of a primary nature that every child born is happy and welcomed.

But let's just go to an advanced phase where we have a child who is in grave danger. He is living with a mother who may or may not be able to protect the child, there is someone that is coming into the person's life who has had a record of imprisonment for harming children, somebody who has broken bones in previous relationships with wives. And when Commissioner Dreyfus raised a question about the investigation phase, let's just talk about the protection phase for a moment.

So we have two systems that are at work here. We have a civil proceedings in which CPS can remove the child from a family. Then you have the criminal proceedings, which can remove a perpetrator from the child, right? Different standards of proof. And in my experience is on some of these more serious cases, social workers and public health nurses can't do a lot to protect a child. And you raised the issue of MOUs, which I think is a critical piece of the foundation that allows a community response that surrounds a child and protects a child. You expressed the fact that a number of them are deficient. You have got, what, 40 or 50 counties in Colorado?

Krow: [Session 1 - 01:14:06] 64.

Commissioner Petit: [Session 1 - 01:14:07] 64, which means you likely have hundreds of police departments operating within that. So when there is an imminent threat and your workers conclude, "This is a dangerous kind of situation," what is the nature of your relationship with law enforcement around the filing of protective orders or domestic violence efforts to enforce the "keep away from the family" kind of situation? Just exactly what is the nature of the relationship with law enforcement, good and bad? You have got, I'm sure, some positive situations that you might relate to us, but also some of the negative situations where there just wasn't enough firepower brought to a case. How do you guys manage that process?

Krow: [Session 1 - 01:14:49] Commissioner Petit, you are pointing out an area that I think we are just on the verge of improving, but we do need more work related to ensuring that protective orders occur for victims of domestic violence. We are submitting a new child welfare rule packet, and actually we submitted it last month, that strengthens our rules around domestic violence, but we are learning a lot and we know that we can do better. We actually moved the Domestic Violence Division from the Office of Behavioral Health into child welfare just last year because we see that so many of our fatalities are related to domestic violence.

We also don't believe that domestic violence is necessarily a behavioral health issue, and so it doesn't fit in the Office of Behavioral Health as well as it fits in my office of Children, Youth and Families and our child welfare agency.

Paige Rosemond, who is here today as my child protection manager, she has a background in domestic violence, and our new Domestic Violence Division Director, Erin Mewhinney, are working very closely together to explore this issue, because I think it is a gap and not enough is known about how we can make sure that those protective orders are followed and that law enforcement and child welfare are working as closely as we would like them to be. I think we are improving, but I think there is more that we can do.

Commissioner Petit: [Session 1 - 01:16:30] Just a related follow-up on that: When an individual has been charged with a criminal offense by the DA's office and the police have arrested a person, during that time awaiting trial, the person is still out and it's possible they may have access to a child. What does your department do? Does it ever deal with the district attorney's office in terms of accelerating the process by which an individual is brought to trial and justice rendered one way or the other; he is either free to go or they lock him up and keep him away from the kid? What is the nature of the relationship with the district attorneys and the chief law enforcement officers of every county?

Krow: [Session 1 - 01:17:05] That is a hard question for us to answer at this state agency because there are 64 different counties. So I don't know that there is a standard response for that particular situation.

Chairman Sanders: [Session 1 - 01:17:22] I would just mention that later today we will hear in some detail from El Paso County, and it might be helpful because I think there is a district attorney as part of that, so we will at least hear how it works in that one county.

Commissioner Petit: [Session 1 - 01:17:34] I agree, David, and I think that is a good point. The issue, of course, as we all agree, is 100 percent of the time brought to scale in every jurisdiction, right? I mean that is what is ultimately we need to be able to do on this.

Chairman Sanders: [Session 1 - 01:17:46] Commissioner Ayoub?

Commissioner Ayoub: [Session 1 - 01:17:50] I believe one of your recommendations was parenting skills education within the school system. What, if any, challenges or resistance do you face with that idea?

Krow: [Session 1 - 01:18:02] You know, this is an idea that I just have been thinking about in the last few weeks, so we haven't approached our local school system about this yet, or the Department of Education. But in thinking about presenting to this Commission, I wanted to be able to offer up some ideas that I thought maybe hadn't been necessarily rolled out across the country.

Commissioner Ayoub: [Session 1 - 01:18:28] For instance?

Krow: [Session 1 - 01:18:30] For instance, educating children about parenting skills, practicing real life skills, looking at things like SafeCare that we did roll out in Colorado. But it hasn't been tested in a prevention strategy related to screened-out referrals of abuse or neglect, so we are testing SafeCare in a different way in Colorado. So what I am intending to say is that I think we might be able to do more on the front end to educate parents about how to be good parents and some things they can do to not get involved in the child welfare system, if we were to start earlier with them.

Commissioner Ayoub: [Session 1 - 01:19:16] But you are talking about the school system, so you are talking about teen parents?

Krow: [Session 1 - 01:19:20] Teen parents, yes, or teens that aren't yet parents.

Commissioner Ayoub: [Session 1 - 01:19:23] Right, so do you expect some resistance, since it is usually controversial about sex education or anything?

Krow: [Session 1 - 01:19:31] You know, we have a great relationship with CDE, so I don't necessarily expect resistance.

Dr. Wolk: [Session 1 - 01:19:36] We have a very strong school-based health center movement here in Colorado, as well. So I think the opportunity is we morph those school-

based health centers from clinics into being medical homes for the students in the school that they serve. And again, as we push more into this population health era, there is a lot of opportunities for us to work through the School-Based Health Center Association, and we have a state fund that actually supports our school-based health center movement, not just federal funds. So again, there is a very strong commitment and there is a lot of opportunity for us to address this through that.

Commissioner Ayoub: [Session 1 - 01:20:18] Thank you very much.

Chairman Sanders: [Session 1 - 01:20:21] Commissioner Zimmerman? Commissioner Rodriguez?

Commissioner Rodriguez: [Session 1 - 01:20:26] Thank you. I think my question is a somewhat narrower question than Commissioner Ayoub's, but I'm curious in thinking about the earlier panel and some of the issues that were brought up around the inadequacy of the child welfare system in supporting youth in dealing with trauma while young people are in care. I'm wondering, you mentioned all of the robust preventive efforts that your state is focusing on, things like the presumptive eligibility for early childhood services and moving toward supportive services. If you are at all thinking about prioritizing young people who are in child welfare themselves and who are already parenting, because the research is suggesting that while some of the children may not be known, their parents are, in fact, known to the system and they're exiting care. I mean you said it very eloquently—they have the desire to be excellent parents, but they don't necessarily have the know-how because of their own early childhood experiences. But also in all honesty, because of the child welfare system's treatment and response to them while they are in care. This seems like a group that would be relatively easy to target. We know they are at risk, both because of their lack of supports in care and all the logistical challenges that we know former foster youth face as they exit care. It is a group that I care particularly about, being both a mother and somebody who grew up in care.

So I'm curious if you thought about prioritizing them for early childhood services, about targeting them in any of the nurse home visitor programs. I'm much more interested in the public health approach, to wrap them with supportive services, than I am to flagging them in some kind of system where there is a focus on taking away their own children.

Dr. Wolk: [Session 1 - 01:22:20] I'll just begin and sort of go a little bit outside of this to say we are looking into and getting ready to take a more serious look at this Healthy Home approach because if you think about it, between nurse-family partnership and child welfare, we have on the environmental side folks going into homes, especially if we are looking at disparities, here in Colorado, whether it is radon, whether it is asthma risks, whether it is lead. So we have all these opportunities and all these folks going into the home for all these different reasons, including safety. So our hope is to take this into a much more sort of proactive Healthy Home approach, where we can take into account and work with Medicaid to

see how we can come up with a reimbursement model here so folks can go in on a proactive, preventive population health basis to do an entire Healthy Home evaluation. Because I think, again, that is what is going to move the needle there.

Krow: [Session 1 - 01:23:23] I have a comment to add. In Colorado we have just completed a statewide youth plan, which was based on positive youth development, and a model called "Colorado 9 to 25." The plan addresses youth, from prevention all the way through the entire system. It is our first statewide youth plan. I'll give you one example, though, that is more specific. We were contacted by Mile High United Way a couple of years ago, and they had family unification vouchers that they weren't using. They had housing vouchers for youth that weren't getting out there, and the barrier was that these youths needed some sort of ongoing case management as part of a requirement of the voucher. So we partnered with Mile High United Way, Nurse-Family Partnership, and local county Department of Human Services to provide youths with housing vouchers, but also to have nurse-family partnerships in the home visiting those youths who needed the case management, and so it was a unique way to provide case management and not have to have an open child welfare case. Once the case was kind of settled with Nurse-Family Partnerships and the youths had housing, we could close their part of the case.

Commissioner Rodriguez: [Session 1 - 01:25:57] Just so I understand, on the broader sort of preventative programs that you are thinking of, is there any special attention being given to the population of current and former foster youth who are parenting themselves, who have a lot of the risk factors?

Krow: [Session 1 - 01:25:11] I would say yes. Through our Youth Unit we try very, very hard to prioritize youths that need these services in our system. In the broader population-based area I think that is mostly in Dr. Wolk's line.

Dr. Wolk: [Session 1 - 01:25:30] I'll defer to Lindsey for later if she has got some more specifics, but I think we are more about the overlap factors rather than specifically about whether or not they themselves came from foster care. I don't know if that is a particular sort of prioritization factor in and of itself. We will get Lindsey to give you a better answer.

Chairman Sanders: [Session 1 - 01:25:55] Thank you very much, Ms. Krow and Dr. Wolk. Thanks for indulging us with a number of questions that obviously extended the expected time of your presentation, but it was very informative. Also thanks to the next panel for their patience in waiting. So thank you, and we will bring the next panel up.

So our next panel will include presenters who will focus on the etiology of child abuse and neglect fatalities. Dr. Brett Drake, Dr. Desmond Runyan, Gary Melton, Dr. John Fluke, and Dr. Chris Graham.

I believe Dr. Drake is going to start.

Dr. Brett Drake: [Session 1 - 01:26:59] My name is Brett Drake, and I am a professor at Washington University in St. Louis. I am a social work professor with training in psychology as well, and I teach child maltreatment both in social work and in public health. I have been doing analysis on child maltreatment in large data sets for 20 years. A quarter century ago, I was a child abuse investigator in San Diego, California.

If we want to understand the etiology of something, we need to know what the thing is. It is a necessary first step. I'm going to try and be responsive to the Chair's request to give information that is applicable and useful in moving forward, rather than purely academic, and I have been very heartened by the panels that came before. I think you will find everything I have to say is very consistent with what you have heard up to this point.

There is no etiology of child maltreatment. Different maltreatment cases are very different and have different pathways. There are, however, some commonalities we can look at which turn up, and I am going to walk you through some of those things.

The first thing is that child maltreatment fatalities are generally attributed to biological parents. We hear a lot about mom's boyfriend. That does occur sometimes, but 80 percent of the time you are looking at biological parents. This is the same for fatal maltreatment and for nonfatal maltreatment.

Child maltreatment fatalities are most commonly related to neglect. Again, I think if 100 people brought up a mental image of child maltreatment fatalities, they would think of a beaten child. But neglect is more common. Again, this is exactly the same—child fatalities and child maltreatment nonfatalities.

There isn't a single indicator that is going to tell you who is going to kill their kid. This is the same for nonfatal maltreatment and fatal maltreatment. As I said before, they are very different pathways.

There are a few ways in which fatal child maltreatment is different from nonfatal child maltreatment. The main way, in my view, is age. Fatal child maltreatment generally happens before the 2nd birthday. This is a big difference, and it is terrifying because it means that we don't have a lot of chances. It means that speed is paramount.

Child maltreatment fatalities are often multitype. They are often involving different kinds of maltreatment. This is true of maltreatment in general, but it is beginning to look, with the emerging research, that it might be more true in the case of fatal child maltreatment.

The good news, of course, the very good news, is that fatal child maltreatment is very rare. If you look at the official national report data, you have got 75 million children and you've got perhaps a couple of thousand maltreatment fatalities, depending on whether you like to look

at NCANDS or whether you like to look at the National Incidence Studies, which are essentially the NCANDS source of data plus sentinels—going out to people in the community who should know about the maltreatment. Not everyone, just people like doctors and educators. They have a somewhat higher estimate, but you are still looking at a couple of thousand out of 75 million. It is about 1 in 40,000. That is about the size of a dinner plate on a football field.

Here is a visual representation of that. You will notice that we are failed by Excel here when you look at the total number of kids in the tall, blue bar. There is no blue on the chart for the number of fatalities all the way at the other side. You would have to blow it up. You would have to take the next largest column and inflate that massively to even see the number of fatalities. I'm not trying to do a happy dance here about how rare it is. I am trying to impress how extraordinarily difficult it is to detect a very few grains of wheat in an enormously large pile of chaff.

Fatalities are mostly or largely due to neglect, they are mostly very young children, they are mostly committed by biological parents, and they are very rare.

So what do we think causes it? What do we think is associated with it? There are a lot of different theories at a lot of different levels. I'd like to say we have a theory that gives you the tools you need to identify this accurately in most cases. We don't. On the other hand, we do have ideas that do lead us to helpful pieces of information. Some of these ideas are psychological. Is there stress in the family? Does the parent have good social skills? Do they have good coping skills? What is the role of modeling and social learning theory? There is a lot of concern about dyadic issues. What kind of attachment do we have? What kind of bonding do we have? Increasingly, there has been a lot of attention to the environment. What does the community look like? What is the role of socioeconomic devastation in causing this?

Causal and associated factors: What do we know from sort of actuarial approaches and looking at generally large data sets? What seems to be associated with fatal maltreatment?

Things about kids: low birth weight, small gestational age, prematurity, and behavior issues. There are some specific things to particular kinds of maltreatment, like insoluble crying has been linked to certain kinds of physical abuse.

There are all kinds of familial issues that we know are linked with maltreatment and fatal child maltreatment: low parental education, poor parental mental health, stress, attitudinal issues, depression, authoritarianism, and inappropriate expectations about the child.

Family structure is associated: no father present can increase your risk, and nonrelatives being present can increase your risk, although it is very rare that nonrelatives are the perpetrators.

You will hear "social isolation" a lot. Young parents tend to be overrepresented among maltreatment and among fatal maltreatment cases. There can be a crisis that causes events to spiral out of control. There can be other kind of usual suspects: parental drug use, parental alcohol use, and domestic violence. All these things may have some association. Those associations are not necessarily causal, but they will serve as good markers, even if they are not causal.

Again, ecological issues are beginning to come to the fore. Poverty seems to be a particularly strong predictor.

Those risk factors generally apply to both maltreatment in general and child fatalities in particular. They don't give us, perhaps, as much leverage as we would like in differentiating between the two, but they do see child maltreatment cases which are fatal may well have more, and perhaps more serious, risk factors. So they may leave a bigger footprint. There may be more clues for cases that are going to be fatal maltreatment cases.

We talked about the fact that there are some things where you need to desegregate type of maltreatment in order to understand the risk factors.

I'm going to give you some of my views on the data as well as giving you the data, because I think we need to move it in an applied direction. I think it is useful if we have the information already. Not everyone in Colorado has a Beck Depression Inventory on file, but everyone in Colorado, ideally, with a good data system such as we heard is being built, and you will notice that was being talked about as being built in a matter of months not a matter of years. Thank God we are moving past the point where everyone believes this is a multimillion, multiyear task. It isn't. I personally, with no computer training, built an integrated data system to support my research from the state of Missouri, working about two hours a day for about a year, at a time when I was making about $50,000 a year.

Okay, so it helps if we have information. There are things that we know about people: arrests, emergency room, things like that. Where they live, socioeconomic indicators. It would be good if we had predictors applied to all forms of maltreatment, and it would be good if the indicators aren't things ... it's a sad confession, but scientists obsess about things that cause 5 percent of variance to change, 20 percent of the variance to change. We need things that have big effects because we need to do some major sorting here.

It seems to me the prior reports are very useful. There is an old saying in psychology, "Prior behavior is the best predictor of future behavior." If you are known to CPS in the past, you may be six times more likely to have a fatal child maltreatment report. This is good and this is useful, but two-thirds of fatally maltreated children don't have prior maltreatment reports.

Another very useful indicator is socioeconomic status. The more I am in this field, the more it is clear to me that poverty, although it may not be cause, is a good indicator. The National

Incidence Studies declined to do analysis on fatalities because they are so rare, which, by the way, is the reason we don't have a lot of research on fatalities. But if you do some back-of-the-envelope calculations by the data they give in their appendices, it appears that poverty is an even better predictor for fatal maltreatment than it is for general maltreatment, and it is a very good predictor for general maltreatment.

I encourage you to think of prior reports in the same way the former panel is obviously thinking about them—not just CPS reports, but medical records and other forms of information. You have heard about accessing some criminal stuff. We are not in the industrial age anymore. We are in the information age, and we have a sort of a Willy Wonka problem. We have a failure of imagination and a failure to realize that the big gun now is information. We need to use it. I'm a big proponent of putting together the sorts of approaches you heard about from the last panel.

Suggestions for prevention. These are not things that I necessarily came up with in my fertile imagination; these are the things that, if you read the scientific literature, other people have said before me. But I am going to kind of put them together here and kind of, again, give you my take on it.

Speed matters. If a child is dead before he is 2, you have got to get to that child. Speaking as a former child abuse investigator, the single thing which chills my bones is the thought of a family that is socially isolated and has very young children, and there are no eyes on that family. That scares the hell out of me. We need to use all the available information we can put our hands on to know about those families, to understand and to get some early eyes onto those families.

Point two. I believe that data are seriously underused. Information from child welfare and other systems should be combined and accessed in real time or near real time. There are programs like the Birth Match program, which simply combines vital statistics and prior child maltreatment data, which is responsive within a 12- to 24-hour decision frame. That is the sort of speed that is easily achievable with the technology that exists in the world we live in.

Getting voluntary service. This is, again, what you heard from the prior two panels. Getting voluntary services to young, multiple-risk families is a really good idea. It is a good idea because some of the services we provide can have some beneficial effects, although not nearly as much as we would like. We don't have anything like a rabies vaccine. We have interventions which have some effect, but which don't have anywhere near the effect we would like them to have.

But that is not the only value in serving these young families voluntarily. The other value, again, is you get eyes on these families. We need to have people out there seeing these very young, very vulnerable children. There are states that are experimenting with these kinds of programs. That is to be applauded. That is what we need to do more of.

Archimedes said, "If you give me a place to rest my lever, I can move the world." In my view, the place to rest the lever is information, and the lever itself is voluntary services to a group of families that are at risk on a series of dimensions like prior reports, young age, and extreme poverty. I think that, based on the ideological literature, is my take on practically how we might consider moving forward.

Thank you very much.

Chairman Sanders: [Session 1 - 01:39:40] Thank you. We will, after all the presenters, have opportunity for questions. Dr. Runyan?

Dr. Desmond Runyan: [Session 1 - 01:39:53] Good morning. My name is Desmond Runyan. I am a pediatrician and the director of the Kempe Center here, and I am a clinical epidemiologist.

I'm going to just talk a little bit about some of the data you have already heard and put a little bit different spin on it, with some data that we have been collecting from parents across the state.

We have been doing surveys of parents themselves, about how they rear their children in both North and South Carolina and now in Colorado, and we have rates in which parents tell us that they have done harsh things to their children that we would regard as abuse, such as kicking, beating, knocking down, and just hitting with an object someplace other than the buttocks at rates that are dramatically higher than rates of official child abuse. We have numbers of 240 to 430 per 100,000 children, or roughly almost 4.5 percent of children. Interestingly, that harsh behavior that parents tell us they have done to their children peaks with much older children—from 9 to 12—not the children that are the highest rate.

Interestingly, parents tell us that girls get more physical abuse than boys. That harsh punishment is dramatically higher for girls than boys. We don't know about the youngest or only child. That peak maternal age for that harsh punishment is for your relatively young mothers with young kids, and so these are moms who were teenage years who are now peak maternal age in the 20 to 25 age group. Single parents appear to be about 1½ to 2 times higher risk for use of harsh punishment.

Income is interesting, found in studies in North and South Carolina to have little relationship between income and harsh punishment, and there may be some cultural things, as we have been hearing with Adrian Peterson lately in terms of the South, because we have much more use of objects on kids buttocks and hitting with objects that we found in North and South Carolina than we have done in Colorado. We also found a little bit stronger relationship between income in Colorado and the use of harsh punishment.

This contrast of what we know about nonfatal physical abuse, in which the rate is about or a little less than a 10th of the rate that we had for what parents actually tell us, and there are statistics in North Carolina suggesting that the rate of what parents tell us they have done is 20 times the rate of child physical abuse that social services knows about.

The peak age is a little bit younger for the kids who get reported to social services, at 6.3 years. The gender is more evenly matched at male and female. Thirty-one percent of the children are the oldest or the only child. The maternal age, again, is relatively young. Marital status, unmarried is at a little bit higher risk, and single parents appear to be a little bit lower risk for physical child abuse, according to official statistics.

Let's contrast with fatal child abuse. This point was already made by Dr. Drake. The rate of physical child abuse pales in comparison under the rate of fatal child abuse. The overall rate of all child abuse fatalities is 2 per 100,000, or you will recall that I was at 230 to 460 per 100,000 for just physical abuse alone. The peak age, again, is very much younger than the age at which children are generally physically abused, and the gender is dramatically different as well. The girls are at much less risk of fatal child abuse compared to the fact that they get more overall physical abuse, and maternal age is a little bit higher; unmarried with partner is higher risk. Single parents are, again, lower risk in terms of these reports.

I wanted to share this slide with you, and I hope you can see it. This is an international study I was involved in, and we looked at the rate of harsh physical punishment, and this included beating up, knocking down, hitting with an object someplace other than the buttocks. In 19 different communities around the world, and they ranged from the slums of Delhi to Chennai, and Chennai was the safest place in the world and the slums of Delhi were among the most dangerous in Bhopal. And the line that is on this graph is maternal years of education. And the safest place in the world was Chennai, where the women had an average of 15.3 years of education. The most dangerous place in the world was actually rural Bhopal, where the women averaged less than two years of education. That is average, and 40 percent had no education. So maternal education by itself, the correlation between the use of harsh physical punishment in this 19-community study and maternal education was –.734, suggesting that more years of mother's education by itself would be one of the most protective things for children.

Our other shaken baby work has some other lessons. We just completed a study on abusive head trauma in a military birth cohort. You may know that the military has followed all the children born for their first year and all their medical concerns. Actually, it goes back to Vietnam and Agent Orange. And so we, a cohort of over 660,000 children, to take a look and see what we could find about which children were shaken and died in that context. We found that enlisted men were 12 times higher risk than officers. Officers had a rate of shaken baby that was about a 10th of the rate of the general civilian populations. These are educated, older parents. In contrast, enlisted men and women in the military, and they are not different from young men and women elsewhere, had a rate that was 12 times higher, and it related to

education, and income, and support. And we certainly found that stress of deployment and stress from disasters both increased the risk.

We also observed in our shaken baby work that we have done a lot of education efforts on the Period of PURPLE Crying and shaking, both in the military and civilian populations. We did a cohort study of over 600,000 mothers and fathers in North Carolina. We found no impact at all on the rates of children being hospitalized for shaken baby syndrome. So I am a little bit nihilistic about parent education classes as fixing this thing. My conclusion is that if we delay childbearing, if we allow children to be children and wait until they are adults to be adults, and if we made sure that people had a chance to complete their education, in particular the girls, those two things probably would take care of close to 75 percent of the problem.

I think I will stop there.

Chairman Sanders: [Session 1 - 01:46:50] Thank you. Dr. Fluke?

Dr. John Fluke: [Session 1 - 01:46:57] Thanks for the opportunity to talk a little bit about child maltreatment data. My intent is to talk a little bit about the sources of national child maltreatment data, some of the trends, some of the limitations of the data, and then also talk about some of the basis for some international comparisons and what some of those implications might be. Among the questions are: What ways are the data that are currently available useful in understanding etiology? And can these data be translated into insights that are useful for policy?

The two sources that I want to talk about for national data are the National Child Abuse and Neglect Data System and data that are available through the Centers for Disease Control and that are also the basis for data that are provided to the World Health Organization.

The data from the National Child Abuse and Neglect Data System are provided from CPS agencies and also aggregate data from other sources than CPS. I think their limitations are pretty well known. They depend upon the particular environments within states, and policies, and the local ways that individuals are involved in reporting those data. And a range of fatalities may not be counted, as a consequence. It is very difficult to get definitional consistency, for example. The CDC data are based on ICD codes, 9 and 10 at this stage. They have to do with maltreatment-related violent injury, which is a specific clustering of ICD codes. It doesn't really address neglect, except in some limited ways, and the rates are a bit lower than they are in the National Child Abuse and Neglect Data System. But they also reflect a broad set of conditions that may or may not reflect what state CPS agencies would consider to be child maltreatment.

The major point, I think, that I want to make with respect to maltreatment fatalities is that our current approaches don't appear to be improving the situation for children, and that is based on looking at the trends that these data represent. When we are looking at the NCANDS

data, for example, we have looked at trends for about a 13-year period, which are included in the materials that were developed here. I'm not sure this will work; this is a movie that we prepared. Basically what this shows you is the rates in each of the states in the U.S. over the 13-year period that we are talking about for the NCANDS data. And I think that one of the things that you might notice is that there is no particular pattern to this data, but it is relatively consistent from state to state and from year to year.

The other thing that we looked at was the possibility that we could identify states that had extreme rates, either below or above the average performance, year after year. And again, looking for particular patterns, the yellow indicating instances that are above, and the blue indicating instances that are below the average rates. And again, states will occupy rates that are very high above the median or average rates, other states will occupy values below, and that appears to operate at random, and I think this is something that is very important to keep in mind when we are talking about patterns of maltreatment fatalities that may be very, very difficult as a result of some of the low base rates that Des and Brett described that make it very difficult for us to identify a common, consistent pattern in data that occurs at such a low base rate.

When looking at data from the CDC, what we did was to look at trends based on the World Health Organization data, and again those data were provided by the CDC here in the United States.

These are some definitions regarding violent death due to homicide, inflicted injury, injury of undetermined intent, physical abuse or assault, and it may be violence that is perpetrated by caregivers and therefore physical abuse. So these are the things that are included in the ICD codes.

If you will notice, this is data for children under age 1 and rates per 100,000—the red line at the bottom. Again, this trend over a very long period of time is very flat, very stable, and hasn't really changed very much over the course of the years that it has been collected. Again, for ages 1 to 10, the lower red bar representing fatalities and violent deaths, according to the CDC data. It is very stable and not changing.

This is—I think the story that I wanted to make clear is this: We really have not, with all of the reforms, all of the changes, all of the policies, all of the funding that we have implemented to date, really been able to move this needle much at all. And part of what, to me, is disturbing about that is that when we do international comparisons for maltreatment-related fatalities, they indicate that children in the U.S. are at great risk compared to other high-income countries. These are relative-rate data, a little difficult to understand, but the basic concept is that these values that are represented in the red bracket are those for the United States, these in the green are those for Sweden, and the rates are more than 10 times greater. For me, what this means is that prevention is key. Public health strategies, I think, are those that are most poised to result in reductions in maltreatment, and that the

experience of other countries, and I think this is really important, suggests that maltreatment-related fatalities can be reduced. That we don't have to contend with the levels of fatalities that we are currently operating within the United States.

But we have a dilemma. And that, I think, is that it is very difficult to develop effective public health strategies in ways that are consistent with our values or where our values are not in conflict. We may be able to talk about some of those ideas a bit later.

What is important, from my point of view, in thinking about the measurement issues, is that we need to have measurement that is consistent with public health policies. That is probably the most important single thing we can think about from the point of view of developing improvements in our data collection programs. These needed to be guided by public health strategies, and other needs for fatality data are important but I think are probably less helpful at the state and national levels in creating conditions for reduction. We have a long way to go, and I don't believe that other sources of information are necessarily going to be productive in the same way.

Finally, U.S. values, I think, may be barriers—but then I also think that they create opportunities for creating solutions that are uniquely based here, and I'm very optimistic that if we consider those values both in the short and long term, we can make progress.

Thank you.

Chairman Sanders: [Session 1 - 01:56:22] Thank you, Dr. Fluke. Dr. Melton?

Dr. Gary Melton: [Session 1 - 01:56:28] Good morning. I'd like to start by doing a couple of caveats related to some roles that I've been in that relate to your work, and then to go to the clear assignment.

First is I am co-editor of *Child Abuse & Neglect*, which is the major international journal on child maltreatment. So I see a very large proportion of what is produced in the field these days, and I will tell you that it has expanded enormously. We do 12 fairly large issues every year. On the other hand, it is incredibly skewed. And the thing that I would say, and I will give a couple of reasons why in a moment, is that the research that we really need, we don't have, and we are not doing it for the most part. If you look at that in particular, I just took the last three issues of *Child Abuse & Neglect*. There were 43 articles published, and 21 of them were on the effects of maltreatment, and I would suggest to you we are a long way past the point where we have to show that child maltreatment is bad for kids. But that is basically where the focus in the field is still, at this point.

There were no articles on policy, there were none that argue, at least as I would construct, that were specifically focused on what we need to know about the context in which maltreatment occurs so that we can prevent it on a moment-to-moment basis. The closest to

that, by the way, was a study of cultural adaptation of SafeCare, which is probably framed as a secondary prevention program.

But in any event, when you get beyond programs, and there is not much on that either, in the journal, to the point of what is happening in the context that makes maltreatment more likely to occur … or to put it differently, where are the leverage points in making kids safe so that the situation demands that safety occurs, that is not being done very much either.

There is, I think, one article on fatalities out of the 43. So the reasons for this are: one, that it is hard to do the research that we really need to do. It is hard to do research that looks at the community level, that looks at even the settings that children are a part of on a day-to-day basis. And when we are looking for fatalities in particular, as has already been indicated, the base rate problem is a huge issue when we are talking about neighborhoods that may have in the thousands of people living in them and we are used to thinking in terms of a denominator of 100,000 for fatal maltreatment. You simply can't show what is going on in terms of effects across time at the community level very easily.

The second is etiology. We tend to focus on finding those people, and I would suggest to you that is a failed strategy, and it is inherently a failed strategy because in fact we don't have syndromes that separate people in that way. There is a long-known principle in social psychology called the fundamental attribution error, which is that both the general public and professionals tend to overemphasize individual factors and underemphasize situational ones, and that certainly has been true in the research in this area.

The third is funding. Dr. Runyan was part of the National Academy panel that met a year or so ago across the year and repeated what has been done before and what the U.S. Advisory Boards also indicated, which was that the amount of support that is being given on a dedicated basis to child maltreatment research relative to other public health problems is minuscule. And it shows up in the journal, if you look down at the bottom at the footnote, it says who supported this. And in the majority of cases on child abuse and neglect, that paragraph is blank, which means that folks are doing it out of their own work. And what do you do then? You take a captive population, if I can be a little bit cynical, of adults in a clinical setting or in an undergraduate psychology class, and you ask them what their history was as a child, and then you correlate it with something, and then you make a conclusion about effects. That is a lot of what is done in the area, and it is because folks don't have the resources to do something, or that is one of the reasons.

Second is I was vice chair of the U.S. Advisory Board on Child Abuse and Neglect in its early years or member the first four years. And I know you have got a statutory charge to look at what that board did. Let me throw in here, don't focus on the 1995 report. It is a good report, but it is not going to give you the answers to your mission. The report to pay attention to is the 1993 report, which is called *Neighbors Helping Neighbors*. The Board postulated a neighborhood-based strategy for child protection that was based on the assumption the

problem really is complex, and that to deal with it the answer is not hiring a lot more social workers, it is changing everyday life—a modest goal, I might add. But I will show you in a moment it is possible to do.

I think the conclusions here … in terms of if I can quickly look at what we know about community factors, again, the research here is not on fatalities specifically because of the base rate issues. But what I can say is that if you look at the kind of factors that are most robust, that are strongest in the prevalence of maltreatment, they are not psychological factors. They boil down; in the way I group them at least, into economic poverty and social poverty. By "social poverty," I mean people not being connected to each other both individually and across the community so that there is now a fairly large body of work that makes that point, along with some other secondary points. For example, the work Bridget Freisthler has done in California that shows that ease of access to alcohol and illegal substances shifts the maltreatment rates, in particularly the serious maltreatment rates in communities. So you can look at liquor licenses, for example, and see something that has to do, especially if it is also in the context of economic poverty.

On the other hand, you can look at positives. So you can take communities of equal wealth and look at how many daycare licenses there are, since one of the main places that maltreatment gets into the public system, at least, is with kids being left alone. So what does it take so the kids are watched? It is kind of a logical look at that. And it turns out that having more child care resources in a neighborhood decreases or is associated with a decreased maltreatment rate.

I think there is a number of groups and individual researchers, and what is striking is the same kinds of findings about the importance of community wealth and community wealth in a social sense, and I will explain what that means in just a moment. Those two factors being really important.

There is Jim Garbarino working in Chicago, Claudia Carlton and Joe Portman in Cleveland, Jim McDonnell and some others among us in South Carolina, Bridget Freisthler in California, Brett Drake did some work of this sort quite a while ago and was one of the first people to do it in Missouri. Clifton Emery in Southeast Asia, Asher Ben-Arieh in Israel, and so on, all showing more or less the same thing.

The particular set of findings that I find the most persuasive in ways about this is some work that my former colleague, Jim McDonnell, did when we were doing projects in upstate South Carolina, which will lead to the intervention side of this in just a moment. One of the things that he did was to drive through neighborhoods simply to check things you could see. He never talked to anybody, but checked, for example, were there fences up around the yards, whether there are signs saying, "There is a dog here," whether, on the other hand, there is a sign saying, "This is the 'whatever' neighborhood," whether there are people on the streets, and so on. It turns out that just those things you can see about the physical characteristics of

the neighborhood, which obviously reflect the social characteristics too, but those things account for about 30 percent of the variance in hospital admissions at the neighborhood level for maltreatment-related conditions. That is way more than anything that is psychological. And the reason why it is so important is because the things that you can see are also the things that parents see and that reflect whether or not they ultimately believe that they can make a difference for their families in their community. And when you get to the kind of psychological factors that do have some relationship, they are mostly around this sort of thing of having the capacity or perceived capacity to cope with adversity when it occurs, and so on.

And by the way, that 30 percent of the variance is after controlling for all the demographic factors. So anything you can get census data on, the housing values, the average income in the community, the residential stability, race and ethnicity, that is controlling all of that. Still, what is a good neighborhood, in essence, in terms of whether kids are safe in their own homes, by the way, because we also did random surveys with match comparisons and across time. We did random surveys of parents of young kids and the proportion of variance in their own account of how much care they gave their children was pretty comparable to what we were seeing in terms of emergency room data.

Let me give you the good news on this, which is you can do something about it. I just had a colleague send me a note about some work we are planning, who said, "I am personally and professionally overwhelmed," in terms of thinking about this. But it is doable. It is not that easy, but it is doable. In the Strong Communities for Children initiative, that I think you will have a handout, it is the operationalization of the U.S. Advisory Board's recommendations for a neighborhood-based strategy. It was done with foundation funding primarily, over about an eight-year period in upstate South Carolina, which is a very diverse area both in terms of ethnicity and also the population concentrations, so it is urban/suburban communities, mill towns, rural, etc. At the time that this was done in early 2000, there were about 125,000 people living in the service area, and we engaged more than 5,000 volunteers and more than 500 organizations. But this isn't the social service agency, it is the churches and other religious institutions, it is the civic clubs, it is the small businesses, it is the fire department, it is the primary school, etc. It is the people that are in your neighborhood, a la Mr. Rogers.

What we found was, by the way, that the communities with the highest need were also the most engaged. It took them a while, but the level of the community, for example, the census tract area that was the neediest, had about 10 percent of the population, about 40 percent of the volunteers, both in number and in time. What folks came together to do was to keep kids safe. The way we operationalized that was in terms of a basic principle that people shouldn't have to ask. So the goal was that every child, every parent ought to know that if they had a reason to celebrate, to worry, or to grieve, somebody would notice and somebody would care. In terms of the work with the organizations and individual volunteers, what we tried to do then was to look at what could be done and how you spend your time day to day that would make it more likely that kids and parents of young children in your community and your

neighborhood would feel noticed and cared for at those times that we all would like that. It is essentially golden rule thinking.

To give you a concrete example of that, there is a small fire department in a neighborhood that has been on decline since about 1930. The schools have left, the kids are bussed. There is, I think, maybe a convenience store, but basically no businesses and a few storefront churches. That fire department used Homeland Security money to build a new fire station, and when they did they put a front porch on it. It has kid-sized as well as adult-sized chairs, has lots of meeting space—it is the community drop-in place. Every firefighter has a half dozen kids that they see every day. They are the ones that, when we were doing this work, organized and went to knock on doors. They didn't change how much time they worked; they changed how they did it. Firefighters are a group, by the way, that are grossly underutilized in child welfare. They have got a safety mission, they have got respect in the community, and they have got time. They often have a secondary mission that is like emergency medical care.

What happened with this? The first thing is, to my amazement, the child maltreatment substantiated reports went down fairly substantially. If you look at the second page of the handout, and it is particularly so with the more focused on families with young children, and we focused on people giving both social and material resources, helping each other reciprocally. With that, then we showed the biggest changes relative to comparison groups with the youngest children and also in terms of prevention of neglect. The same in terms of what, to me, is even more convincing even, the emergency room visits and hospitalizations for kids—again, a decrease of 68 percent in the service area, relative to 19 percent in the comparison area, and for the kids 2 and under, 23 percent down and 6 percent down, etc.

We used other data that were already being collected for elementary schools, with surveys of teachers, parents, and children, and showed relative to comparisons and across time a greater perception of safety at school and on the way to and from school, and school being welcoming. And then again in random surveys of the parents of young children in the community, most of whom, of course, we never met, you can look at the list of things that changed. It is essentially the norms of how people take care of their kids and how they perceive the community to do it.

In terms of the next steps with this, to close, to me the big thing is the Board's primary recommendation is for what we called "Prevention Zones." But basically, for trying out full-scale efforts with these kinds of principles behind them that engage the whole community in building safety for kids day to day, making child protection part of everyday life, we are currently starting some replications in Colorado and in Israel. And the things that we are trying to do now, since we have shown you can do it, is to show how we can do it even more efficiently. So we are talking about questions about primary health care you are interested in. We are working with our Department of Family Medicine and with other providers, including possibly the Army Hospital in Colorado Springs, to build well care as the base of the system. So using group well visits as the way to organize people and to connect them to community

institutions, and then with the University of Colorado, Colorado Springs, and Tel Aviv University, we are also trying to make campus-wide emphasis that brings university students into being the supplements to outreach workers who, by the way, are the key to this. We had one outreach worker to a town. One person really can make a difference.

So this is doable, and we need to look more at how to do it to adapt it in different kinds of settings.

Thank you.

Chairman Sanders: [Session 1 - 02:16:36] Thank you very much, Dr. Melton. Dr. Graham?

Dr. Christopher Graham: [Session 1 - 02:16:42] Yes. Good morning. My name is Chris Graham, and I was one of the authors of the Texas Child Fatalities Study, and I've studied caseworker decision-making.

First of all, I want to thank the Commission for your work in this matter. As I have prepared for this talk, I have realized the extent to which you are bringing together information from a lot of different areas and synthesizing it. I think you are really doing a service to the field in this regard. I also thank you for inviting me here today to share my views with you on etiology and directions of future research for understanding the causes of child abuse and neglect fatalities.

I don't know if the point has been made to you before, perhaps it has, but there are many, many child fatalities, an unknowable number, that are prevented. You may have heard some number, like there are four child deaths related to maltreatment every day. Well, also there are deaths that are prevented every day, and this is much to the credit of caseworkers, and supervisors, and people throughout the child welfare system, some of you at this table included, I'm sure.

It is important to understand that, and that this is relevant to etiology because the risk factors for a child fatality that happens may be different from those of a child fatality that is prevented. I think one direction for research would be to understand why certain cases that turn out to be child fatalities were not reported to begin with. We know that being reported to CPS is a risk factor for child fatality. Sure. Because risky families are reported, as they should be. But it is also a risk factor *not* to be reported when they should be, because it is a very risky situation. One thing we learned from the Texas Fatality Study is that the risk factors don't happen in isolation; they happen within the context of a system, these that are reported to CPS. So starting out, we looked at something like immediately dangerous situation or severe harm, and you would suppose that these would be risk factors for child fatality. But lo and behold, they turn out to be protective factors. Now why would an immediately dangerous situation be a protective factor? Well, it is because people were investigating this case, and they saw, "Well, this is an immediately dangerous situation.

There is severe harm. Let's do something. Let's mobilize. Let's get this child protected." And it tended to convey some protection.

On the contrary, some factor that you would think would be protective, like say, a cooperative caregiver or cooperative with CPS. That might be a dangerous factor in terms of child fatalities within the context of the system, because it may lull the caseworker, or if there is good protection, for example, it may lull the caseworker into a false sense of security, and then they are not looking deeper at some of the underlying patterns of risk that convey risk for fatality in spite of that.

Understanding is very important, and that is going to be a theme. There have been great strides, and you have heard some, I know, about predictive analytics and in our own study. In spite of the low base rate that some people have mentioned, we came up with a model, and this is in a validation data set, we came up with a model that had over 80 percent classification accuracy. Less than 20 percent of the cases we were looking at were misclassified, either as child fatalities or not child fatalities. And looking at advances in other fields, I believe within the context of CPS it is really going to be very possible to identify with great accuracy which particular families are at extreme risk and get them help. But the thing I want to stress is that prediction isn't enough. Identifying risk factors isn't enough, even predicting very accurately isn't enough. We need to go beyond that to really understand what is happening in these families. And the reason is that, for one thing, we need to justify intervention. Going to a court and a caseworker saying, "I have a bad feeling about this," doesn't usually suffice. Courts typically want to see some behaviors that are harmful or some immediately dangerous situation, and we depend upon research that has yet to be done to be able to say, "These may be subtle factors, but this is a very dangerous situation for the child, given this risk factor, and it does warrant intervention, even though there is nothing really tangible we can put our hands on."

Another reason understanding is very important is for treatment, because just removing a child out of a situation isn't necessarily the best approach. And to really treat the situation, the family context, you need to really understand what is going on there.

So I think it is not just looking at risk factors, but understanding the interactions of the factors, the constellations of risk factors in a particular family, and the patterns of risk factors over time, rather than just focusing on those that happen to be prominent at a given moment. These are, in large part, chaotic families, and there may be recurrent cycles of crisis. There may be an immediately dangerous situation, but by the time that it is reported and by the time the caseworker gets in there, it is somewhat resolved, and they say, "Well, we're not finding this is such an immediate threat anymore." But it may be a recurrent thing, and the next time they may not get better in time.

Also I want to emphasize that etiology and understanding causes depends both upon good data and also evaluations of the treatment, because you may think you know what the causes

are, and you may design a treatment, but then when you apply the treatment it may or may not work, and if it doesn't work, that informs your understanding, "Well, maybe the causes were somewhat different than what we think."

The etiology, if you look up in the dictionary, it is the study of origin and causes, and the origins may be very internal, having to do with neurology or sociobiology, caregiver capacity, gene by environment interactions and so on. The contributive causes can be at all different kinds of levels, and not just that, but also having to do with family dynamics and social conditions, as Dr. Melton was emphasizing, and systems responses or lack thereof. And this is something I will return to, that things about caseworkers and even CPS organizations can be understood in terms of etiology being a risk factor for child fatality. If the caseworkers are overburdened with workload and because of that are going in and just focusing on a particular allegation and saying, "Is that allegation true or not?" And then saying, "Well it's not true" or "It seems to be under control," and getting out of there, then they are not taking the time to understand the big patterns of risk in that family. And there may be other things that weren't alleged. Maybe it was a physical abuse allegation, but neglect is the problem that would result in child fatality if it is not resolved.

I read in one of the documents, preparing for this, from the Commission that you are interested in factors that are very distinct to child fatality in particular, rather than just maltreatment, and that is understandable, but I do want to say that risk factors for maltreatment are also risk factors for child fatality, as Brett was mentioning. They may be more intense, they may be in more combination, but for this reason, understanding maltreatment will also advance our reducing child fatalities better. Domestic violence, mental health, and substance abuse—these things occurring in combination may be especially dangerous for child fatalities, even though in isolation or at lower levels, they are in many of the cases of maltreatment.

I wish I had more time to talk to you today. I really have a lot in my notes and I see that my time is elapsing quickly. So let me just hit some of the high points beyond what I've said already.

Another thing I wanted to mention is that child fatality is an outcome, it is not a disorder. We wouldn't try to understand the etiology of death or fever deaths, that wouldn't get very far. We might be able to get them some medication that would reduce the fever, but to really treat the disease or disorder you need to understand more fundamentally what the agents are and what is going on. I think it is the same way with child fatality. We need to start understanding particular syndromes or dynamics that result in it, and I think this is important in terms of reporting, too—not just reporting how many fatalities there are, but how many fatalities there are due to these different ways and different situations so that researchers can start getting distinctive risk profiles for the different ways that children die.

I also want to say that we learned in the Texas Child Fatality Study that interactions can work in more than one way. For example, an immediately dangerous situation and severe harm was predictive of child fatality, but it might be both of those are present, which we would understand, but it might also be that both of those are absent, because when it is not an immediately dangerous situation and there is not severe harm, caseworkers may think, "Well this is a safe situation," when it is really not because there are other factors that are perhaps more subtle that are involved, such as lack of connection between the child and the caregiver, or something like child vulnerability and the caregiver being somewhat self-absorbed and narcissistic. Things that are difficult to document and understand but nonetheless can result in child fatalities.

Much of my work has been framed within the decision-making ecology, which Dr. Fluke and Don Bowman in particular have proposed that talk about they are not only being case factors but also organizational factors, caseworker factors, and I'd add social factors that contribute to any outcome, and child fatalities can be seen as such an outcome.

Factors from these different domains should be understood in terms of that etiology of child maltreatment. So even work that helps us understand how caseworkers are rewarded in their jobs, and what keeps them on the job and gives them the seniority to develop the expertise so that they can recognize these patterns in the families. That is where there is the study for etiological research is, in this area. Because this is a difficult problem and we need not just one approach, even though sometimes things are pitted against each other. I think we need both predictive analytics and clinical judgment. I think we need both a public health approach and also an investigative approach. I don't have time to go into detail, but these can inform each other so you can look at arcane, statistical interaction terms in a predictive model and then that can inform clinical judgment as they are better understood. The research into etiology can help us understand, "Well this is a problem where a public health approach would really help advance it, but here, this has to do with some mental health issues or something that a public health approach isn't going to get as much traction, and it will help us to more tailor the interventions into more effectively intervene in ways that can most address the problem.

We found in this Texas Child Fatality Study a number of interactions—two-way and three-way interactions that really did contribute to high risk. And I don't have time to go into detail about those, but I think that it is worth understanding that it is not enough just to say, "Here. Is this risk factor present or absent?" "It is safe," or "It is not safe." But it does really require a more subtle understanding.

Another point is that you know that many child fatality cases were not in the child protective services system or the child welfare system at all, we are told, and yet some have hidden histories. It is through integrating data sets across multiple agencies, and even within the agency there may be a person in this family constellation that was even listed on another case, and the cases weren't merged properly or they may have shown up in other systems, or

in another state, or so on. This has to be taken into account in order to get the full picture of what is going on.

Finally, I have about a minute to tell you a little bit about evaluation, but as I was saying, I think it is important and it is especially because many of the cases aren't within the child welfare system so it may mean evaluating interventions that are more general. For example, home visitation or supportive housing or CORHIO, or ROSC, recovery-oriented systems of care for substance abuse treatment, if child fatality is considered as one outcome of these and there are analysis done so that the program evaluations can be seen with as large an *N* as possible. We may see that some of these other programs really are having an effect at reducing child fatalities.

So I think we need to depend upon integrating multiple systems of data to better understand the causes of these fatalities, and then learning how to adaptively bring to bear multiple systems of care to prevent them based upon an advanced understanding of etiology.

Thank you for your time.

Chairman Sanders: [Session 1 - 02:31:45] Thank you very much, and thanks to the entire panel. Again, I'm sure that there will be a number of questions and so I'm going to call on each of the Commissioners, and I'll start with Commissioner Petit.

Commissioner Petit: [Session 1 - 02:32:00] I have a number of questions and comments. One on the...and it was an excellent combined presentation, thank you very much. One is for Dr. Drake on the data that you presented, seemed to be aggregate data from across the country not by individually state-comprised data. In other words, in being able to show the differences between the top states, say for reporting, and the bottom states for recording, it might be a difference of three-, four-, or five-fold among the states. So in terms of federal oversight and in terms of accountability, how do you factor the differences among the states?

Dr. Drake: [Session 1 - 02:31:45] Policies will change radically who gets reported in each state. From a scientific perspective, you're introducing a lot of error when you try to combine states together—you need powerful effects to burn through that barrier. That said, in many ways a state, which has certain kinds of procedures for classifying maltreatment, and another state...can simply sometimes not be comparable. Back in California, Orange County at one point called a case a child. San Diego called a case a family. If you try to combine those variables across states, you're in trouble. So I think when you do start to delve into the state level, which is critically important, you have to go in very well informed about those differences. I was simply trying to provide kind of an overview using the best national data available. It's heartening to see that sort of in this data is not terribly different than in the NCANDS data, which suggests that someone going out and asking questions is going to get fairly similar results to some of this national data. And I would also say that it's reassuring to see that much of the administrative data that's been done by Emily in California, by Diane

DePanfilis in Maryland, by other people in other states, by myself in Missouri, we tend to come to the same conclusions, which is good.

Commissioner Petit: [Session 1 - 02:34:00] The number, 2 per 100,000 is I think sticking with all of us in terms of predictive risk factors and analysis. How many of the 100,000 children do you think have the predictive risk factors that will allow us to narrow it down? Is it 10 percent, 10,000 children? Is it 1 percent, 1,000 children? Is it 1/10 of a percent, 100 children? How do you narrow it down so specifically that you actually know which of these two kids in this large haystack would trigger certain kinds of interventions and behaviors?

Dr. Drake: [Session 1 - 02:34:32] We've already heard that most of these kinds are on some kind of public assistance, so right away that chops out a good portion of the population. The more data elements you can put into a model, and the more sophisticated ways you can look at those data elements, the better opportunity you have to really narrow that number further, further, further, further.

Dr. Melton: [Session 1 - 02:34:55] One of the reasons argued, starting with the universal approach while then, and then doing focus on individuals, is most of us have risk. A risk is endemic—it's not that my own family, my first wife had late onset schizophrenia. I didn't predict that when we married and when we had children and so on, but obviously … when that happened she was in her 40s. She is now deceased. We had all kinds of needs that we wouldn't have had otherwise. And I was making a good income. Highly educated, strong network, etc. And I could go into what people did with and for us that made a difference, but the point is everybody experiences grief. Everybody experiences anxiety about their families. It's not just joy, for anybody, and a lot of it is not predictable. It is bad luck, if you will.

And the other part that goes with that though is our time is such that people are increasingly disconnected. And that's much stronger the younger you get. So every cohort for about two generations now has been more disconnected than the one that came before. That is year to year. I mentioned the door-to-door survey; we randomly selected houses and then went and knocked on the door and found whether there was a child under 9, young children. Amazingly, by the way, for an hour, a pretty probing interview, more than 80 percent of people agreed to it and went all the way through.

But the thing that stuck with me the most is in that part of South Carolina where I think people living there and probably looking from outside would say, this is a place where there's southern hospitality, etc., and folks are connected and so on. About 45 percent of the respondents, this is young parents, parents of young children were highly isolated by our definition. What did that mean? They didn't know anyone who would help them if they needed assistance with shopping, home repairs, or other chores. They didn't know the names of any children in the neighborhood other than their own children. They didn't know whom they would call if they needed emergency child care, and they belonged to no organization other than a church. And even for the church, about half of the isolated parents, compared

with about 90 percent of the others, said they had a religious affiliation. But what's striking about that is about a sixth...it is true, the less you have, tragically, the less likely you are to be connected to both social and material resources, but about a sixth of the isolated parents had a college degree. About a sixth of them were in families that made more than $70,000 a year in the early 2000s, and the majority were married.

So we need to build...if you start cutting out the people whom we think have resources, first of all you're going to miss people who in fact do get to points where they're not able to care for their kids on their own. It's not substitute care or care in the family, it's supplementary care from zero to a hundred. And the other, though, is then pull out the people that can be of assistance day to day. When they notice that families need help.

Commissioner Petit: [Session 1 - 02:38:50] David may I ask if I can just come back? I have other questions but I'll just hold off but if we have time I would like to ask some additional questions.

Chairman Sanders: [Session 1 - 02:38:58] Commissioner Martin.

Commissioner Martin: [Session 1 - 02:39:01] First of all gentlemen thank you so very much for the information. Your panel in totality was very informative. Dr. Melton I want to thank you. It's rare that we hear from someone as distinguished as yourself and remind us that all of us, every family, no matter what our background is, we all have risk factors. And the issue it's not "those people," it's all of us that we're trying to look at and trying to figure out how best to treat and how best to care for. I love the idea of safer communities. I love the idea of connectedness. I think those are things that we all rely on and we forget that my families in foster care, for instance, need those same things too.

My question is directed to Dr. Fluke. I am interested very much in this whole international issue and the Sweden issues versus the American issues, and the values that you are talking about. I guess what I really want are some examples of American values or U.S. values that you think are detrimental or not as conducive to safe children. Are there things like connectedness to communities? Or what are these American values that you're talking about that makes us less likely to prevent the fatalities that we're experiencing?

Dr. Fluke: [Session 1 - 02:40:26] I think there are a couple of examples that are maybe worth considering. And these are things that are probably on our agenda at some point, if they haven't been already. One that I think is really intriguing is the whole issue of suffocation of children in vehicles for example. Whereas a value … when we accuse families or parents of neglect under those circumstances, we ignore the opportunity that that value creates to sort of change up the way we think about this issue. We consider the possibility that there are technological solutions that we could implement, that we could enforce, that would actually prevent those types of fatalities all together. But the focus on the values

sometimes interferes, as we create stigmas about these types of behaviors that to some extent we all may be at risk for.

Commissioner Martin: [Session 1 - 02:41:28] Are you talking about co-sleeping?

Dr. Fluke: [Session 1 - 02:41:31] Certainly that's one of the types that we are talking about. Access to health care. The ability to access health care. These are all things that have to do to some extent with the nature of our values, and I think are important to consider in terms of strategies that either could avoid conflicts of those values or ways that we could think about perhaps changing some of those values over a more extended period of time.

Chairman Sanders: [Session 1 - 02:42:01] Commissioner Dreyfus.

Commissioner Dreyfus: [Session 1 - 02:42:04] Thank you very much. I think one of the things for this Commission that we are finding is I think everybody goes into this issue and they think if we just fix CPS we'll fix the issue. That's where media immediately goes. That's where...I've worked for two different states, that's where people just go. What you're reminding us as a Commission is we've got to move from program thinking to social change thinking. And I really, really want to thank you for that, Dr. Melton. I am definitely going to be reconnecting with you on a number of levels. This really I think challenged us at a much bigger level in terms of the comprehensiveness of the work we have in front of us.

My question though is for Dr. Graham. And I'm going to focus back on the CPS. I'm trying to change my own language and no longer call CPS the child welfare system, because it is not. It is but a part of a community's child welfare system. One of the questions I have is about the quality. When I heard you talk about everything that was needed for an investigative staff person or case manager and/or their supervisor, the kinds of competencies and capacities they would need to have experienced, they would need to have, in order to assess in a way in which you were talking about, I don't doubt for a minute that it's correct. I put on my former child welfare director hat and I go wait a minute, I am recruiting twenty-something-year-olds out of social work, maybe they have a social work degree, if they do, and putting expectations on them, that from what you're saying is like, wow, they need to be able to think about a whole lot more than maybe we're giving them and the training that we're giving them before we're putting them out on the street to do their work. So I'm sitting here thinking, what do we need to do as a country, whether it's in the training, in the preparation of people for this work. Whether it's the kind of teaming we've got to normalize that's got to be around them, in order to do the kind of comprehensive work in that home that you're talking about. To really get at what those risk factors are. When I heard you talk about this, I agreed but I'm thinking, how do I get there?

Dr. Graham: [Session 1 - 02:44:10] That's a great question. I want to say, first of all, I intentionally mentioned child welfare not just CPS as part of my thinking that it's got to be a larger system, that it's not just CPS but all these different agencies that are involved with the

families need to be working together. If there's some child welfare worker outside of CPS is in there and sees risk of child fatality, they need to be part of the solution, too. One thing that Washington state is rolling out soon is "lessons learned" training for caseworkers. In which child fatalities that have been subject of child fatality review hearings and are particularly lacerative, I use as a basis of training, both in terms of the families I believe and also in terms of the system response. I didn't have time to get into this as much as I would have liked to in the main body of my remarks, but I think that it's insight that is at a premium here. And my impression is that child fatality review teams are doing great work at generating insight, both in terms of the families for their child fatalities and also in terms of the system responses. And I'm glad that there's some effort to integrate these, but I think it can go a lot further. In Washington I think you noticed, Commissioner Dreyfus, there were countywide child fatality review teams. But then funding was lost by the state, and many of these dropped away, and I think one role for the federal government is to provide funding so that there can be a comprehensive system of child fatality review teams.

Also, not all the states then report to the U.S. National Child Death Review Case Reporting System, and I think that they should. Beyond that, I think that there should be effort put into analyzing, to bringing them all together, and to analyzing them and disseminating those results so that insights that are in one jurisdiction can be made available to all jurisdictions and to the caseworkers so that these brand new caseworkers who are coming at least have a heads-up on: okay here are the kinds of things to look at in terms of stories.

One of our colleagues, Homer Kern, did some research where he interviewed inmates at a penitentiary who were there because of severe child harm, and he found out that many of them reported a combination of obsessive concern with the partner and jealousy of the child. And that in a nutshell is kind of a narrative in that situation when caseworkers can be told, okay look out for that kind of dynamic. That could be a very dangerous situation. Or in terms of a safety plan, "Oh, here's a case where the perpetrator was put in jail and everybody thought it was a safe situation, but then they got out of jail and came back home and there was no provision for that in the safety plan." So caseworkers can be told these stories and these narratives that highlight to them the importance of it.

Chairman Sanders: [Session 1 - 02:47:42] Commissioner Covington.

Commissioner Covington: [Session 1 - 02:47:44] Oh, I could have a million questions for all of you. Thank you so much for such a good panel. I have a short question and a longer question. The shorter question is, you know, with the Adrian Peterson in the news story, I'm wondering if you see a difference in the state laws related to corporal punishment. You mentioned North Carolina and Colorado, Dr. Runyan. If values related to corporal punishment have an impact on child maltreatment. That was my first question, which is an easier one I think. My harder one is, could you talk some more about this whole piece Dr. Melton, how did you put it, I just about died when I heard you say it, "Ideology is a failed strategy." Could you

talk some more about that and what do you mean by that. Can we answer the first question first though? I had to get both my questions in.

Dr. Graham: [Session 1 - 02:48:38] I'm not familiar with all the different states, but generally speaking parents are allowed to use discipline, including corporal punishment, without a lot of constraint as long as there is no harm is done. I think as a clinician—I've seen the pictures that came from the Adrian Peterson case—I have an opinion that that kind of … goes far beyond what different states would allow for that. But it is interesting that there are very strong cultural differences, and our studies in the south found sending children out to get a switch was pretty common, and I talked about it with my medical students and my medical students at the University of North Carolina, black and white, all talked about the same experience. Those of us who grew up in Connecticut, I guess there was enough snow on the ground that we couldn't find a stick on the ground for four or five months of the year, and we were safe. And here in Colorado the sticks are few and far between in much of the state, and that may explain why the rate was so low here.

Dr. Melton: [Session 1 - 02:49:36] What I was referring to was the strategy of trying to find those people has been I think one that has failed miserably. It fails miserably for a couple of reasons. One is you will always miss people. There are always false positives. There are always false negatives. In lots of communities, the number of positives are so high that trying to...using resources to try to find the 80 percent of 100 percent just is not a wise thing. I do a lot of international work, particularly in Southern Africa and Eastern Europe. When those countries began...what happened was when their democratic process started, it was okay to recognize social problems. The first thing they wanted to do again was to go find those people. But if you're living in a country where 80 percent or more of the families are in housing that's not safe by international standards, then who's neglecting among them?

So it makes much more sense to think about what we need to do to keep kids safe, than it does to try to find the people who are potentially abusers of neglect. That's the way Henry Kempe started. It's heresy since I'm at the Kempe center to say this, but I will do it nonetheless, then Des will do something terrible to me later. He was apparently, I didn't have the pleasure to know him, but I obviously know people that did. He was a very charismatic, caring person. By the way, a Holocaust survivor. So his trying to find children that were suffering the most is related to his own history. But he did these surveys of emergency rooms and a prosecutor's office and concluded there were a few hundred kids a year maltreated in the United States. That's in a battered child syndrome article in 1962.

If you think there are a few hundred kids in the country and the reason that people are not "saving them" is because health professionals think they have to look the other way because of their legal or ethical obligations, then it's a logical thing to do to do case findings. Our whole system is set up on case findings. It's not based on needs for help. It's based on allegations, and then trying to find out what was done. When you have people, a neighbor may call, or a teacher, or whoever to CPS and say, "I'm really concerned about the family

next door, because they have this problem, this problem, this problem, and I've noticed that when mom goes to her shift work in the morning that the 6-year-old is watching out for the … 6 and 4 until the school bus comes." The answer then that CPS is legally obligated to follow is to decide whether that's neglect. It has no relevancy to what it is to what people are trying to ask about, and so part of the reason it's failed is we are talking a massive problem. Not finding those people. And the other is that even if you do know; I can relate back to my experience on the U.S. Advisory Board, one of the first things that we did which I would encourage you to find somewhere, it's no longer being sold I think. But there's an old Frontline documentary called, "Who Killed Adam Mann." The question relates to all the people who could have acted. It was an instance where a family who could have been filmed in a child welfare exposé, then in the context of that another story turns out there was a death, and so the reporter put 2 and 2 together, and they had all this film on this family from before.

But anyway besides this, there are all kinds of lessons in that film, including what people's obligations are. But one of them again is just how darn complex it is. And that was an easy case. This was an instance where there were multiple instances of brutal physical abuse. The answer then is simple. It's a tragic case, but it's an easy case. That's not what CPS spends their time on though. What CPS spends their time on is the majority of the instances in which there are fatalities or ones where just everything is just going to hell, and not just today but over time.

So if you've got that kind of situation, and you've got to what I've already alluded to, that people who are basically doing okay also have times when things aren't going so great. You need to be able to respond where people are in that context. We need to change the norms. So the board's argument in its '91 report was that the federal role in child protection ought to be to facilitate community efforts, ought to keep kids safe. That's a very different way, and I would argue the state role relative to municipalities, school boards, etc. is much the same. That seems to me, if I can interject, to be both a Democrat and a Republican view.

Chairman Sanders: [Session 1 - 02:55:46] Commissioner Rubin.

Commissioner Rubin: [Session 1 - 02:55:50] Thanks, Dr. Melton. I think in some ways the context of your comments, this is not my question but just to finish up your thoughts, sort of rings similar to the discussion of Promise Zones and what a Promise Zone really is. I'll leave it at that and sort of what that strategy is, not just for this administration but moving forward. I'm glad that my Commissioner to the right over here established a precedent to two questions, so I wanted to take advantage of the expertise across the entire panel. As we start to try to think about, to deliberate around a national strategy, certainly there are many components to a national strategy. It strikes me that there are two specific areas that we could leverage your experience on this panel. Help us think about. The first area, and I would suffice to say for those of you, if you don't feel like you got your comments in terms of your answer to this, feel free to send us your comments electronically.

The first question is about the relative importance of getting the count right, and thinking for example anywhere from … Why do we just count fatalities? Why are the nonfatal severe injuries, like abusive head trauma, why aren't they counted and help to inform this? Because for me in my clinical experience they represent the same continuum. To … Who should be doing the count? And what does that national effort look like? So commenting on it from your experience, the relative importance, and if you had a blank slate, how would you begin to aggregate this information that would be helpful both to a clinical practice audience, as well as to a research perspective?

And the second part of the question relates to investments in research. I think the elephant at the table would say, we're trying to develop a national strategy to reduce child abuse and neglect fatalities. I'm a researcher, but I will acknowledge people say we don't need more money for research to tell us what the risk factors for child abuse are. How do you think of it ... if we're going to meet with the CDC or the National Institutes of Health and they are going to ask us, "Well, what do you want us to do?" Lay out the strategic agenda for where research helps to inform a national strategy to reduce neglect and child abuse fatalities.

Dr. Runyan: [Session 1 - 02:58:09] I'll start on the research question. And David, in terms of the national research strategy, because I sat on the IOM committee and we heard reports from the different groups. I had the experience back when I first started my career of writing to the NIH to ask about who I should talk to about getting funding from the NIH for research in child abuse, and the letter I got back was a very nice letter that said it's policy at the NIH not to support research in child abuse. That's an area that's left to the Children's Bureau and the National Center on Child Abuse and Neglect, at the time. And good luck with my career. It was a sobering letter, and I ended up getting funded through NIJ and several other places along the way, but there hasn't been a long and strong track record of support for investigators, which has resulted in a dearth of senior investigators who can answer the K awards that were announced in '96 by NIH. There's a dearth of people working on it. And so when you look at the NIH RePORTER now, and you look and see how much money is spent in the area of child abuse versus how much is spent on cystic fibrosis or fibromyalgia, which are both diseases that are probably a lit bit less common than the millions of children reported. It turns out the answer is about $3,000 per incident case per year spent on fibromyalgia and cystic fibrosis, and something less than $200 is spent on every incident case of child abuse. Using substantiated cases as the incident cases. So there is clearly a dearth of support in this area.

There's also a dearth of mentors and kind of senior investigators that know what they're doing in this area. That makes it so you can't just dump a bunch of money out there because there aren't going to be the people that know how to use it, and there are also not reviewers that are qualified to review these proposals. I'll let the other question be answered.

Dr. Graham: [Session 1 - 03:00:06] I can add something to that. If you look at the CDC's morbidity, mortality reviews, it's broken up by many, many categories. I think as far as aggregating the data, it would be helpful for research to take a similar approach in child maltreatment, so it's not just child maltreatment mortalities but child maltreatment fatalities of these different types. And having that would allow researchers to go in and better understand risk factors and patterns of risk factors underlying particular causes. Rather than looking at it as a whole. This has been done to date. I think also there is an important role for evaluation research, so that different programs like short-term respite care or nurse public health, nurse home visitation, are also evaluated in terms of child fatality, so we can see which programs at a broader social level or even community revitalization projects are having an effect on child mortality in terms of maltreatment-related fatalities.

Chairman Sanders: [Session 1 - 03:01:25] So before anybody jumps in on the research question, I do think we would all benefit from the question about counting and the relative importance. Who does it and so forth.

Dr. Drake: [Session 1 - 03:01:37] So now that you mentioned that. It's an excellent question and I know that it's one that has been addressed by members of your Commission as well as a number of other people over the years. I have to say that I'm not terribly optimistic about the prospects for getting the count right. I think that part of it has to do with some of the barriers that are systems placed on how we go about gathering information. Whether you are talking about coroner's systems that don't necessarily involve professional development of individuals in those fields, to that of the nature of what the data would be used for in a given type of setting, those things I think can create issues for us. I think that, in my opinion, and as I said in my presentation, I think we need to focus on a public health approach to the counts that we would be looking for, and I think that they need to be relatively broad based. Not necessarily as concerned that we would be absolutely clear that something is or is not child maltreatment. I think that we need to look at the conditions that might be related to child maltreatment. Some are being done currently, with the ICD code structures for example. I think that the notion that we can precisely identify whether or not child maltreatment occurred is not necessarily a good use of resources from the perspective of actually trying to keep children safe.

On the other hand, we can I think pay much more attention to our public health systems. We can expand the nature of the questions that are being asked in health care settings, for example. There's changes underway with the ICD-11 codes, for example, that might be helpful in that regard. Even if these are underestimates of child maltreatment fatalities. Having consistent data that's available to us to be able to look at trends is, I think, ultimately where we need to be going as far as evaluating the effectiveness of our policies, particularly public health policies.

Dr. Fluke: [Session 1 - 03:04:07] There's a lot of kids who die in maltreatment families. They don't die from maltreatment but do die from preventable means. And so I think that is

something we need to think about. So I think the question really should be preventable deaths, not fatality deaths. If I leave some pills around, my child eats it and it's not ruled to be maltreatment, he's just as dead as if I beat him to death. And it's just as avoidable. So I think we need to really get away from that 2,000 number and start to categorize things in a way that makes sense. Gradations of death: unavoidable deaths, cancer, avoidable deaths, car seat, pill ingestion, drowning … and sort of just say what it is and allow people to look at those data and take from it the information that suits their purposes.

Chairman Sanders: [Session 1 - 03:05:02] Thank you. Commissioner Rodriguez.

Commissioner Rodriguez: [Session 1 - 03:05:05] Well, I just want to say I found this panel incredibly helpful. I think specifically the frame that you put on who it is that we're looking at, and to me I haven't had that up to this point, so that frame of who we are really focused on are the most disconnected families and children. To me makes it very clear, and it also makes it clear, it echoes what we've heard thus far from both our families and the youth who have testified. It allows us to bring in those young people that we heard earlier talking about the risk of suicide, because certainly when we look at young people who are in our child welfare/juvenile justice system, they are some of the most disconnected families of one. My juvi days are certainly disconnected. When we look across all those other risk factors, we're not just looking at the risk factors but we're looking at the level of connection, and it makes why the interventions that are being developed, why they are not effective also much more clear because they are not seeking to connect families or to reduce the level of social isolation, they are instead seeking to change individual sort of factors or individual situations. So I feel like I had a light bulb go off while you all were testifying, and I really appreciate that.

I also thought it was fascinating … and much more commenting than questioning, but there is a question coming. I also thought it was fascinating the discussion about the parental education and about environmental changes versus individual changes in that a primary sort of goal is to help parents believe that they can make a difference for their family, because that is not the goal at all of any of our parenting education. When we refer our families who do come into the child welfare system, that third, we don't refer them out to services that help to empower them so that they feel as if they can make a difference. Instead we refer them out to anger management and parenting classes and substance abuse treatment that doesn't foster that.

And then the other piece that I think is really interesting is that I don't think we...you mentioned sort of having child welfare systems anecdotally express what we're learning about some of the systemic factors that families are faced with, that are putting them at risk, like lack of access to child care or poor living conditions, but I'm not aware of any child welfare system that systemically analyzes any of those environmental conditions and sort of elevates them on a regular basis—not sort of when the legislature asks or when a commission

asks, but on a regular basis. Sort of brings out what those systemic issues are and attempts to address them.

So my question is, Number One: If any of you are aware of child welfare systems that as a matter of sort of policy and internal practice are doing that analyzing around not the individual factors but the environmental or the systemic factors and trying to addressing them? Then, Number Two: If any of you are aware of systems where we really do have interventions that are seeking to increase parents' beliefs that they can make a difference in the lives of their children and trying to increase social connectedness and decrease social isolation, as opposed to sort of teaching new individual behaviors?

Dr. Graham: [Session 1 - 03:08:44] One example I recently heard outside of the field of CPS, I was in Seattle, some hospitals were noticing what a burden it was in emergency room admissions and the approach they took really impressed me, because what they did was to create low-income housing, specifically wet-housing for alcoholics, and it had a tremendously positive outcome. In various work I've done in this field, I've seen that bad housing is such a problem and underlies so much of child maltreatment, and I wonder if we can similarly think outside of the box and maybe some social interventions like that—just having safe, secure, collaborative, supportive housing might be more cost-effective in the long run than foster care, for instance.

Commissioner Rodriguez: [Session 1 - 03:09:35] I immediately thought of, I'm sorry this is a comment back to you, but when you all talk about the connectedness, I immediately thought of, I recently became aware of a couple of jurisdictions that when a child welfare report comes in, they are sending out somebody who is a family finder to that family. It comes after the investigator to identify family members to come in and wrap around that family as sort of a triage approach. So there's an investigatory function, but then there's that connectedness, and although I thought that was interesting it never made as much sense until hearing your panel today that that is exactly the right approach that we need to take. So thank you.

Chairman Sanders: [Session 1 - 03:10:14] Commissioner Zimmerman.

Commissioner Zimmerman: [Session 1 - 03:10:18] Yes, I'd like to just say thank you; it's a very informative panel. I'm going to get a little more specific in my question, but it's about this connection and the community strategies. So you've said there is fewer emergency visits and hospitalizations for injuries. Were the emergency room providers a part of this community connection, and were they less likely to call it child maltreatment because they were connected and knew that there was a referral process that this family would have support, or were they using their own sort of clinical criteria that they've always used?

Dr. Melton: [Session 1 - 03:10:58] Emergency rooms weren't a part of it. Although I think that's actually not a bad idea. We have speculated a little bit about what would happen if we tried to de-strung communities from our emergency department, as children at the base. But

in terms of the data in this instance, although South Carolina doesn't like government, they have lots of it. One of the ways they have lots of it is any hospital visit that a South Carolinian has is coded. Whether it's paid for by Medicaid, private insurance, or self-pay, and we simply went to the grand database in the sky, after the fact, and there was a panel of expert physicians, actually Des was one of them, of different specialties. So emergency docs, community pediatrics, etc., they went through the ICD-9, the classification of diagnosis or diseases, and rated how likely they thought it was that it was either an abuse or neglect cause or likely to be associated with that diagnosis. And we did a cutoff, but I don't remember exactly where it was. But anyway you had to be pretty high on the likelihood. So it was injuries that probably is the preventable injury idea, other than traffic accidents would be excluded.

Chairman Sanders: [Session 1 - 03:13:24] Commissioner Ayoub.

Commissioner Ayoub: [Session 1 - 03:13:29] We're taking in such an overwhelming amount of information as we've been doing over the past months, I find myself spending a lot of time trying to make sure that the message I receive is the message that the speaker is meant to send. So I think that I've heard conflicting information on income, and I just wanted to clarify that between Drs. Drake and Runyan. I felt sure that I heard poverty is an important indicator of maltreatment from Dr. Drake and I thought I heard that there was no relationship between income and maltreatment from Dr. Runyan.

Dr. Drake: [Session 1 - 03:13:34] Poverty is an overwhelming indicator of all forms of maltreatment, particularly neglect.

Dr. Runyan: [Session 1 - 03:13:35] My survey was actually on behaviors of parents' report, and we didn't find that when parents were asked about what they did. In North Carolina, we didn't find an income differential for harsh punishment of children. Beating them up, knocking them down, was not quite so determined by income. We were surprised by that because all the prior survey work showed an income differential, and we just finished in Colorado and there is an income differential of poor families do more harsh punishment of children. So we were surprised by the North and South Carolina data from 2003.

Dr. Drake: [Session 1 - 03:13:59] Reporting of violence can often be subject to various kinds of bias. If you look at the national victimization survey, for example, it doesn't come forward at all with the rest of data or medical data.

Dr. Runyan: [Session 1 - 03:14:10] And I think by the same token, where you go for your medical care may alter your likelihood of being reported. Some of Dr. Rubin's colleagues have addressed that and even before the Eli Newberger you heard it many years ago in Boston that poor families go to community hospitals where they get reported, and wealthy families, they go to private practitioners and do not get reported. It's a systematic bias in terms of who gets into the system at their level.

Dr. Melton: [Session 1 - 03:14:35] But probably not in terms of the group differences. So if you look, Leroy Pelton's famous for having written an article a long time ago called, "The Myth of Classlessness." And he has an article coming out in *Child Abuse & Neglect* in about two months, three months that will again reiterate how strong the evidence is for the significance of poverty as a risk factor. And that basically the more severe the injury is, the more pronounced the class differences are.

Dr. Drake: [Session 1 - 03:15:18] The National Incidence Study shows that, too.

Dr. Melton: [Session 1 - 03:15:20] Yeah, there are all kinds of studies that show basically the same thing. And so it's again the things that you would think would sort of separate, I'm not saying this very well, but for the most part there doesn't seem to be a bias of reporting that's accounting for the differences that you see ultimately. There may be in terms again of what goes in, but in terms of the...particularly the kinds of things this Commission is concerned about, the class differences that show up there, there's pretty strong evidence are real.

Chairman Sanders: [Session 1 - 03:16:01] Commissioner Ayoub did you get your question answered?

Commissioner Ayoub: [Session 1 - 03:16:05] I have one more quick one. Who spoke about the mother's education?

Dr. Runyan: [Session 1 - 03:16:12] I did.

Commissioner Ayoub: [Session 1 - 03:16:13] Was that for being a perpetrator...that lesson where they would be a perpetrator of violence or in any situation of violence?

Dr. Runyan: [Session 1 - 03:16:22] That was in any situation of violence. Whether that was either the woman or the husband or partner could be the perpetrator, but the relationship was stronger for mother's years of education than it was for father's years of education.

Chairman Sanders: [Session 1 - 03:16:35] Commissioner Petit.

Commissioner Petit: [Session 1 - 03:16:37] Yeah, I was involved with a number of studies at one point that tried to establish whether there was a difference in the premature death rate. Death by the age of 18 of children who were poor versus non-poor, and what we found is that in fact there was a difference. There was about 3.5-fold, 350 percent. We also looked at was there difference in poor white kids dying by the age of 18 versus black kids, it was the same. They were just dying for different causes. They were being murdered with guns in cities and they were driving cars off the road in rural areas. But I have a question on that, and I guess it's for Dr. Drake. I haven't heard much talk about race as an element in here. And I have

read previously that black children are triply overrepresented among child abuse and neglect fatalities. The point that you raised, doctor, about fundamental attributions—is that the term that you used? What was that term?

Dr. Drake: [Session 1 - 03:17:30] [*Inaudible—far from microphone*]

Commissioner Petit: [Session 1 - 03:17:32] That seems to be really at work in this particular situation. In terms of blaming things on individuals first. But first of all, is that number accurate?

Dr. Drake: [Session 1 - 03:17:41] There's an emerging consensus in the literature that if you control social-economic and other factors, that blacks and whites look very similar. The people who don't look similar are the Hispanics, who are doing better than the blacks and the whites.

Commissioner Petit: [Session 1 - 03:17:57] So, there being much more poverty among black families, etc. you would say that…

Dr. Drake: [Session 1 - 03:18:01] In Missouri, if you look at any indicator of black family/child well-being, the disproportionately is greater than the child welfare system involved in disproportionately. I would argue that in my state, if anything, black children are not coming to our attention as much as they should. That our failure may not be harassing black families but maybe failing to protect black children.

Chairman Sanders: [Session 1 - 03:18:24] Commissioner Dreyfus.

Commissioner Dreyfus: [Session 1 - 03:18:27] Okay, so that's perfect for my lead-in to my question. So I'm going to go way out there. I feel like I'm sitting in front of some really smart people who are going to tell it to us like it is. So I'm sitting here thinking to myself this country has a failed CPS system. We have a failed CPS model. We depend on a call to come in to a hotline. And those calls get screened in and screened out based on individuals. In my child welfare work I used to go and sit and listen to calls coming in, and just listen to calls coming in and the decisions that were being made. Even if they had statewide centralized intake, you are still dealing with a dependence on people calling in and someone deciding if we're going to screen it in or screen it out. Right?

By the time we get involved from CPS it's in an investigative, "I'm here from the state and I'm here to help you," kind of thing, "I'm investigating you," and chances are a whole lot has gone on long before that first call ever came in or we ever get a screened-in decision and decide to go out. I am here today, something that made me think that maybe part of our answer as a Commission here is that we've got to rethink CPS in this country, and that I appreciate where CPS becomes that police function, where, "Houston we've got a problem here, we've got to go out and investigate." I get that. But we're also hearing about the need

to get further upstream, more supportive. Right? Doctor you talked about the ability to use different data systems to identify these potential risk factors that are not sitting in that CPS record, that intake record. Right? That might lead us to a larger community response. Trying to go, "How are you doing here? What are you needing? What's going on?" Long before the fact. So I'm asking you to challenge us a little bit in our thinking as a country of this definition of intake, that right now from everything I've heard here today, I'm thinking that's a 20th century model in a 21st century world, especially around Willy Wonka and that imagining and what data could allow us to do. So there's a lot there.

Dr. Fluke: [Session 1 - 03:20:47] So there's a project that's going on right now in New Zealand where they are essentially asking exactly that question, and the idea is that while using data from the health care system, by using data from the social services that are non-child welfare, by using law enforcement data, by using a range of data that has been compiled by the analysts in the country, that you can do a reasonable job of predicting children who are going to end up in the child welfare system. And they've got pretty good results with those sorts of models. But the real question I think for them, and this is something that they've been struggling with a lot is, so what does that intervention actually look like? What do you actually do when you have some sense that a particular family is at elevated risk, when there's no particular evidence that they've done anything at all. So there are a number of different strategies that are being evaluated in New Zealand. I would certainly recommend that you contact them about what they're looking at, if this is of interest. I had a graduate student there who was actually interviewing staff in the public agencies as well as other agencies to try to find out what strategies they were recommending would they feel would operate best in their communities. So some of that information could potentially inform some of the thinking. But the fact is that with this sort of technology and this sort of information that are potentially available to us, it's possible to do it. The question is, what do we do? That's an elite question, that's a values question, and one I'm not sure we have a clear answer for you.

Dr. Melton: [Session 1 - 03:22:51] I think I'm going to give you an analogy, bullying prevention, which is a topic that's taken off not only in the United States but just about everywhere. The particular approach that I think has the best data behind it is one that sees the school as the focus, not the individual kids, to find the bully or to find the victim. This doesn't mean not responding to those people in humane ways, as part of this. So they do a couple of things.

One is they survey kids about where they've been bullied and when and how often. And you'll find answers, not surprisingly, like behind the lockers is a bad place. Well you change the lockers. And then they changed the norm so that it's not just that we'll tell the teacher that ... we will not bully, we will tell. But we will let no child be outside, is one of the norms. And so they do a full-court press for everybody in the school, that that's part of what they all do as the Wolverines or whoever. So it's essentially getting more to what the context is in which

bad things happen, and by the same token, the context in which there's reciprocal help—that is where the effort goes.

One of the problems, without getting too focused on our system. Two things: one is we thought it was a rare problem, which it's not. And we thought it was an easy problem, which is not. And we thought they were in fact people with syndromes that you could diagnose and then you did something and it was going to take it away. And our system that was derived from that not only has everything keyed to allegations, but it also implicitly tells people, once you pick up the telephone your job is over, get out of the way. And that's exactly what we don't want to have happen.

It also tells people who usually are not willfully doing bad things to their kids—obviously some people do, and that is a moral problem, and it's a criminal problem. But most of the time it's people that are in really bad situations who for whatever reason can't get it together, and the system basically keeps telling them now, yes you really are a bad person, and no you can't do anything to make it better for your family, and by the way we're going to send you to classes and we're going to keep counting whether you're there are not. We're going to keep looking for evidence, so we can go further, and the whole system is set up that way. So we need to flip this around. It's like when we were doing Strong Communities, if we would ask a community group or a professional group what should be done to prevent child abuse and neglect. People immediately do, well we should have counselors, and we should have parenting classes, and so on. If you ask them, though, what would it take for kids to be safe on your block or in this school and for them to feel that they're being treated with respect, that they are being treated humanely, that when it is a tough day or if it's a really good day, somebody's going to notice and somebody's going to care. People know the answers. And we systematically have taken the power away from people to do what instinctively I think most people would do. The way in which our volunteers represent the community is just extraordinary. We didn't get religious differences or racial differences or political differences on this one. Everybody has this gut instinct about security.

Chairman Sanders: [Session 1 - 03:27:23] So we'll take one more comment from the panel and then we will go to a break.

Dr. Graham: [Session 1 - 03:27:28] I have something to say.

Chairman Sanders: [Session 1 - 03:27:29] I think it was.

Dr. Drake: [Session 1 - 03:27:30] I would argue that the Commission should not take those comments as based on evidence. I don't see any evidence that the child welfare system is suppressing community function. Furthermore, it is not true that the ability of us to determine who is at risk is a failed strategy. It's simply wrong. Dr. Putnam-Hornstein's work has shown that for a small part of the population, we can know in advance that there's a 90 percent chance that they will encounter the child welfare system. I would argue that a failure

to take individual action based on such evidence is negligence on the part of the state. We also have other evidence emerging, again, from large, multisector, longitudinal databases that we can help out individuals. I'm a social worker, okay. I am all about solving this problem and many other social problems through community development and community strengthening. But it's not good enough just to have streetlights. It's not good enough to have community policing. There needs to be someone to answer the phone and deal with individual children. And when we have good evidence that those children are at risk, we need to go out there and help those children.

Chairman Sanders: [Session 1 - 03:28:42] Thank you. This has been incredibly informative, and I think all of us are left with additional thoughts about how to move forward, and I'm sure we will want to come back and hear further from you. So we're at a point of taking a break. We're not too far off our agenda. We'll take a break for 15 minutes, and then we'll convene with our next panel.

Morning Break: [Session 1 - 03:20:05]

Chairman Sanders: [Session 2 - 00:00:01] We had a long first session, so sorry that we are pushed back just a little bit. We are really looking forward to this next panel. We are going to start with David Olds, followed by Paige Rosemond, Kathryn Wells, and Elizabeth Collins. Dr. Olds will have about 15 minutes or so, and then the remainder, between 5 and 8 minutes, and then we will have time for questions. Dr. Olds?

Dr. David Olds: [Session 2 - 00:00:26] Thank you so much for inviting me to testify. I have been involved in this kind of work since 1970, when I went to work at the Union Square Daycare Center on West Lombard Street in inner-city Baltimore. I thought that if I could just help poor preschoolers get off to a good start, that they would have a better chance of succeeding in elementary school and later on in society. But it was soon clear to me that for a lot of the children in my classroom, it was already too little and too late. Children were being abused. A little boy in my classroom had been exposed to alcohol and drugs during pregnancy and he couldn't talk; he only gestured. I offered parent group meetings for parents during naptime, and what struck me was that it was the parents whose children I was least concerned about who showed up, and the parents that I was most concerned about I never saw. I realized that we needed to do a better job of addressing parents', what I thought was, instinctual drives to protect their children. And we needed to start earlier, but we also needed to pay very close attention to the kinds of contextual factors that led to compromised self-protection on the part of parents; compromised protection of parents' abilities to protect their children.

So after eventually going to graduate school, my colleagues and I developed a program that is known today as the Nurse-Family Partnership. It is a program of prenatal, infancy, and toddler home visiting by nurses for low-income mothers having their first babies. We focused on families living in poverty because so much of the action exists in poverty. The likelihood of

poor outcomes is so much more pronounced for families living in poverty, that we have a moral responsibility, I think, to focus scarce resources where the likelihood of impact on that is going to be greater.

We also focused on mothers having their first babies. We have done that because women going through that first pregnancy are going through massive hormonal changes and restructuring of their brains to cope with the challenges of becoming a parent. So the opportunities at that point in human development, during pregnancy, birth, and the early years or the early months of caring for that first child mean that the brain is plastic, and that it is susceptible to all the kinds of adversities that this panel has been talking about today. But it is also an opportune time, I think, for producing good because in the process of that rewiring of the brain there is an opportunity, I think, to create more competent parents who are aligned with those instinctual drives to protect themselves and to protect their children.

As you may know, the program has evidence that it makes a difference. I think one of the reasons it makes a difference is that there is clarity in what the nurses are trying to accomplish, clarity about how they are going about accomplishing those goals and objectives, and a key feature of that work is that nurses align with them in a way. Parents are angels. That is their desire, to protect themselves and their children. We think that all human beings are fundamentally instinctually driven to protect their children.

One of the features of this program is that it is not a child abuse and neglect prevention program. It is a more broadly defined program to promote maternal and child health. Over the years we have actively avoided having this program be identified as a child abuse and neglect program. The program has been identified as a program that prevents maltreatment, but we think that having it narrowly defined as a maltreatment-prevention program will undermine its effectiveness, by discouraging parents from committing to be part of the program.

The nurses have three major goals. The first is to help women improve the outcomes of pregnancy by improving their prenatal health. The second is to help parents improve their children's subsequent health and development by helping them provide competent care of the baby in the first two years of life. The third is to help parents improve their own health and their economic self-sufficiency by developing a vision for what their lives might be like, and then to make wise choices that are consistent with the values that allow them to accomplish what they want for themselves and their children.

Now, we have tested this program in three separate scientifically randomized controlled trials since 1977. First with a sample of low-income whites in Elmira, New York, living in a semirural community that has shown benefits in each of the outcome areas that the nurses were charged with affecting. And many people, when we first published the results of this trial, said, "Gee, you have got a program that works. You ought to make it more widely

available." We took the position that we ought not to promote it, that we needed to know whether the program would work with minorities living in a major urban area.

So we replicated the study with a large sample of primarily African-American families living in Memphis, Tennessee, in an urban setting. And as you will see in a moment, the findings are essentially replicating. We registered around 1,100 families for the prenatal phase of the study, and by design followed up on only 740 of them postnatal.

More recently, because many people use the results of our trials to promote all kinds of home visiting programs, including programs delivered by paraprofessionals, when the results for randomized controlled trials with paraprofessionally delivered programs are equivocal, we decided to try to get a better handle on the real opportunities that might be presented by having home visiting programs delivered by paraprofessionals. Then when both nurses and paraprofessionals followed essentially the same program model, and what we found is that nurses produce effects that are about twice as large and more enduring than paraprofessional visitors do. I'm not really going to talk more about that this morning.

One of the things that we have been most concerned about is to what extent do these findings replicate with different populations, living in different contexts at different points in our country's history? On this slide, you will see outcomes that we have the greatest confidence the program can affect, because they have been found in at least two of the three randomized, controlled trials that our team has conducted.

We see significant improvements in prenatal health, especially reductions in tobacco use and hypertensive disorders of pregnancy. We see significant reductions in injuries, which everyone on this panel knows is the leading cause of death among children age 1 through, actually, middle adulthood.

We see significant reductions in children's language delays and reductions in problems of school readiness. These effects, along with the effects on injuries, are most pronounced in children born to mothers where the mothers themselves have the fewest psychological resources to live in a context where there are many adversities; that is, living in poverty. And by low psychological resources, we mean the mothers who, themselves, have limited intellectual functioning, higher levels of depression and anxiety, limited sense of control over life's circumstances. It is when women themselves are least capable of coping with adversity that their children are at greatest risk.

We see significant reductions in children's behavioral problems at school entry, based on both parents' reports as well as teachers' reports. We see significant reductions in children's depression and anxiety, in middle school years as well as early adolescence. We see significant reductions in children's emerging substance use, in early years and in adolescence. We see significant reductions in maternal impairment due to their use of substances. We see significant reductions in the rates of closely spaced subsequent pregnancies, because one of

the things that nurses do is help women make wise choices about when they are going to have that next baby. We see significant improvements in women's participation in the workforce and reductions in welfare and food stamp use.

One of the outcomes that has given the program a lot of attention has been its impact on state-verified reports of child abuse and neglect. In our Elmira trial, we had a group of families that were visited by nurses during pregnancy alone. And in this slide you can see the graded effect of adult response relationship between having a nurse during pregnancy alone, during pregnancy and infancy, and here, the control group. What we see is that there is about a 50 percent reduction in the rates of state-verified reports of child abuse and neglect over the first 15 years of the child's life, and that is most pronounced, not surprisingly, for those children whose mothers were visited during pregnancy and in the first two years of the child's life. These effects are more pronounced when we look at subgroups where there was overlapping socio-demographic risk. So that tells us, it reminds us, it drives home the point that we should be focusing these scarce resources where there was concentrated adversity.

We also see that overall, the impact of the program on maltreatment is attenuated in households where there are moderate to high levels of intimate partner violence or domestic violence. I know we are going to be talking more about this with Beth later on in the panel. This finding that showed that the effects were attenuated where there was moderate to high levels of intimate partner violence has led us to develop a program of research to figure out how to help nurses address intimate partner violence more effectively. And in a recently reported randomized controlled trial from the Netherlands of the Nurse-Family Partnership, they have reported significant reductions in intimate partner violence both perpetrated by the mothers as well as in which she was a victim.

That was before we developed this new innovation of the program to address intimate partner violence, so we are hopeful that we can do an even better job once we get this new program of research fully implemented.

In our Memphis trial, we knew that we would not find program effects on the rates of state-verified reports of child abuse and neglect. By the way, we have never been able to get rates of CPS records from the state to look at that. But we knew, based on data from the state that we had analyzed prior to conducting the trial, that the official rates, at least, in the records, were too low to discern any program effect on maltreatment through CPS records. What we did hypothesize, though, was that we would see significant reductions in children's injuries revealed in the medical record. Overall, we saw significant reductions in children's health care encounters for injuries, and we found a particularly large effect in the number of days children were hospitalized for injuries and ingestions.

This slide shows the three cases in which children were hospitalized in the first two years of their life, and they were nurse-visited. All three of these children were age 12 months or older, and two of the children were hospitalized with ingestions. This slide shows the

corresponding rates for the children of the control group. Now the control group is twice as large, but 44 percent of these children were hospitalized with serious trauma or hospitalized before 6 months of age. They were not mobile, and they were not creating risks for themselves. 58 percent of the children were hospitalized with serious injury, and many people at the time when we first reported these findings said, "There, but for the grace of God, many of these children didn't die in the control group." More recently, we have just reported that over the first 20 years of the children's lives following their birth, among live-born children, nurse-visited children were less likely to have died from preventable causes; those are sudden infant death syndrome, injurie, and murder, homicide, over that 20-year period. We see corresponding effects for mothers' all-cause mortality. These effects are present for women who are visited during pregnancy alone and pregnancy and in the first two years of the child's life.

Since 1996, we have been helping new communities around the country develop the program, and we have been doing this with outside research context, and we believe that it is really crucial that there be a really rigorous implementation architecture created that allows us to support the program. We believe that organizations and communities need to be well prepared to deliver the program and that nurses need excellent education and consultation, and that there be an information system in place that allows us to monitor implementation and outcomes. We use that information to improve the program and its implementation, and to devise innovations of the program model.

So thank you for the opportunity to speak with you this morning.

Chairman Sanders: [Session 2 - 00:15:16] Thank you, and similarly, at the end of the presentation we will have an opportunity to ask questions. Paige Rosemond?

Paige Rosemond: [Session 2 - 00:15:28] Good afternoon, Paige Rosemond, Child Protective Services Manager for the Division of Child Welfare. Thank you for this opportunity to share some of our child welfare best practices in our service provision to Colorado's children, youth, and families.

In our state-supervised, county-administered child welfare system, it is our responsibility at the state to ensure statute rule and practice tools to provide the essential support and guidance to assess present and prospective child safety and risk.

We begin assessing safety and risk upon receipt of a report of child abuse and neglect. As Julie Krow referenced in her earlier remarks, every county in Colorado was trained on enhanced screening and RED teams. Enhanced screening expands the scope and depth of information gathered from a reporter during our initial contact. In addition to asking open-ended clarifying questions regarding the allegation, this process also explores the family supports and strengths from a reporter's perspective. This allows us to be less incident-

focused, more holistic in our approach, and in turn better assess safety and risk from the onset of our involvement.

The referral is then screened through RED teams. RED team is a group decision-making process utilizing a framework and an agency response guide to determine if the referral meets statutory definitions of abuse and neglect, and if so, the response time. The framework explores the family's prior child welfare and criminal histories, elements of danger and harm, complicating factors, strengths, and protective capacities. Through this exploration, the team considers both safety and risk when determining response time and next steps.

In an immediate or same-day response time, there may be present danger of moderate to severe harm or the child's vulnerability, caretaker drug and alcohol use, violence, isolation, or risk of flight increase the need for an immediate response.

To receive a three-day response time, there may be impending danger of moderate to severe harm or the prior list of concerns increase the need for intervention in the near future.

In our five-day response, the referral indicates maltreatment or risk of maltreatment in the absence of a safety concern. So this last category would encompass those reports with higher risk concerns that necessitate child welfare involvement, yet there are no allegations of a safety concern.

For those reports of abuse or neglect that do not meet the criteria for child welfare involvement, we have increased our referrals to community resources and the flexible use of funding through both our IV-E waiver and core services to provide supports to strengthen families and prevent child maltreatment.

Upon initial contact with a family, Volume 7 states, "The county department shall assess for safety and risk." To assist county departments in this initial assessment, we utilize our safety and risk assessment tools. The current tools have not been modified or validated since 1999, so beginning in January 2012, the Division of Child Welfare, Colorado State University, and several counties worked collaboratively to revise the existing tools to improve clarity, usability, reliability and validity. CDHS then partnered with the Kempe Center to develop a comprehensive training to address the foundations of assessing safety and risk, the purpose and use of the tools, and how to engage a family in the process.

Engagement of families in this process is a shift in our practice. In the past, the tools were a documentation exercise in Trails, in our SACWIS system. Now, all safety and risk assessment tools will be completed with the family. The safety assessment must be completed during the initial contact with the family and documented in Trails within 14 days. Likewise, the risk assessment must be completed with the family and documented in Trails within 30 days.

These tools are currently being field-tested in three counties differing in size, geographical location, and implementation of differential response. The field test concludes on November 30th. The outcome of the field test will inform our statewide implementation in early 2015. All case-carrying child welfare staff and their supervisors in the state of Colorado will be trained in the use of these new tools. Only upon completion of training will staff be able to access the new tools in our SACWIS system.

The changes in how we gather information, the use of RED team process, and the new safety and risk assessment tools are being incorporated into our SACWIS system and into proposed rule in an effort to increase consistency throughout their use in our 64 counties. We, at the state, strongly value the correlation between state rule and our tools to provide consistent guidance for our county practice. Both the safety assessment and risk assessments must be completed with the family whenever there is a significant change in family circumstances, prior to reunification, and prior to closing services.

We continue to assess safety and risk throughout the involvement with the family. Safety and risk should be a primary focus of each contact with a family, as it is the premise of our level and duration of involvement. If ongoing services are needed, the safety and risk assessments provide the basis for what to address and/or to mitigate through family services planning.

We maintain the following principles in creating a family service plan with the family: A child's safety is paramount. Children belong in families. Families need support of communities. And community partners are key to achieving strong outcomes for children and families. We do not separate potential child maltreatment from fatal child maltreatment.

Characteristics of families within successful involvement are similar to those families involved in incidents of egregious, near-fatal, and fatal child maltreatment. As referenced in our 2013 Child Maltreatment Fatality Review Report, some of these characteristics include substance abuse and domestic violence, which we will talk about further on this panel.

I am also participating in another panel this afternoon, so I will focus more in depth on potential contributory factors.

In regards to assessing present and prospective child safety, I recommend we continue our efforts to better support caseworkers in attaining the needed critical thinking and engagement skills to assess safety and risk concerns. We need to lower case load numbers, increase the number of caseworkers providing direct practice with families, and equip them with the skills to make informed decisions.

Seventeen years ago when I began in this field, I was the one providing the service. I was the one in the home on a weekly basis. I knew my families. But current case load numbers and workload demands do not allow for this level of attention. The support of caseworkers cannot lie solely with the state. We need your support, our professional partners' support, and our

communities' support to ensure the safety of our children. Only through this collaborative effort will we be able to positively impact the numbers of child fatalities in Colorado.

Thank you.

Chairman Sanders: [Session 2 - 00:22:35] Thank you. Dr. Wells?

Dr. Kathryn Wells: [Session 2 - 00:22:39] Good morning and thank you very much for the opportunity to speak with you and also for the hard work that you all are doing. I did give you some slides, and obviously I'm not going to make it through all of them, but I wanted to just touch on a few issues. I will be speaking with you this afternoon a little bit more in the context of health care providers in general and how they can interface regarding this issue.

I wanted to take the opportunity this morning to speak with you specifically related to an issue that I have been involved in, even when I began my career as a very young, green, naïve pediatrician in a small, rural community in Idaho. I became interested in the issue of substance-exposed newborns, and really, honestly as a way to think about how do we truly prevent abuse and neglect. To me it was sort of simple, you said, "Well, if we knew certain things were not necessarily causative, but families were very frequently struggling with certain factors when they were involved in the child welfare system. For example, substance abuse, domestic violence, which you will hear about shortly, and mental health. It just seemed to make sense to me that if we could assess those issues and those families at that time that they were identified, we could potentially prevent cases of abuse and neglect. So that is sort of how I got involved. I actually, as a young pediatrician, had several families with this issue. It was when the methamphetamine epidemic was just sort of raising its fierce head again. I had a couple of babies die in those circumstances, and quite frankly in unclear circumstances related to whether or not it was abuse, suffocation, an intentional or unintentional injury.

So what I really wanted to do was give you a sense that we believe there are about 12 percent of kids in our country that live with at least one parent who is in need of substance abuse treatment. By the way, your handouts are a little bit out of order because I got back from Shaken Baby [Fourteenth International Conference on Shaken Baby Syndrome/Abusive Head Trauma] last night and had to make some last minute changes, so the substantive information is still there.

We know that substance abuse is a critical factor in the child welfare system. Studies have shown anywhere between 7 to 8 out of 10 child welfare cases have that as a component of what folks are struggling with. There are lots of reasons, obviously, related to a lack of resources, neglect issues, and then also just access to different things.

When we look at pregnancy, we know that typically this situation is someone who has an addiction, who then happened to get pregnant, and not sort of the other way around. Those

women, really, it is such an amazing opportunity, which just was alluded to. They really do have a real desire to have a healthy baby, so it is a real opportunity to make a lifetime difference that may really affect the health of that baby.

In Colorado, we recognize that we are not just dealing with illegal substance abuse; we are number two in the country for prescription drug abuse. We know that binge drinking is a huge issue, and not just here but throughout the country. We have an amazing social experiment occurring right now with the legalization of marijuana. So we think about the different risks to children, and I have put a little bit of data in there. Those are really data that was collected before the legalization, but really just around the expansion of medicinal marijuana. We are now seeing a tremendous amount of cases of kids coming in exposed to ingestions. We have all the other things that go along with that, including other things that make environments unsafe for children, and of course pregnancy. We have a lot of moms, and I guess the only good news is that they are pretty free to admit that they are using marijuana during pregnancy because now it's legal.

We know that the data we have is really a pretty significant underestimation of the cases of babies that are exposed prenatally for lots of reasons that you see listed, and I include in that poor systems tracking, because quite frankly I wish I could get up here and give you a bunch of data, but we just don't have it because we are not collecting that kind of data, and we are not relating it from system to system.

In some of the data that we do have from the National Survey on Drug Use and Health, we do know that use declines a little bit during pregnancy. We know that the folks that probably have the least decline are folks that are younger. But the reality is that it is not uncommon that once that baby is delivered, that use will then sort of rebound by about 3 months of life.

We know the effects are variable, but we know there is really no safe amount of drugs and alcohol to use prenatally, and there has been a lot of things that have created this as an emerging issue, particularly around our understanding around the effects of alcohol. The CAPTA amendments that happened in 2003 and then 2010 increased the numbers of issues related to methamphetamine, prescription drug abuse, and now marijuana, as I have mentioned.

Just as a reminder, CAPTA really required states to have in place policies to identify these babies and get them referred for services. I actually received a grant from the Children's Bureau to look at how does this happen in the context of multiple different systems engaging with the families, not just child welfare. And it really relies upon systems beyond child welfare. Based on that work that we did with the Children's Bureau, we were fortunate enough to get some additional support from our state, then Methamphetamine Task Force, now Substance Abuse Trend and Response Task Force. One of the first things we wanted to do was decrease barriers to women telling their medical provider about their prenatal use and addiction. They were fearful of being prosecuted, quite frankly, so we were able to work with

our legislators and actually pass a law that would protect them from criminal prosecution if they admitted to use or were tested positive during pregnancy. We thought this was a really important first step to them even being identified during pregnancy. A lot of doctors don't even want to ask the question, quite frankly.

So there is our legislation, it has been signed into law. Then we actually put together, as a part of this subcommittee that I co-chair, several recommendations, and you see the web link there. But we really wanted to base this on the five points of intervention, so we didn't want to just focus on drug babies, we wanted to focus on everything from prenatal and pre-pregnancy all the way through the effects during childhood. You can see in the slides I just listed our major recommendations that we really wanted to sort of get across as far as those five points of intervention.

But at the end, what I wanted to do was tell you that if I could have a few things that I would ask most to address, this population, which I really think is one aspect of really trying to prevent abuse and neglect, it would be a couple of things. First of all, I think we need better training and education across the board for all professionals that touch families that have substance abuse as a component, including child welfare, but also the health care community and even our prison systems. When a mom is pregnant in our prison system, we have to be focusing on her other needs—the need for prenatal care and then also treatment. We need standard policies, because I can tell you hospital to hospital, jurisdiction to jurisdiction, there is not consistency in whether this is detected and whether it is screened for, whether there is testing, and what resources are available. We need better information sharing—so in Colorado we have a law that says if a baby tests positive it is a mandatory report and it is under the Civil Code. But the challenge we are seeing now is just some information-sharing issues where the test is positive, the report is made, and the hospital doesn't ever hear back from child welfare about whether there is a response. They are very fearful about sending babies home. We have actually had some fatalities. Data is incredibly important to know if what we are doing is making any difference at all.

Lastly, we need effective and available treatment. When I ask my treatment colleagues the two things they would ask for, it would be treatment and training, and funding for that.

So the rest of the slides are in your packet and you can look at them at your leisure.

Elizabeth Collins: [Session 2 - 00:30:29] All right, good afternoon, Chairman Sanders and respected committee members. My name is Beth Collins. I am with the Colorado Coalition Against Domestic Violence, as well as a five-year member of Colorado's Domestic Violence and Child Protective Services Coordinating Council, which created a practice guide that I will reference in some of my slides. I've also been a part of the Colorado Child Fatality Prevention Review Team, and I know you will be hearing from Lindsey later today.

Domestic violence is a pattern of coercive control, which is used by a person to dominate and control their intimate partner. This is not fighting, but rather an intentional entrapment, which yields the offender advantages that they desire, such as having their needs prioritized within the family. Domestic violence is perpetrated at epidemic rates in the United States, with the CDC reporting that one in four women will be victimized in her lifetime. We also know that offenders' sense of entitlement to abuse goes beyond just their partners and extends into their interactions with children. Domestic violence offenders are much more likely than nonoffenders to abuse children, because physical and emotional abuse are accepted tactics towards their goal of control. Caseworkers frequently tell me that they see domestic violence as one of the factors in the families that they work with, about 40 percent to 80 percent of the time.

In 2013, domestic violence was found in almost 40 percent of Colorado's substantiated child maltreatment fatalities, near fatalities, and egregious incidents that were reviewed, and it was found in 17.4 percent of the fatalities, if we separate just that out, which compares to 20 percent of child fatalities nationally.

Knowing that there is domestic violence is insufficient to determining where, on this spectrum of risk, an individual child lies. There is much that can be said about that spectrum of risk, but in specifically considering the role of domestic violence in child fatalities, it is really important to recognize that some domestic violence offenders will purposefully kill their children as a means for tormenting and punishing their partner. This is at that most extreme end of the spectrum.

Currently, the best method to assess the degree of risk to children is via analysis of the power and control tactics within the relationship. Building targeted interventions to address the domination, and then observing whether the offender engages in interventions and shows signs of actual change. Such analysis is greatly enhanced through collaborative conversation with co-located anti-domestic violence advocates, as promoted through the Green Book Initiative.

Currently there are tools that can help workers to sort out and specify the patterns of perpetration and survivorship. A caseworker's ability to get contextual information is significantly improved through a trauma-informed approach to engagement and a genuine interest in partnering with the adult victim towards their common goals of ending the violence and promoting child well-being. Strength-based assessment of adult survivors should be codified in worker training and in administrative practices.

Once families have been determined to be experiencing maltreatment and domestic violence, it is valuable for caseworkers to bifurcate cases and to recognize that reunification of offender parents back into families may not be safe for children. With the ability to contract for services, child protection has the ability to promote research-based community offerings specifically designed for abusive men as fathers, such as the Caring Dads curriculum.

For children and adult victims, programs such as the Kids' Club and Moms Empowerment program should be made available. Mainstream parenting programs are dangerous referrals for offender parents who, after all, do not need child management strategies, but rather do need specialized education on relinquishing their controlling regimens.

Multidisciplinary approaches to offender accountability are also important, since many offenders are highly skilled at performing well under observation, and also because offender perception of having "beat the system" emboldens them in their use of abusive behavior.

In Colorado, offender treatment engages with child protection to strengthen the messaging and monitoring of domestic violence offenders. Universal screening assessment that gets to the underlying coercive control dynamics, caseworker partnership with adult victims and caseworker accountability and connection with abusive men, targeted referrals to research-supported community services, and multidisciplinary monitoring are necessary measures for caseworkers to assess which offenders are most likely to persevere and escalate in their use.

I recommend that child welfare adopt a core principle regarding the philosophical and practical approach to co-occurrence cases—this varies state by state as to whether they have this—and also ensure that information skills and critical thinking about domestic violence are embedded in worker training.

So I have outlined the best existing strategies I know of that would fit within our current paradigm, and these, perhaps, are the extent of what you might consider in your work of developing your own recommendations. I must say, however, that I do not believe that we can eliminate domestic violence-related child fatalities within our existing paradigm. Caseworkers do incredible work with families on behalf of vulnerable children, and yet workload demands far too often prevent them from thoroughly doing the work to which they are dedicated. At minimum, additional caseworkers will be necessary for the task of eliminating child abuse and neglect fatalities, especially in the face of domestic violence co-occurring.

To truly eliminate domestic violence-related child fatalities requires us to take on a fundamentally new approach, which would center child safety and well-being as the foremost concern of our social institutions. We need to recognize the intentionality of abuse, the doggedness of offenders, the danger which accompanies access, and we need the resources and the will to ensure child safety. We need new information to equip child welfare workers with research-based and validated tools to identify children at high risk for homicide, perhaps similar to the tool Dr. Jacqueline Campbell created regarding adult victims.

When a high-risk child is identified, the response needs to include swift and significant safeguards for the child and their primary caregiver, while keeping them within their communities. We need more robust means of actively monitoring offenders and holding them

accountable for sustained behavior change. We need to push aside the historical wall between child protective services and family courts in order to ensure that offenders do not swamp child needs through prolonged custody litigation.

Additionally, our existing paradigm does not dismantle poverty, racism, or other systems of oppression, which manufacture vulnerability. We need creativity, righteous anger, and a collective spirit to actually end all abuse and neglect against all children. May we indeed see that day.

Thank you for your time.

Chairman Sanders: [Session 2 - 00:37:43] Thank you. I know we have a few questions. I think we will try and limit it to maybe three or so and then move to our last panel before lunch. Dr. Rubin?

Commissioner Rubin: [Session 2 - 00:37:56] Thanks for everyone's testimony. I wish I could ask each of you a question, but I'm going to address a question to Dr. Olds around the timeliness of discussing home visiting and how we support that, and its relationship to a national strategy that we are trying to develop around child abuse fatalities.

You know, with the success of the trial evidence of home visiting, particularly for the Nurse-Family Partnership, it would be expected, it is not something that is germane to home visiting, but any successful trial program, when it moves to implementation, is always going to have challenges and barriers to maintaining the same level of success and efficacy that it had in the trial environment. It is just harder as you replicate. With respect to home visiting or Nurse-Family Partnership, there are challenges that we have seen on the ground, knowing this issue intimately in Pennsylvania, around retention of women into the program and acknowledging that unless we retained women into the program after birth we are going to have a challenge addressing child abuse and safety issues for families.

There are also issues of how the program is being used locally, given that particularly Nurse-Family Partnership could be expensive, that a lot of communities may choose just to offer Nurse-Family Partnership to its highest risk clients who were either incarcerated or in the child welfare system, with high rates of these problems.

Then there is the connectedness to other programs like child care, etc. So what I am asking Dr. Olds to talk about is what is the national strategy around community context, and what should we be expecting communities to do, and what can we do to support programs like Nurse-Family Partnership and other home visiting programs to be successful in the mission we all want to achieve?

Dr. Olds: [Session 2 - 00:39:45] Okay, I'm going to try, Dr. Rubin, to address those issues in order.

We believe that on average there will be some attenuation of program impact as the program is rolled out in new communities. I think that there are some communities where the program will be delivered better than it was in the original trials. But it is almost inevitable there will be some attenuation of the crude metric that Ted Miller, who is an economist at the Pacific Institute for Research and Evaluation, has used as the number of completed home visits as a crude metric. Nationally, the number of completed home visits compared to the trials is about 78 percent of those that were delivered in the original trials. So that would mean that there is likely to be about a 22 percent discount in terms of both functional outcomes as well as economic returns. That's the first point.

I think you were exactly right about communities learning about the program and sending their highest risk families into the service. And we think that the Nurse-Family Partnership nurses, in many ways, are front-line mental health workers, front-line environmental health workers, front-line health providers, and that they should embrace those highest risk families because the evidence that they are the ones that are at greatest risk for a host of problems, including child fatalities. In many cases, this may mean that the nurses need to work with communities to address the fundamental inability of some parents to protect themselves because of severe mental illness and substance abuse. This, we believe, should not rest on the shoulders of individual nurses or nurse teams, but that there needs to be a fully functioning community that will back up the nurses and these nurse teams in addressing these extraordinarily high-risk cases.

As part of our national implementation strategy that we set in motion, or that really kind of evolved, early on we failed. I failed to really support the creation of community advisory boards to support the nursing teams in the context of this program. And what I see nationally in those two states where we failed to do that is that the quality of implementation and the sustainability of the program in those states suffers. So today we see that there is variation in the extent to which there are fully functioning community advisory boards to support the team in both programmatic and clinical ways. That variation, in my view, is a significant contributor to whatever attenuation of program effect may exist.

So you saw on the slide, there are a lot of things we do to try to ensure that the program is conducted with a lot of fidelity to the model. We do that partly because we don't say that just home visiting works, we say this particular program at this particular point in human development, delivered by nurses who are following detailed visit-by-visit guidelines, have a good chance of producing the kinds of results that all of us in this room are committed to. So that kind of clarity, I think, from a programmatic perspective, that kind of commitment to evidence and developing really rigorous evidence to help us guide in a policy sense, in a practice sense what works, what doesn't is, I think, in my view, the hope for the future. We need to turn up the microscope and we need to be really rigorous, accountable, and willing to admit when things don't work the way they should. It is that kind of an attitude, I think, that will help us get closer to what we all want.

Chairman Sanders: [Session 2 - 00:44:05] Commissioner Petit?

Commissioner Petit: [Session 2 - 00:44:10] One for Dr. Wells. I understood you to say that the legislature passed a law saying there would be no prosecution if a pregnant woman stepped forward, right?

Dr. Wells: [Session 2 - 00:44:23] Correct.

Commissioner Petit: [Session 2 - 00:44:24] What happens when, despite that effort to provide services, the woman persists in drinking, let's say she has two previous children, one with fetal alcohol syndrome. What should the intervention be in that particular case? What do you do in that kind of situation?

Dr. Wells: [Session 2 - 00:44:41] You know, I think from our perspective as a committee, and we are really fortunate, we have professionals from all areas on a part of our committee, is that each one of those cases needs to be looked at individually and independently. The hope would be that in a collaborative manner child welfare would be at the table, the health care community would be at the table, the treatment community would be at the table, so that all of the folks could be wrapped around them. Then part of the challenge is confidentiality and communication, and we always say, "If you are in the treatment world you are a mandated reporter," so if she does something, if something is not going well, I have to report that, but I don't get to report the good things. So getting signed releases for sharing of information amongst all those agencies and those systems, and being able to determine, with child welfare's rules around determining risk and safety in that particular moment, and then making a decision. You know, there are times, and I have worked with them, of folks that have struggled with addiction. Part of the challenges of addiction is it is chronic and there are relapses. We know that happens as part of any chronic disease. Women can get clean and actually can safely parent another child. But as we all know, there are times when, for whatever reason, at that time in her addiction process, she may not be able to be able to safely parent, and at that particular moment that child needs to be, I think, as quickly as possible that decision needs to be made as far as long-term safety and protectiveness for that child. So what I don't want to see is kids linger in the system where they are back and forth, back and forth. I think that with all hands on deck, best decisions can be made about the safety of that particular child in that particular situation.

Commissioner Petit: [Session 2 - 00:46:14] But I'm talking about in utero. So in addition to that, in an in utero situation where the mother says, "I'm going to keep drinking even if it is the third one." The legislature must have considered and rejected any kind of involuntary detention, which I'm not recommending, but I'm asking, what do you do in a situation when it is an in utero experience?

Dr. Wells: [Session 2 - 00:46:32] Well in Colorado right now, unless there are other kids in the home, a report might be made to child welfare and they would assess the safety of the other kids. So at that point, they could potentially put some expectations in place for the mother to try to keep her from using. But right now, and I understand your concern, and I think we all struggle with this, and that is where law enforcement sort of came with sort of their response of saying, "Well at least we can put her in jail and we can keep her from using we will protect that baby," but certainly, in our state right now, our hope was sort of … we talked a lot about that, but our hope in passing the law was to try to get to those folks as early as possible. Get them to openly talk about their addiction, and get the help that they need. We know that if we can get them to decrease their use, even if they don't stop using, the outcome of the baby is better. So I think our hope, and even law enforcement, our district attorney's office, and everybody signed off on this legislation to try to drive it the other way rather than being punitive and drive people away from the system.

Commissioner Petit: [Session 2 - 00:47:28] Okay, last quick related question to Paige. Paige, you said when you are three days out there is an immediate reply that you do right away, right? Then there is something that is three days out.

The question I have is if a felony has been committed, or alleged to have been committed, or maybe proven to have been committed at some point, at what point do you guys engage law enforcement in specifically enforcing the behavior or the intervention that somebody does not want to comply with, say a guy that is just angry and has hurt people. When does law enforcement come into the picture?

Rosemond: [Session 2 - 00:48:02] Well, often law enforcement is our reporter and so they are engaged from the very beginning. We always want to work collaboratively with law enforcement. Of course, we have different statutes that guide our practice and our involvement, and we adhere to those. But as mentioned by Ms. Krow earlier today, we want to monitor those memorandums of understanding and ensure that we are working collaboratively throughout the process with law enforcement, so from the onset and throughout.

Commissioner Covington: [Session 2 - 00:48:35] Beth, you gave us an enormous amount of information in a really short amount of time. I thank you so much. I don't know how you did that, but I'm hoping we can maybe get your prepared notes because you really covered a lot. I think what you made me realize is how much more attention we need to pay to this as a Commission, and at some point I hope we can really spend some significant amount of time on the interplay between domestic violence and child abuse just because of the numbers.

I did have a question in terms of where you were going really quickly through your information on the issue of making it child-centered because a lot of what we hear about is it should be women-centered in terms of not revictimizing the woman. How do you make that

work in terms of making a child-centered approach when you are doing domestic violence with women and their children?

Elizabeth Collins: [Session 2 - 00:30:29] Thank you for that question. So I think that oftentimes one of the confusions that I've encountered with caseworkers is this notion of neutrality. I don't want to take sides with a parent, right? I'm here to be a neutral advocate for what the child needs, and I absolutely agree with that. You start with the fresh place of approaching the parents, sorting through the information saying, "Okay, I heard about somebody took the keys and prevented the other person from leaving. What does that mean? Is that protective? Is that abusive? Are you isolating?"

Okay, so once they can make that determination that this parent is using domination strategies within the household and this parent is attempting to engage in protective strategies, you have identified the adult victim. At that point, partnering with the adult victim is in the best interests of the child. We know that the number one resiliency factor for children who have witnessed domestic violence is a strong, protective relationship with a primary caregiver, oftentimes the adult victim. So that is the point at which you began with a child-centered approach, and you are looking at what is the circumstance that is producing risk for this child? What have been the attempts to protect this child? And even when those attempts have not been sufficient to arrive at safety for the child, it is very important to acknowledge and validate those. Sometimes the strategy is to go in the other room and put on the Disney video. This does not protect a child; however, it is a safety strategy, and when we can recognize it as that, even though it is insufficient, then we can start to build that alliance with the primary caregiving parent who does, in fact, share the common goal of wanting elimination of the violence.

There is so much I could say, but I will simply say that sometimes what an adult victim can find useful is for their partner to be given a genuine opportunity, from a place of respect, to change their behavior in ways that make it so it is not dangerous for children. And child protective services can, through appropriate engagement, offer that opportunity. And if that offender engages, fantastic. Wonderful. But for those offenders who are most dangerous to children who do not participate in services, who try to manipulate, spin the information, and undermine the primary caregiver's parenting, that is actually new information for that survivor. "Here is what he did when he was given a genuine opportunity for reform and new information." So again, that can reinforce the alliance and help the protective parent to arrive at a new set of strategies.

Chairman Sanders: [Session 2 - 00:52:24] So I want to thank this panel for again providing us tremendous information in some different areas, and I know we will see several of you again later this afternoon.

We have Senator Linda Newell and Representative Jonathan Singer, who will bring the perspective of the legislature into what the federal government can do to reduce or eliminate child abuse and neglect fatalities.

Welcome and thank you for being here.

Senator Linda Newell: [Session 2 - 00:53:06] Good afternoon. This is a horrible place to be in the timeframe. I know stomachs are probably grumbling by now. I will speak as fast as possible, how about that?

Chairman Sanders and Commissioners, I am so grateful to be here. Thank you for the invitation and thank you for the opportunity just to be in the room with so many of my heroes. I really do appreciate it.

My name is Linda Newell, and I am from Littleton, Colorado. I am a State Senator for Senate District 26, which is just south of Denver. I am Vice Chair of Health and Human Services, Vice Chair of the Judiciary Committee, and Vice Chair of the Joint Technology Committee, among other committees. I am also the founder and co-chair of the Children's Caucus, as well as the Behavioral Health Caucus.

I don't need to tell you that it truly does take a village to safely raise a child, and your invitation for us to speak with you today is proof of your belief in that collaboration and alignment at all levels.

While none of us would prefer to have a system as our parent, we recognize that when it is necessary for the safety of the child, we better have in place the best processes and the best safeguards possible. So thank you for inviting us here to share with you today, from a Colorado legislator perspective, the federal assistance that we might be able to use, then to recommend to President Obama and the administration.

Next to me is one of the best additions to our lower chamber that we could ever have, Representative Jonathan Singer, who is my partner, not in crime, but in solutions when it comes to children.

Representative Jonathan Singer: [Session 2 - 00:54:57] Able to rouse from his nap to get you out here today. Far be it from me to be between this panel and lunch, but my name is Representative Jonathan Singer, I represent Colorado's House District 11, which covers the suburbs of North Boulder County all the way up to Rocky Mountain National Park, and I walk two lines in Allenspark and Longmont, a pretty diverse district. Before I had the fortune of doing this job, or at least I consider it a fortune, I was actually sitting in a child welfare office doing work with child protection, investigating allegations of abuse and neglect, doing intake, whether it was physical abuse, sexual abuse, child neglect, drug-endangered work, and also working in juvenile delinquency and truancy court. So I have to say it was interesting being

able to work with kids and work with drug addicts, and at the capitol I sometimes just feel like I've joined them. But the more important thing is that I look forward to discussing with you some of the things that we have put together in Colorado, and we have really been able to … I won't say do a 180, but certainly turn things on its side in Colorado. So with that I will hand it back to Senator Newell to talk about some of the changes that we have made over the last several years.

Sen. Newell: [Session 2 - 00:56:25] Knowing that when you have a legislator in front of a microphone we can go on for hours, I prepared my notes so I can keep to a script and talk as fast as possible.

So as you heard this morning from our partners, we are making significant strides in Colorado with the protection of children and families, since I came into the State Senate in 2009, after a long string of child deaths due to abuse and neglect within the system.

We have made some of the most significant reforms and advances in Colorado child welfare policy than we have in two decades. Amidst the resistance of some, the collaboration of others, and a whole lot of persistence, we have, in just six years, created the Child Welfare Training Academy, established the Child Protection Ombudsman Office, launched our innovative public health-based child fatality review teams, launched our Early Childhood Leadership Commission, and created a preventive, responsive, integrated Office of Early Childhood. We have also been making national news as well, with advances in preventing our youth, oftentimes youth in foster care, from entering our criminal juvenile justice systems with diversion for juveniles, removal of zero-tolerance school discipline policies, and incorporation of restorative justice practices in our schools and in our criminal and corrections systems. The early data, by the way, on restorative justice is already showing that our recidivism rate is going down from 50 percent to 11 percent for youth in RJ programs.

This year, as part of our human trafficking legislation, we are now forming the country's first multidisciplinary statewide Human Trafficking Task Force and a new statewide Suicide Prevention Commission. Parenthetically, unfortunately, we have one of the highest suicide rates in the country, with suicide being the leading cause of death for ages 10 through 34.

Those are just some of our major programs. We have enacted almost 50 pieces of legislation protecting children from abuse and neglect, or aiming to prevent kiddos from entering our juvenile justice system.

In the legislature in the last few years we have also created the Children's Caucus and Behavioral Health Caucus, and Children's Obesity Caucus, all bicameral, all bipartisan. These have been very helpful in educating the general assembly members about the most timely policy issues and the complexities of the problems and solutions. These collaborative efforts have brought a new culture of focus on children's issues, and I believe we have seen more bipartisanship and more effective, well-designed policies as a result. We have been doing all

of this amidst new marijuana regulations. Some of us didn't vote for that, but we are bound as legislators to uphold our Constitution, so we are dealing with really post-prohibition times in Colorado.

So turning to recommendations or requests for you, a few items rise to the top for Colorado. You will be pleased to note that not all of them come with an additional price tag, just with additional focus. To me, these are categorized as either intervention or prevention.

First, with intervention. As you might know, Colorado has increased our kinship care over the last few years, but there is much more to be done with it—meaning training of potential kinship providers and respite care availability. One inequity that is often pointed out is that foster care parents, when they are strangers, are compensated. Yet the children's relatives are mostly on their own. However, as you know, the data shows that more families remain intact over time, and children remain safe, when placed with safe, loving kin.

So our request: Is there a possibility of more support to kinship care programs for these purposes, either with funding or program-specific incentives?

Another intervention model that we started a few years ago was our Child Protection Ombudsman Office, where people can take their concerns, complaints, and compliments confidentially about the child protection system or a specific case. It was clear, at that time, that Colorado needed an independent source where citizens or members of the system itself could go to help improve the system. It took me two years to get that through, due to some resistance and intense collaboration, yet in the end it passed unanimously in both chambers. So we have strong, legislative support for the office.

As expected, there have been successes and challenges noted from all of the stakeholders. And due to Senate Bill 14-201 this year, we put together a Child Protection Ombudsman Advisory Work Group, revisiting the autonomy and accountability of the office and making recommendations to the governor, legislature, and executive director of Colorado Department of Human Services.

I give you all of this explanation to give you the foundation for our request for federal guidance regarding child protection ombudsman offices. Could we put federal legislation or regulations in place similar to the Long-Term Care Ombudsman Program that is federally protected, supported, and consistent across the states? The numbers of children who die at the hands of those in the system is preventable. If states could take advantage of national expertise and research, and potential funding or incentives, and the stability of their ombudsman offices, we believe children's lives could be saved.

Also unfortunate in Colorado is our finding that human trafficking is alive and well in Colorado. We have well-situated highways going east and west, north and south, and one of the busiest international airports in the country. We are trying to get fuller data on our child

sex trafficking, labor trafficking, and modern slavery, but we do know it is prevalent and often targeted on the children from broken homes, in foster care, and, tragically, the homeless youth. As a result of our human trafficking bill this year, which helped with our alignment with federal legislation, we went from Tier 3 to Tier 1 ranking with the National Polaris Project, with enabling state human trafficking legislation. However, we are still failing when it comes to victim assistance. So the new, statewide task force will be addressing these concerns and making recommendations.

But this is an international problem needing national support that can help us prevent more children from being stolen, re-homed, and sometimes even killed. We need federal support with interstate and regional solutions and relationships to help each other in the problem solving. With prevention, over the years I have come to realize that we sometimes have our priorities upside down when it comes to kids, and I was listening to Commissioner Dreyfus and we are so aligned in that. It is said that a governmental budget is a moral document showing what we care about, what we are willing to stand up for, and what we take action upon. If that is true, every year we have many more dollars budgeted to intervention compared to prevention. It is sad to see every year the prevention programs either cut, minimized, or left dangling, while those are the programs to prevent children from entering the system in the first place.

As we all well know, the Nurse-Family Partnership programs, with the nurse home visits, have consistently shown the best outcomes of any prevention model out there, and yet is it in every county in Colorado? No. Gratefully, we hope to see some successes with our new prevention work that we are doing with the department and Kempe Center as well. Personally, I would love to see nurse home visitors in every home across the country, but that becomes a values battle, as well.

This year, when we implemented our public health child fatality review team, and thank you, Commissioner Covington for all of your help with that, I was thrilled to see the hope and willingness of the public health professionals. They are so excited to be formally recognized as part of the solution in eliminating child abuse and neglect deaths.

Going even further back in the cycle, we need to prioritize moving toward a more peaceful culture in the United States. Prioritizing peace and conflict resolution and anger management, conflict management programs, especially in early childhood and schools, so that we are building our next generation of peacemakers and those able to solve problems without violence.

Perhaps more push for a more child-centric culture, a Children's Bill of Rights, although I am well aware of the politics there, and of course easier access to mental health services would also contribute to helping that almost 80 percent of those abusive homes with the presence of mental illness or addiction. Although I am one of those working on intervention, I believe that by the time someone makes a report it is too late in the cycle.

My last request is a blend of intervention and prevention. Intervention through Colorado and Washington and prevention for the rest of the country. As you might have heard, we now have parents moving into Colorado from all over the country in order to find medical marijuana help for their kids with seizure conditions. The research would definitely help them and us in setting regulations. On the flip side, our emergency room visits of children due to accidental ingestion of marijuana have tripled. Hash oil explosions in people's homes with children present are now frequent. So we are working as hard as we can to get the marijuana regulations right when it comes to protecting the children.

So our request: Without the legalization of marijuana federally it has been very difficult to get much research or evidence-based data on the effects of marijuana, especially on young developing brains, let alone their caretakers' brains. Just this year we have been able to finagle a little bit of help from some state resources and universities, but we could use some assistance from federal research dollars so that we have the appropriate medical responses and/or protections for the children.

May I say again how grateful I am to be here with you as a part of the solution, hopefully, in preventing children from dying from abuse and neglect.

Thank you for asking, and thank you for inviting us here, and thank you for listening.

Rep. Singer [Session 2 - 01:08:02] You are welcome. Thank you, Senator Newell. I think that, like I said, if someone had told me three years ago, sitting in a child welfare office, that I would be sitting here today, and within my second year at the capitol I would have successfully passed a statewide tax increase on legal marijuana, I probably would have asked what they were smoking.

But the truth is I really want to first of all, thank the media, which is not something you hear a lot from elected officials. But I want to thank the media and the *Denver Post* and other outlets for their "Failed to Death" series that really brought the eye of the storm to light. People just don't think about this. We talk about, you know, the anniversary of September 11th and how tragic and horrible that was, but we know the victims of intimate partner violence, we know that children dying in homes from abuse and neglect far outrank the dangers that happened due to international terrorism. We have domestic terrorism every day. But without that "Failed to Death" series, I don't believe that we would have been able to accomplish what Senator Newell talked to you about or some of the other things that we were able to do.

In a state-supervised, county-administered system, one of the challenges that we frequently see as lawmakers, and one of the issues that I frequently saw as a caseworker, is what happens when you have a family that is split because of divorce and you have got one living in one county and another living in another country, and you have got two counties that are

both overwhelmed, that are wondering if the other county would be willing to assess this family.

Now we have a new hotline system that will create a routing system that anybody can call anywhere in the state. It will go the county where that call originated, and there will be monitoring at the state level to make sure it goes to the right county. And if it doesn't make it there or if it needs to go back, we will actually have a system of actually collecting that information.

The other thing that we successfully were able to do is stop treating our hotline workers like secretaries. You can laugh—I got coffee for a lot of my caseworkers working the hotline. No. I mean that, unfortunately, culturally, when you see someone with a headset answering a phone, you don't think "caseworker," you don't think "investigator," you don't think "someone who is diagnosing a problem," you think "secretary." We have changed that now in Colorado, where we now have consistent training for our caseworkers that are working those hotlines. That wasn't happening before. If you can't ask the right questions on the front end, how can you expect a good result on the back end? It doesn't happen. So now we have started to put those things into place over the last couple of years, and like I said, in large part thanks to the media standing up and saying, "This is what is happening to our kids." And thanks to our state Department of Human Services for allowing some of the best access to the media that we have ever, historically seen in Colorado. We still have a ways to go on that issue. The hotline hasn't come to fruition yet because we are working on doing it correctly. We want to do it right because we know that if we don't get the hotline system and the routing number correct, that more kids will end up getting hurt, more kids will end up dying.

Secondly, in just a response to some of the comments that were made, some of the other revolutions that you've seen over the last couple of years is a move towards differential response, which I'm sure you have already heard a little bit about. Because caseworkers aren't there to be bureaucrats; these family caseworkers aren't there to be cops or police officers. They went to school to be trained in how to partner with families to make sure that kids are okay, that moms and dads have what they need to do the right thing for their families. Now, differential response is allowing those opportunities to come to fruition.

But that begged a larger question, and that was the question of do our workers have the tools that they need to do their job? I don't like metrics for the sake of metrics. I know we all like looking at numbers. I spend a lot of late nights on C-Stat, our system of looking at how we are best handling our cases in Colorado. But metrics for the sake of metrics is a dangerous thing. We put more and more money into studies when we could be putting that money into services. We need to look at that balance, both on a federal and a state level. That being said, Senator Newell and I, with several other legislators, were able to pass a bipartisan audit of our caseworker system and do a workload study. And I want people to be very clear on the difference between a workload study and a caseload study. Too many times we have been doing long division. You see a certain number of caseworkers, you see a certain number of

cases, take the number of cases, divide it by the number of caseworkers, or vice versa … well, if your caseload is looking okay, then you're meeting certain federal and state standards, then you are okay. The fact of the matter is, if you get three shaken baby cases as a caseworker, as opposed to a kid that is coming to school with holes in his shoes, there is a big difference in that workload as opposed to your caseload.

So what did our workload study actually say? Well, the state is short at least 574 caseworkers and approximately another 180 managers. There are several counties that decided not to participate in the audit, which is something I will be working on in January. But the fact of the matter is there is a huge deficit in our capital in terms of our foundation. We talk about building a better house all the time. We use that metaphor. How are we going to create better preventative services and better interventions, work on the front end? But when your foundation is cracked and we're not filling that foundation with the caseworkers that we need to do the job when those calls are coming in, then how can we expect good results in the first place?

Some of the other statistics that came out of that workload study said that two-thirds of caseworkers were saying that their caseload is unmanageable, and 99 percent more time needs to be ensured that kids in placement, kids in foster care are getting the follow-up from the caseworkers that they need, and 25 percent of those caseworkers are spending the time that they need to get that monthly contact with those kids.

So if we give people an impossible task and we start convening these Presidential Commissions, and we start looking at these things, we need to ask at the very foundation, "Are we doing the right thing?"

This year will be an interesting year. Senator Newell talks about the fact that we find out this year how many of our lawmakers really are pro-children because this is going to take money. This isn't going to be an innovative solution. I always warn people we shouldn't use metrics for the sake of metrics, we shouldn't innovate for the sake of innovation. There is no innovative program that is going to solve a deficit of 574 workers. So the question is how do we get there? How do we fill in the cracks in that foundation? And what we are looking for, and what I am looking for, is to see whether there are opportunities for federal matching funds, to see whether there are opportunities to make sure that if we invest in kids that we see the federal government stepping up and making an equal investment or greater investment to make sure that we can do what we need to do for our kids in Colorado.

Thank you.

Chairman Sanders: [Session 2 - 01:16:03] Thank you. Thanks to both of you for the work that you have done, and great to hear of your experience, Representative Singer, I didn't know that. That is great.

We are at a point where we should take a lunch break. I know there are questions but it depends on how hungry you are. [*Laughing*]

Commissioner Petit: [Session 2 - 01:16:26] I am always hungry, never satisfied. But we have lawmakers here, and ultimately the nation's policies and budgets are shaped by our lawmakers, and in the end it is a political question and a values question. So I would just like to hear from the two of you what kind of political support you are getting in your own districts. Are you getting any pushback from particular groups? Do the elderly like you? Do the rich like you? Do the blacks and whites like you? Politically, how does this play out in a profession when only 49 percent of the people don't like you it is a good day?

Sen. Newell: [Session 2 - 01:17:00] Chairman, thank you for asking that question. Commissioner, we both come from somewhat what we call "purple districts." Mine actually has some of the wealthiest and some of the poorest in the state. And it is literally a third Republican, a third Democratic, and a third Independent, and some Libertarian mixed in there too, of course, it is Colorado.

So it is very diverse, and I can tell you that not only in my own district, but in our "purple state," I get calls and emails from around the state, who are begging to come help with a solution, who are thanking me for leading the charge, who are thanking me for doing this kind of work. And I can tell you that it is a nonpartisan issue.

Now how we approach the solution might be a little bit different, but both Representative Singer and I work across the aisle very well, and if I can, in fact, over my tenure I've got 97 percent of my bills that have been bipartisan. The last two years have been 100 percent bipartisan. I make a point to engage in the stakeholder process, all stakeholders from all different value systems.

So at the state level, I will say children are a nonpartisan issue. However, just an example of the Foster Care Bill of Rights bill that I tried to call it that, I could not call it that because of some of our right-leaning opposition to that. So you do have to be careful about how you phrase things, but you can still do the same programs that are there normally.

Now I cannot speak for Congress. That is a different story, but at the state level I can tell you that it is truly nonpartisan.

Rep. Singer [Session 2 - 01:19:06] Yeah, I think one of the tough things that you need to look at, and I apologize, after lunch I am actually meeting with AARP, so I get the whole spectrum today, but one of the things that we need to talk about is individual rights as opposed to the importance of a strong community, and how you balance those. That is a challenge at the state capitol. One of the quotes that really stuck in my head from one of my, actually, Republican counterparts in the Appropriations Committee, when we were voting on creating the statewide routing system is: "This is too important to not fund. This is too

important. I know I'm going to get beat up by my constituents, but this is too important." And of course he was term-limited, so that helped.

But those are the kinds of things that you need to build the case, and where Senator Newell and I co-chairing the Children's Caucus, and being able to talk about the stories and the numbers behind those stories, you can break down some of those barriers. But it is not an easy task to do. None of this is a slam dunk, and it is a dedication to a long process that, like I said at the very beginning, I don't think we would have made the headway we would have without the media shining a light on this issue.

Chairman Sanders: [Session 2 - 01:20:29] Thank you very much. We will take a break for half an hour and return at 1:50 from lunch. Thank you.

Chairman Sanders: [Session 3 - 00:00:01] Our panelists are all gathered for the next presentation, which focuses on the state and county interaction related to preventing and investigating child abuse and neglect fatalities. We have state officials who will be leading this off and then followed by a discussion on El Paso County, which sounds like it is doing some very innovative work. We have some data, and we will get a chance to hear about what they have done.

So we have on the left Lindsey Myers and Marc Mackert. Go ahead. We will have you present.

Lindsey Myers: [Session 3 - 00:00:40] Good afternoon, everyone. Welcome back from lunch. My name is Lindsey Myers, and I am the Injury and Violence Prevention Unit Manager at the Colorado Department of Public Health and Environment. Before coming to the Colorado Department of Public Health and Environment, I actually worked at the local health department in El Paso County, so I am very excited to share this panel with my colleagues from El Paso County because I think they are a really great example of what can be done for prevention when agencies collaborate. They have a really good example of that you will hear about in a little bit.

What I am going to talk about is our Child Fatality Prevention System from the public health perspective, which Dr. Wolk talked about briefly this morning. In addition to the Child Fatality Prevention System, I oversee a number of prevention programs for a variety of injuries through sudden violence prevention-related causes from primarily CDC funding and other grant sources. So having the Child Fatality Prevention System, from the public health perspective, grounded and based in the Injury and Violence Prevention branch at the health department puts the focus on prevention in a way that really allows us to leverage resources and gives us an opportunity to learn from these cases and immediately apply what we have learned, and to capture the risk factors and protective factors that we learned through that process and write for funding to implement the prevention strategies that we oversee.

In Colorado, as was mentioned this morning, we have two complementary systems for child fatality review in Colorado. I'm going to speak to the public health side, obviously, and Marc is going to talk more about the human services child fatality review process.

From the public health side, we do look at all preventable child deaths that occur in the state of Colorado, so not just residents of Colorado but any death that occurs here. We use death certificates as the primary way to identify those child fatalities, and then we go through and look at the circumstances, the ICD codes, and those types of things to determine which cases or deaths we can delve into in more detail and look at prevention strategies. So we look at all accidental manner, all undetermined manner, suicide, and homicide, obviously, and the unique thing, as you all know, for child abuse and neglect is it really can cut across all of those different manners and causes of death.

So by looking at them all, at least from death certificates and then for many of them looking at any record we can find on these cases from coroner records and investigative records, hospital records, and public health records, where they are available, we compile all the information and do use the National Center for Child Death Review's tool to be able to capture that data, have an aggregated look at it, and delve into it.

We have in Colorado an average of 650 to 700 child fatalities a year under age 18, and we really do a thorough individual case review on about 200 to 300, depending on the year. Of those cases, from 2008 through 2012, 230 child fatalities in that period are team-classified as child abuse and neglect. This definition that we use differs from the human service definition. Our legislation now asked us to reconcile those numbers and try to get a better understanding, so we have been working together to do that.

But from the public health standpoint, we are really looking at any death using the National Center for Child Death Review's guidance on omission and commission, and how to look at these things. What is the broadest public health definition that we can use so that we can really focus on the risk and protective factors and start to develop prevention strategies. So some in … that number includes cases, but those were known to human services but did not meet the level for substantiation. A great example of that, since suicide has come up a number of times today, might be a suicide death where we learn in the course of reviewing the case materials that sexual assaults had happened earlier on years and years before, so not directly related to this death but contributed to the child being in such despair that suicide was an option. So we really are looking at a very broad definition.

Senator Newell and Representative Singer helped pass Senate Bill 13-255 to really make improvements to our child fatality review process in Colorado, so some of the collaboration between our two teams which already existed prior to the legislation was codified into statute, thus really looking at and reconciling the numbers between the two different systems as well as making sure that we come together and have our teams issue joint

recommendations. That is really great because that is solid statute now, and when Marc and I leave that will still happen, so that is a good thing.

The other thing from the public health side that it did was really strengthen our ability to have a true statewide system for child fatality review. So we have been conducting public health reviews of child fatalities since 1989. Our first legislation passed in 2005 and was really, until recently, a state-level process. Local review teams could exist if they wanted to, but they weren't required to. One of my roles when I worked at the El Paso County Health Department was actually to coordinate their local review for a short time, so they did have one that they pulled together.

What this new bill did was mandate that it happens across the state and puts the onus on local public health to create that process. So we now have 48 local teams across the state able to look at and review these cases. We also, as part of this legislation, receive funding. We received about $570,000 in state appropriation to be able to provide some funding to local teams and to allow us to hire some state staff to really provide that prevention support. So we are in the process of training these teams, which don't have to be fully functional until January of next year. We are training them both on the review process as well as on the prevention strategies that they will hopefully be working on, with the intent to really evaluate the system as a whole. So it is not just state versus local, but how these things work together and how different parts of the system feed into each other. So we are really looking for what comes out of this process, what are we able to do at the local level, and I think that the example that you are going to have from El Paso County will really demonstrate what happens when local community members and investigating agencies come together and take community action.

Chairman Sanders: [Session 3 - 00:07:43] Thank you. Dr. Mackert?

Dr. Marc Mackert: [Session 3 - 00:07:46] Thank you, good afternoon, and thanks for allowing me to participate this afternoon. My name is Marc Mackert, I'm the director of the Administrative Review Division. ARD is the third-party independent review body for Colorado's child welfare system, so each year we conduct approximately 11,000 reviews across all the different populations in child welfare. That includes children in out-of-home placement, children receiving in-home services, assessments, screened-out referrals, and appeals of substantiated abuse and neglect allegations, where citizens can appeal their substantiation. We also review the foster home certification process and then we run the child fatality review team process, so really the gamut of experience across our system.

I'll describe the CFRT process in just a moment, but first I want to make sure to have time to highlight a couple of key points. So the CFRT is authorized in statute. Over the last three years, from 2011, 2012, and 2013, in each of those years the process went under legislative review and experienced statutory changes. Those were helpful and supportive, but we are looking forward to some stability this year.

The CFRT members are a multidisciplinary group. We have 20 members, and some of them are quite clearly defined in statute, while others the team selects. We have health professionals, law enforcement, we have some detectives, we have a district attorney, we have county commissioners, we have state and county child welfare experts, we have a domestic violence expert, the ombudsman sits on the team, and we also have child advocates, so it is a pretty diverse group. I think one of the strengths of that is that we ask each of those members to really, as they review the prior history and look at each of those cases, look at it from their unique area of expertise and bring that to the discussion. As a child welfare expert, I have limited knowledge of law enforcement, physical health, and those things, so we ask each member to really bring the knowledge of their profession and look at whether there is something in my profession that we could have done differently. So the intent really is to take a systemic look not necessarily to identify blame within any one particular person, but to look systemically at what potential barriers are there as well what strengths there are.

In the process, we work really hard to engage collaboratively with the county departments who had prior experience with this family. They are invited to participate in the review. Here in a minute we will go through the process. They provide lots of feedback to the final report and documentation as we go along, but they really inform a lot of that discussion of what that prior involvement involved, and they bring to the table a lot of lessons learned themselves as well.

Statute now requires that each July we author an annual report, and that is a unique opportunity for us to look more at the aggregate level of that data and try to step back for a moment and look at those larger lessons learned versus looking at each specific case individually to see what could be learned.

I think one of the real strengths of our system over the past three years is that we have learned to look at the child fatality review team as a singular component of a much larger CQI framework. I think because of the tragic nature of these events, there is often a pressure to look at this as being one of the sole opportunities for us to learn as a system. In Colorado we are fortunate that we have a lot of QA mechanisms. I just went through all the reviews we conduct. We have C-Stat. So we use it as a piece of those to really inform some of our larger systemic change efforts. It is a very important stopping point to look back, but it is not the only review process we have.

At the back end of that, we do track all of the recommendations that come out of the individual reports, as well as the annual report. We work with the Division of Child Welfare, and we have a shared document where we track all the recommendations and implementation, whether that is a recommendation specific to a county practice or at the state level regarding policy, programs, or practice.

So that is a high-level overview of some of the key points. The process itself works in such a way that statute requires that a county department provide the Department of Human Services and the state department notification within 24 hours of becoming aware of an incident that is suspicious. So it is a fatal, near fatal, or egregious incident that is suspicious for abuse and neglect. We then have three calendar days to post that notification on our public-facing webpage. Once that happens, there is a 60-day timeframe where the county conducts their assessment. If the conclusion of that is unfounded, then the process stops because it was determined that it was not the result of abuse and neglect. If it is founded, then it goes through the rest of the review team process. Those 60 days are our only opportunity to offer an extension, and those are only for things outside of the county's control. So if they are waiting for a law enforcement report, a coroner's report, or there is some important piece of information we feel like we would need before the team can have a fully informed conversation, then we can grant exceptions. Once we have all of that information, the rest, by statute, is locked into timeframes. So as soon as we have all of that we have 30 days for the team to hold their review, discuss the case, and make their recommendations. We then have 30 days from that standpoint to author a draft report that goes to any county with prior involvement. They have 30 days to give us their feedback. We then have 30 days to finalize it, and those 30 days are for us to collaborate with those counties and make sure the report is accurate. If there are any inaccuracies, we have conversations with them, come to a common agreement on it, and a common agreement as to the recommendations, and finalize the report. We then have seven days to post a nonconfidential version of that report, again on our public-facing webpage. And that whole timeline is all tracked on our webpage as well, so it is very transparent in that regard to the public as to which stage.

There is one time we may delay posting a report, and that is if a district attorney asks us to delay because there is an ongoing criminal investigation or prosecution. We get a specific request from them, and we would hold publishing that final report until they give us another letter releasing us, saying that the criminal investigation is done and they are not asking us to withhold that anymore.

So I know that is a quick, high-level overview of the process, but that is the timeline for how it runs.

Thank you very much.

Chairman Sanders: [Session 3 - 00:14:40] Thank you, and we are now going to hear from El Paso County. On my right we have Sallie Clark and Dan May. Sallie is the County Commissioner and Dan May is the District Attorney.

Sallie Clark: [Session 3 - 00:15:00] Thank you, Chairman Sanders, and members of the Commission. I am Sallie Clark, and I am also the liaison to the Department of Human Services Advisory Committee. I also serve on Colorado Counties, Inc., Health and Human Services

Steering Committee, and I'm first vice president of the National Association of Counties. So I will speak from several different perspectives here.

One of the things we wanted to talk to you about today is the Not One More Child effort. It is an initiative that we put together in El Paso County after we saw a startling 10 child fatalities due to abuse or neglect in El Paso County. Basically, District Attorney May and I started talking about how we were extremely concerned about the high number of fatalities. So we got together and brought a group of many different organizations together from government, nonprofit, including the military, first responders, and the medical community to see what we could do to combat not child abuse in general but really the child fatalities were what we were concentrating on.

We had our first meeting, and we created the Not One More Child Coalition. In 2011, we saw 10 child fatalities. Four were between 1 and 5 years old, seven were abusive head trauma, and seven were military families. In four, the perpetrators were active-duty military, and then three were non-active-duty military, and that certainly was something that was a major concern to us, so we really approached the military community, as well. We are not going to go into a lot of detail about that today because we have someone here from Ft. Carson, and Jill will be here to talk about this a little bit later in the presentation. The majority of them never had any contact with the Department of Human Services, so it would have been difficult to identify them had they not been in our system already.

Dan May: [Session 3 - 00:17:17] Hi, I'm Dan May. I am district attorney for El Paso and Teller County. You may not know, but El Paso County is actually the largest populated county in the state of Colorado. Most people think it is Denver. It is not. I have more felony prosecutions in Colorado Springs than any other D.A. in the entire state. I've got five military bases down there, and we have been impacted by the wars that we have had over the last few years.

As Sallie said, a lot of times we know the military members giving the sacrifices they make. A lot of times we don't realize the sacrifice of the spouse that stays at home. So when she is talking about the three fatalities, those are spouses staying at home, trying to run the family by themselves. So we knew that was something.

As we looked at our data for that, or some of the data, and you are going to hear a lot more about it, one thing we found is that not a single one of these children had seen a pediatrician. They were using emergency rooms for their pediatrician, which becomes important then if we want to communicate with that group as to how we can communicate with them and tell them how to prevent things.

You have seen it was a high group of military, and that is why you will hear from Jill, who did a fabulous job with some of the military stuff.

We are really excited by where this program is starting to go. If you see in 2012, we dropped to three fatalities, in 2013, four fatalities. Our first this year was actually here in the last two weeks. Up until that point, this year we had zero.

One of the things we were looking at, we have some fabulous things going on in our hospitals. We had a great program in Memorial Hospital that you are going to hear in a minute that dropped child abuse rates in 75 percent of kids born at Memorial Hospital. We have now put those into our other hospitals, because we have two other major hospitals babies were being born in.

So when I look at these numbers, it is significant to me that the child who passed away here in the last two weeks was not born in our community. Their family didn't have the opportunity to go through the things we are doing. The same thing in 2013. None of those children were born in our community. When I go back to 2012, one was, and I am still researching because I'm not sure they actually went through our program, because at a couple of the other hospitals it wasn't until the fall that they fully adopted the program that we already had in one of our hospitals.

I will say we looked at what type of child abuse do we think is preventable? Certainly the head trauma, which is usually what you think of as shaken baby. We thought, this we can educate on. This is usually someone getting angry and regrets what they did in those two minutes for the rest of their life, obviously. The other is where you have got abuse going on, and can we empower neighbors to report and do it in a way that they know they can't be held accountable? We want you to be able to report and not worry about getting sued, and yet at the same time we can get in to that family.

Certain ones are very low. When I look at 2013 with our four deaths, two of those were a murder/suicide. He killed the two children and he killed himself. That is a very low percentage for us to be able to prevent, quite frankly. It is a bigger mental health issue, but it is not one that I can necessarily train or that necessarily neighbors would have known it was coming, because it was really out of the blue.

That is where we are going to go through how we got this community group together. We are guarded. It has only been a few years, but these are fabulous returns for what we are seeing going on.

Clark: [Session 3 - 00:20:40] So the group makeup of our initiative includes the Department of Human Services, the district attorney's office, we have brought law enforcement to the table, public health, military, the hospitals, nonprofits, the media, and in terms of emergency services, our first responders, our fire departments, and the faith-based community. As it relates to our meetings, we meet at least quarterly. We were meeting more frequently at the very beginning, but more than 150 folks have attended at least one meeting of the big group meetings, and we generally have about 40 people at each of the meetings. At

every single meeting we have had newcomers, which we think is very positive and shows, as the word gets out, just how many people feel compelled to participate and how best to carry the message.

We broke up into seven task groups. So we have communications, which really works to communicate not only with the media but to message and bring some information to our constituents and our citizens out in the community as to how to prevent child abuse. We have a data committee, which is headed up by our public health director, Dan Martindale, and he has worked with folks from our IT department to put together very detailed maps on where the hot spots are that we need to pay more attention to. We brought in the faith-based community, which sometimes I think folks forget to bring them along, but they are an important outreach group to their particular constituencies as it relates to their congregations. We are trying to continually work on messaging to get that out through the faith-based community, not only from a sermon standpoint but really mentoring and creating better support systems for families.

For our first responders there is first responder training that goes on. Karen Logan has headed that up from our Department of Human Services, and so we are trying to get the messaging out as well to our first responders as to how to identify the child abuse as it happens in the homes when they are able to make that decision of whether they call human services or not and do the reporting.

The hotline committee, working with 2-1-1 has been important. The medical community, as District Attorney May said, has been really imperative in the early educational piece of this, and the military community.

So a communications task group, and we've given out some community cards you should have in front, as well as the video that we are trying to get out through various waiting rooms, public service announcements, and a lot of the media has been very good. We invite the media because we want them to understand what is going on at all of our meetings. We keep our meetings very open and public. We contribute monthly articles, and we have a website, which has really generated some very positive media coverage on this issue.

May: [Session 3 - 00:24:04] The other thing with media is we try to target the right times of year; certainly around the holidays we see a bump in child abuse, so we target it. That is where Jennifer has been fabulous at getting out and getting the messages out. The other peak time we see in our community is actually around March, and so again we are trying to get a lot of messaging out during that time.

You mentioned the faith-based, and one of the other things they have done is we have got a data map. We are getting data on where are the kids born? Where are the contact points that we could meet them? Where can we communicate with the families? This is just going by the density of where our child abuse cases, not necessarily fatalities being reported. On that

map, the browner it gets the more density in terms of where our child abuse is happening. Now some of that is also due to high density area, but quite frankly, one of the highest density areas is on the upper side, or what would be on the north end of that map, yet we are not seeing child abuse. The highest concentration is in the middle, which for me is Fountain and Colorado Springs, which happens to be my highest homicide, highest smoking, one of the poorest areas, high density, and it is where we are getting our child abuse.

B Street is the one down there on the south, which was near Ft. Carson. That has actually disappeared. That, today, is yellow, and a lot of that will be due to Jill, and she will talk about that and some of the other things we are doing there.

So data is trying to identify. When you get into the faith-based, for instance, one of our faith-based groups actually goes in to the 7-11s in those darker areas, the dark brown areas, and they will put out the flyers at the 7-11 or they will ask the Wal-Mart, "Will you carry it?" or they will bring it in specifically to do sermons in those churches or other faith-based there in terms of how we prevent.

Clark: [Session 3 - 00:25:57] And just to go back a little bit to the faith-based task group, Hope & Home, which is one of our child placement agencies, started the Kendra's Hope program. Kendra was severely abused when she was a child, and they didn't expect her to live, and she was eventually adopted by her foster parents and is doing well today. She still will be disabled for life, but she is doing very well and is very happy in her home. And that is one of the things that we have been able to utilize is the Kendra's Hope program and the film that was created. Our Department of Human Services just provided a new film that talks about Kendra and the strides that she has made in the years since her abuse and with her new adopted family.

Then the first responders task group, and I won't spend a whole lot of time on this, but that is an important point as it relates to, again, education of our first responders as they go into people's homes, and in being able to identify child abuse at an earlier point before parents take that unforgettable step.

The hotline task group is, again, working with 2-1-1. We identified, and I heard you mention, the 1-800-4ACHILD, and we are using it as well to make sure that parents know there is a place to go where they can get 24-hour counseling if they need a little bit of extra support.

The medical community task group: All the hospitals in El Paso County now—Memorial, Penrose-St. Francis, and Evans Army Hospital—have the abusive head trauma education. Again, with Memorial, in 2012 abusive head trauma rates were down 75 percent from preprogram rates. We are also utilizing our community health center, which is Peak Vista, and trying to get that information out any way we can.

May: [Session 3 - 00:28:05] Sally mentioned Kendra's Hope. If you want a feel-good video, and I think it is on YouTube, look up Kendra's Hope. She is a victim of shaken baby. They thought she would die. It is amazing. She is legally blind, but it is an amazing story if you want a feel-good moment. In terms of the first responders and the 15-minute videos, cops come on duty and they have got 15-minute roll calls to do training. It takes 45 minutes, so if they have the opportunity to sit down and do 45 minutes that is great, but particularly for some of my smaller agencies, because I have one law enforcement agency that is 1½ people on up to another that has 800 officers. So they have different times, but it is made for those 15-minute slots, three times, and they get the training of what to look for. It is also usable by fire departments who respond and ambulance companies that respond.

Clark: [Session 3 - 00:29:03] Before we wrap up, and certainly we will be here for questions, a couple of things that are important to us on a national level are continuing to use IV-E funds. Colorado is now a state that is participating in the IV-E waiver program to look at different ways to deal with family issues and prevention of child abuse before it happens. Certainly the Social Services Block Grant, SSBG, is really important, as it provides us the flexibility to tailor those services to address our local needs, and because of sequestration even the budgeted money isn't completely coming in at what was budgeted. And I think looking at things like the Second Chance Act, and My Brother's Keeper is an initiative that is going on now and things like education and trying to be proactive in the community rather than just reacting to it are extremely important.

We would be happy to answer any other questions you might have.

May: [Session 3 - 00:30:03] I am going to throw two things in the national issue. One is you are going to hear Jill who has a fabulous program they have done down at Ft. Carson. The General there who left is now at Ft. Bragg, General Anderson, and he is introducing it out there. When you get a new general in, though, you don't know if they are going to implement it again, and quite frankly we are having discussions because we have noticed she has been put into a smaller space, which provides for fewer soldiers and their spouses to be able to go through the program. So there is something, I think, at a national level that can be done where if they think it is a good program we need to have the access to the soldiers and their spouses, and that can just change by who your new general or commander is.

The second is Memorial Hospital, that you saw had a 75 percent drop, Memorial has actually been bought by another hospital group up here in Denver. I know that there has been some discussion about whose program do you use? You find that generally they are measuring if the program is successful by how many times they have given it in the hospital and how many parents took the program when they went through the hospital. We are measuring ours by how many kids come back. Quite frankly, it is a bigger eye-opener. I think it is a little tough to sit through the program they do, but it is effective. We are waiting to see what happens, and if things get mandated, I don't know what the regulations are with hospitals, but which one they are going to blend between the hospital programs.

Chairman Sanders: [Session 3 - 00:31:26] Thank both of you for your leadership on this. We will now hear from those in El Paso County who are doing much of the work: Karen Logan, the child welfare manager; Keith Brown, law enforcement liaison; Laura Rago, chief deputy county attorney; and Jill Nugin, family advocacy manager, as you heard, on the Ft. Carson Army Base.

Keith Brown: [Session 3 - 00:31:50] Good afternoon to you. My name is Keith Brown and I'm the department's field investigator. I have a background in law enforcement, both military and civilian, and one of my jobs is the position of liaison for the law enforcement agencies with the county.

The department created the position probably about five years ago now, in order to bridge the gap between law enforcement agencies and the department, and they wanted someone who knew and could teach the evidence of rules to human services staff.

I would say it has been a struggle making those bridges with the law enforcement agencies. We have developed a very good relationship now with the Springs Police Department, and I am co-located in that department, and I do have access to their records management system and on the mobile field reporting system, and they have access to our Trails system through two of the people down there who were former DHS employees.

So in the five years it has taken, I have come out with a wonderful working relationship with that department now, but not so much with the other departments and the county. Some of the struggles that we come across really are the mere fact of being notified that there is an allegation of child abuse and neglect. Even though it is mandatory to report it, sometimes they just don't do it. If they are involved in an investigation we don't get notified, and therefore there is no joint investigation, we are finding out on the back of it. Just with the common sharing of information sometimes we even find out about these abuse and neglect allegations on the news. So then I have to make a follow-up call with the relevant police department to find out what is going on, and sometimes I get told, "Well, we report stuff to you guys and you don't do anything about it," and unfortunately that is quite a common comment when I make those inquiries.

One system I do have access to is with CSPD, and that is phenomenal. I can access from any web-based system, so I can access it from anywhere I am. I put some parameters in it, and it will send me an email every morning to tell me how many domestic violence cases evolved that night, how many child abuse cases developed that night, and so on and so on. I can change those parameters and it will send me an email, and I can cross-reference that with the calls that we received on the hotline.

All DHS requests for law enforcement records go through me, as well as all law enforcement requests for DHS records, to create a single point of contact, basically, so we can control the

flow of information to and from so we know who it is going to and what it is that is going to them. That has been working very, very well with all agencies.

Like I said before, I have access to the CSPD records management system, and there are various checks and balances in place in order for me to even print a report from that system, never mind releasing it; I have to go through various groups in order to do that. The only requirement for me to release Trails information to P.D. is to ensure that any therapeutic type of information is redacted prior to it being released.

The sharing of information generally ceases, and the line in the sand is really where we reach adjudication and it moves to an ongoing case, and therefore becomes a therapeutic type of case for us.

One of the big problems we do come across is access to NCIC. We are very lucky in our county to have an agreement with the sheriff's office that in emergency cases of placement we can call the sheriff's office and check on the home we are placing a kid with for an NCIC check. The problem after that becomes there is no way to check if a family member comes to visit from out of state or somebody turns up for whatever reason, a family friend comes and stays in the home and so is going to be looking after the kid we placed in the home. We have no way of checking that because it is not an emergency. So the courts are ensuring we are doing best practice in checking these people and that we do enough in doing that.

I have only got a minute left so I want to move on, basically, to one of the biggest problems we do have, which is CPS records from out of state. Every state has their own record-keeping system; some are statewide, some are countywide, and they really don't want to share that information readily. Some of them will send it as a fax, some of them will send me an email, but on the whole it can take me six weeks to find out any type of child protection issue in any other states. And that is a problem, because we have the large military population in our county, and they could have come there and there could have been anything going on in any other state. So what I think would be really, really helpful would be some type of national child protection database where certain professionals can have access to something like that in order to pull that type of information readily, so we can make an informed decision on best practices for the care of that child.

Thank you.

Chairman Sanders: [Session 3 - 00:37:39] Thank you.

Karen Logan: [Session 3 - 00:37:41] Thank you, this is Karen Logan with the Department of Human Services. I am the child protection manager, and I have spent the last 11 of my 22 years with El Paso County in child protection. I want to cover a couple of issues with you as far as our connection with our law enforcement agencies.

We have struggled over the years with connecting with them. It has been kind of hit or miss. One of the good things that was really a good turning point for us as a county was the DVERT program, which is the Domestic Violence Enhanced Response Team program, which was a grant program to work with families that had the highest incidence of domestic violence that was the most lethal. That collaboration and communication opened up an opportunity for us as a county to work with not only our law enforcement agencies but also our family advocates, and we do a joint response to specific cases of domestic violence in our county.

We really liked the program, but we really weren't seeing that in a lot of the other areas of what it was that we were doing. So as a result, the DVERT team, that was co-located and discussed all their cases on a regular basis and went out on an enhanced response with everyone together when those instances happened, gave us an opportunity and idea that perhaps we needed to open our communication a little bit better in a lot of the other areas.

Of course, the DVERT grant itself had gone away because of funding and things like that, and so Howard Black and I, who was not able to be here, but Lt. Black with the Colorado Springs Police Department and I have continued to commit to providing similar types of services that the DVERT grant had, even though we didn't have the DVERT grant funding for it. So we were still sending caseworkers out on these DV cases, we still had caseworkers that were co-located with CSPD on the DV instances, but what we were finding was that it wasn't just DV that we were really worried about; we were having a lot of felony responses where kids were being hurt at a felony level, meaning it was serious bodily injury, it was pretty significant, where a person could be ticketed as a felony assault or something else against a child.

So what we decided to do, Howard and I, was rather than just have it a domestic violence response team, we created a felony response team. What we did was selected, with Department of Human Services, a handful of workers that are the more seasoned, veteran staff and that have been there a little bit longer. We trained them specifically with law enforcement and DHS staff together and decided that we were going to respond to these felony responses. So when they have an instance that happens out in the community that is at the felony level, where there is a detective that is responding to it, they will call us and say, "We need a felony responder," and it is picked from that handful of staff that are trained to work with them that will respond with them.

If it is on the other end, and we get out and see something that is pretty significant for a child, we can contact them and say, "Hey, we are out here on XYZ, we think it is pretty major," and then they can make the decision if they want to come and join us.

This is offered not only during business hours, but it is offered after hours as well. So we respond 24 hours a day, 7 days a week, as felony responders with Colorado Springs Police Department, which is our biggest law enforcement agency in our community. It has worked really well. We do quarterly meetings with the police department and our felony responders—we review cases together, we do trainings with them, and we also do trainings out in the

community. So as a part of the Not One More we do some of those first-responder trainings at the hospitals with the fire departments. They ask us to participate and train their cadets coming out of the academy, and things like that. So we have a really good, strong relationship. They help us with a lot of things that in the past we kind of struggled with. There were a lot of territorial issues that we just don't see anymore because of this collaboration that we have with them. If our department is struggling with something, we can contact them and they can see if they can assist us.

In addition to this, they have asked that we respond not only to the fatalities where it is suspicious of abuse and neglect, but any fatalities in El Paso County where CSPD is responding, they are asking for us to go with them, and we have offered to do that, not because we want to circumvent the process, not because we want to overstep our bounds, but because we see a family that is in need of some type of help. We want to make sure that we assist with those types of areas. We will do, in addition to the joint training, internal reviews on our fatalities, even the ones that are not reviewed by the state department. We do have a military unit within our county as well that responds to the military-specific issues. They understand what the military dynamics have, as well as they help to respond to some of those issues.

I absolutely can tell you we still have lots of hurdles. CSPD is our strongest connection; some of the others not so much. We have almost a dozen law enforcement agencies in our county, and we still continue, every day, to try and have that connection with them that we have with CSPD, and hope does spring eternal so we will continue to do that.

I wanted to make one last point, and I do have some recommendations and I will just leave them for you. I heard earlier they were saying that we were an intervention program, but I want to be really clear that our caseworkers across this state are not just interventionists, we are also prevention, because every family that comes to our department's attention, if we are doing an assessment on them, only about 10 percent of them result in a founded allegation of abuse or neglect and an open case. That other 90 percent is an opportunity for us to provide prevention and to talk to them about how their kids can be safe, the things they can do to help them, and to make sure those families don't come back to our attention again later.

So I want to be clear that even though it sounds like we do a lot of intervention, we do a whole lot more of prevention than people think we do.

Laura Rago: [Session 3 - 00:43:40] Hi, I'm Laura Rago. I'm chief deputy county attorney in El Paso County.

And as Karen spoke to the 10 percent of cases that get court-involved, we are the legal representation for them. Our model in El Paso County is different than a district attorney's

model, where you are representing the people of the state of Colorado; we see the Department of Human Services as our client.

We have 100 percent of our caseload is abuse and neglect. I have eight lawyers, all handling cases. We are a very quick process, versus a criminal prosecution. We are getting in and out of these families' lives, hopefully, between one and one and a half years. That is the goal. For children under 6, the state mandate is under one year, and so we are trying to tighten that up and get in and out of their lives quicker.

Our burden of proof, compared to a criminal standard, is much more limited. At the adjudication phase, which is the decision of whether DHS should remain involved, that is the only jury trial option that the parents have. That is a "preponderance of the evidence" standard, and to terminate parental rights is a "clear and convincing evidence" standard. So our burden is much less in order to protect kids in our community.

DHS starts their investigation. They are looking for imminent risk. As soon as they feel that there is imminent risk, or even before they feel that there is imminent risk, they consult with the county attorney. We have three attorneys on call 24 hours a day, 7 days a week to consult with the Department of Human Services. Sometimes we are talking to them about safety plans and what would be appropriate, or if there is a legal basis to open a case and call a judicial magistrate.

The verbals go through all of our judicial magistrates and judges. Some have never touched a dependency and neglect case, so we get that verbal order immediately. If there was a surviving sibling, we would be working the case. If we get a call from the hospital and there is a surviving sibling, or from police that there is a surviving sibling, and we feel that child is at risk, we can immediately call for a verbal order. The caseworker would consult with the Office of the County Attorney and immediately call. So within hours of the fatality, we would be involved in the family's life. When we call in for a verbal order, the main components that we are worried about is: where should custody be? Do we have a protective parent who can have custody? Do we not have a protective parent where we need to place outside of the home or in foster care? We have stressed, in the last few years, kin or kin-like placement. We start investigating that within 72 hours of the verbal order, and they have beefed up the kinship unit at the Department of Human Services in hopes to find placement or resources for these children, because it is obviously less traumatic if they are going to go spend the night with someone that they know versus stranger foster care.

We are asking for the verbal order to talk about custody, and we are also asking about protective orders. So if we have an abuser in the home, oftentimes at that point in time they have not been arrested. So if it is a suspected abuser, we can ask the judge to order them out of the home immediately, to order no contact with the child, to immediately put the child in a forensic interview position, and we can be involved within hours of that fatality, starting that with the surviving sibling.

Within 72 hours of the verbal order, we are mandated to get the parents in court. The parents are given a lawyer, and I would say in 99 percent of our cases, because they qualify financially, the children are given a lawyer to represent their best interests, and the perpetrators are also given a lawyer.

We file a dependency and neglect petition that alleges why we are involved, and we are very lucky in El Paso County to have designated judges and magistrates where this is a big part of their docket, so they come to know dependency and neglect cases very well. In El Paso County, if the fatality comes in at the same time and opens up our dependency and neglect case, those cases are tracked together with the same judge, so that judge is able to determine if they are cooperative or noncooperative, and we don't have conflicting orders.

So our goal with all of our cases, statutorily, is reunification of the family, if we can do that safely. However, serious bodily injury or death of a sibling that is proven by dependency neglect is a way for us to get to termination. At a termination hearing, it is by clear and convincing evidence, and there is no right to a jury trial, so it is in front of the judge or magistrates that have designated a majority of their time to dependency and neglect cases.

My one minute was up.

Jill Nugin: [Session 3 - 00:48:32] Good afternoon. I'm Jill Nugin. I work at Ft. Carson. I manage the family advocacy programs, which are all those programs that contribute to child and spouse abuse prevention.

I will start off by saying one of the things that is great about sitting in a forum like this is I heard all this research. I'm not a researcher, but it so mirrors what I see among our military population. You guys and researchers have talked about the income aspect, and you have talked about the social isolation aspect. You have talked about young parents. You have talked about mothers with not a lot of education, and those are the kinds of folks that I deal with.

The Army, by definition, is a lot of young people and a lot of young families. And because of some of the economic situations in this country, we have got a lot of families that are deciding, "Let's join the Army because there is not a whole lot else out there for us." I was excited when we started the Not One More Child Committee because I think it takes all of us to make a difference in El Paso County. Ft. Carson has over 25,000 soldiers, and you times that by three or four, because they have all got a couple of kids, and a wife, and a grandma, and that kind of thing. So it is a big part of El Paso County, and 70 percent of our families live off the installation, which means that I need to know about those resources that are available off the installation for those families.

We have a lot of young families, and there was a statistic earlier about noncommissioned officers versus officers. You know, the biggest rank in the Army is Specialist E4, and most of them are about 20 or 22 years old, and most of them live in a place where they don't have social networks built in around them. I probably see 10 or 15 young families come in my office a day, and there is always baby in a stroller, and I always say, "Where is your grandma?" and mom always says, "Back in South Carolina" or "Back in Virginia," and so we have got isolated families without a lot of support.

The other thing we were able to figure out when we had the bad year that Sallie and Dan talked about was lots of our child fatalities were at the hands of or the result of a male caregiver, a father or a boyfriend who was not equipped to deal with an infant that wouldn't stop crying, or wouldn't stop making their diaper messy, or mom had to run to the store. So we knew from the research and anecdotally we had to target some specific populations, and what we did with the help of Not One More Child is look at programs that helped dads feel like they are better dads. We do a couple of things at Ft. Carson, and some of them are done across the Army.

The two things I can think about that would be awesome things to have consistent across the military in general is we teach a boot camp for new dads. It is taught only by men, they don't even let me go in there. There are three or four sessions, and they learn how to calm a baby, they learn how to care for a mom, they explore what makes them dads, and what kind of dad did they have, and what does that speak to about the kind of dad they want to be? They learn how to swaddle a baby, and they learn that babies cry for absolutely no particular reason, and it is not because they are pissed at their dad. That's not the reason; it is because babies cry. So we have done that, we do that class every month, and we also train trainers so that different units have mentor dads in the units. For instance, a young guy that might not want to come talk to me about that, but may go to his Sergeant Major and say, "How did you get through that time in your life when you had these little kids?"

The other thing we did is we trained folks that were down range. We had some chaplains get on the phone with us and learn how to be boot camp mentors, and then they got groups of soldiers together that were going to come home to a new baby. You know, you leave a young wife, and you leave a house with just a puppy, and you come home to a baby, and after you have been at warfare that can be a tough transition to make. So boot camp has been very positive for us.

We also have a piece during soldiers' reintegration training. When they come back from the war, and we have them for several days, we do a block of instruction on reintegrating with your family, and talking about kids in developmental stages.

The other big thing that we do, and we talked a little bit today about evidence-based programs, is we teach the Nurturing program. The Nurturing Parenting program is a 12- to 16-week program that has a pre- and a posttest, but it works on things like parental empathy. It

works on things like clear developmental expectations. What I know about the offenders that I see is that most of them don't mean to be mean and malicious. They don't believe that they are empowered enough to be able to figure out how to help a crying child, or how come the 2-year-old is not potty trained, or how come the 3-year-old still wants to take a bottle. So when we can educate parents about appropriate expectations and increase their empathy—"Remember what it was like to be 2, and 3, and 4?"—we have seen a significant decrease in the number of child abuse cases that we are dealing with at Ft. Carson. If I had any recommendations, it would be that consistency, I think, is huge. I think our families deserve to know at Ft. Bragg they have this service and at Ft. Carson they are going to get the same thing.

The other one is to remind people that funding the Department of Defense means funding programs like my home visitation program and my Boot Camp for New Dads program, and those incentives that I have to reach those families who are vulnerable like everybody else's group is across the country, but they are also fighting wars and coming home to stressors that lots of Americans don't face.

I appreciate you having me here. Thanks.

Chairman Sanders: [Session 3 - 00:54:27] Thank you very much to everybody. I know we have some questions up here, so I will recognize Commissioners and start with Commissioner Rubin.

Commissioner Rubin: [Session 3 - 00:54:40] Thank you, you have terrific suggestions, all of you. It is very diverse. I have two very specific questions in two different ways.

For the fatality review team, and neither of these questions are Colorado-specific or Ft. Carson-specific, as I am going to get into some of the military issues in a second. For you guys, I am going to have you answer a question about how our usual inclination in fatality reviews is to look at how many kids were CPS-involved. What about how many kids were seen in a pediatrician's office, in a home visiting program, the WIC program, and whether there were opportunities in other systems to prevent kids from slipping through the cracks? I'm going to have you guys look at and address some of those issues.

Then for Ms. Nugin, I'm fortunate to be part of a group that is looking at child abuse injuries across the U.S. Army, and so this is not a Ft. Carson-specific question. Suffice it to say that what I have learned as I've done this with our DoD partners and with our family advocacy partners is that you have civilian and military authorities. You have the Family Advocacy Program and you have civilian authorities. What we are discovering is that all military children who have suspected child abuse and neglect are supposed to be reported to the Family Advocacy Program. Like you said, 70 percent of your families are off base. Often medical providers may or may not report. Sometimes they are reporting to civilian authorities, but civilian authorities are supposed to report back to military, and that creates

potential important barriers to identifying who have medically diagnosed child abuse. Have you, in your experience, seen that as a problem in terms of within military reporting to the Family Advocacy Program for suspected child abuse?

Nugin: [Session 3 - 00:56:30] I will tell you that there is a potential to be a problem. We have a very clear, very concise memorandum of agreement with Department of Human Services, although we are a federal installation, but they have jurisdiction over our children. So our MOA says that when my Family Advocacy Team gets a case that is child abuse, I am mandated to report that to Karen Logan and her folks. When she has a military family that her folks are working with off the installation she lets us know, as well. So she can refer to me and I can refer to her, and it is not just that I can, it is that I have to. I have to let her know so those numbers count. Then treatment-wise, Karen can say, "What do you have on the installation this family could use?" and I can say, "Well I don't have that, but what do you guys have?" I have home visitors, she has caseworkers that go in, so we can get together on the treatment plan. I think we could have that problem, but I don't think we do.

Commissioner Rubin: [Session 3 - 00:57:25] Do you think there is a need, though? I mean it sounds like you guys are doing stuff terrifically here, but, based on some of the conversations we are having elsewhere around this issue, is there a way to enforce that strategy more systematically? You mentioned sort of making sure of some consistency around your prevention programs, which were terrific, but are there ways to more consistently enforce the relationships between civilian and military authorities?

Nugin: [Session 3 - 00:57:49] Well the federal regulation that I come under, 608-10, is the Family Advocacy regulation, and it says in there that I will have a memorandum of agreement with the local department of human services. No military installation has the ability to remove a child unless they are overseas, so I have to have an avenue. Even if my team goes out and says, "This situation is terrible!" I can't take those kids. So I have to be able to call Karen and her team. But the federal regulation that governs my program says that, "You will have agreements with your state authorities."

Logan: [Session 3 - 00:58:25] I think the piece there that we have to clear about is that value you place on that collaboration, which is pretty strong in El Paso County. I mean we have five military installations in El Paso County. About 10 percent of our population is military-attached, meaning there is an active duty member that somehow is attached to this family, and we can't do, with our resources, everything that we could do or want to do with these families, and therefore that collaboration is key. So similar to how we work with our law enforcement agencies, all of those reports are identified when they are military and we send them over to our Family Advocacy. Our staff and their staff connect together to determine is it a joint response to the home? "Here are some things that we have done and here are some things that you have done." We do work together as far as trying to identify services. You have to remember also that the military can order and require of the active duty member, but they can't necessarily order and require of the civilian. That is where we

come in to play because what is good for them is, say we are in the middle of an investigation and we can't really sort out what is going on. If it is the active duty member that we feel like maybe we need to get some more information from, the Command can ask that active duty member to step out long enough for us to finish and sort through what we need to do. If we did that in the civilian community we would have to have a court order to do that. Oftentimes what we see, even though our military is 10 percent of our reports, we're assigning at a higher percentage rate because there is more vulnerable children in those households, not because we believe they are being abused or neglected more often. But we open less cases in the military because they have better resources for their family members. And we know that is a strength, so it is really about that value you place on the collaboration and that you have to have with those communities. That is the buy-in you really need to make it work a little bit better.

Commissioner Rubin: [Session 3 - 00:60:10] I'm going to give you guys time to answer the question on the other systems that you look at.

Myers: [Session 3 - 00:60:23] Thank you, Commissioner Rubin, for that question. I think it is a great point, and we absolutely, from the public health perspective, look at all preventable child deaths, and in doing that there is a percentage of those that were known to human services or cases that may have even been substantiated for child abuse and neglect. But I would say the majority of what we talk about in our review meetings are sort of the systems as a whole and identifying as many of those systems as we possibly can to be able to identify a broad range of prevention services. What I enjoyed about El Paso County's presentation today is you really got the sense that it is not one intervention, it is not one system, it is all of these things, all of these prevention strategies working together.

To this point, I want to make just one mention of our transition to a Child Fatality Review System. From the public health perspective, that will operate at the local level versus the state level. I think we will have an even better opportunity to interact with those different types of systems, particularly physicians and knowing who went to a Nurse-Family Partnership type program, or who was on a military base and received advocacy services, and so on.

At the state level, in the report that was provided from us in your preparation materials … and this is really based on a state process that was largely driven by what paper records we could collect from different agencies, which had a lot of variability as to what we can get in our hands at the time of review. At the local level, there is an opportunity to have investigators who actually participated as part of the investigation in the fatality, as well as community agencies that have these programs going on, so that you can identify prevention strategies that are grounded across different types of systems, so I think it is a great point.

Dr. Mackert: [Session 3 - 01:02:09] From the CFRT standpoint we look at those as well, would be the easy answer. The difficult answer is with some of those we run into issues with confidentiality. So at times when we try to find out information about participation with WIC

there is some interpretation of, can that be shared for non-WIC purposes and with a non-WIC agency? So sometimes you run into those. Two months ago, during one of the team discussions, when we were looking at collaboration around issues with domestic violence, an issue that has come up in several of the discussions over time is the difficulty that caseworkers have if they contact a domestic violence shelter trying to locate a child and/or a mother. Again, due to confidentiality issues those shelters won't provide information on whether that family is even there, and that is a real barrier to being able to offer services and assess the safety of that child. And my understanding from that conversation is that is actually as a result of some federal legislation and confidentiality requirements, whereas there is exceptions for the medical field and mental health professionals that does not exist in the domestic violence field. So we always have those conversations. We try to gather a lot of that information, but there are some barriers sometimes to sharing that information.

Chairman Sanders: [Session 3 - 01:03:27] Commissioner Petit?

Commissioner Petit: [Session 3 - 01:03:30] Yes, a couple of questions, one for the District Attorney and one for Karen Logan. I'll do Karen's first since the District Attorney has stepped aside for a minute.

Karen, the specifics of what you described, the felony team, was very concrete and is the kind of thing that I'd like to see in a lot of different places. Two things, and one is: when the felony team is involved and they pick up somebody who presumably has committed a felony, have you seen any difference in the prosecution rates of those individuals committing a felony, and is the prosecutor winning more convictions as a result of that process from the beginning?

The second question I have of you and then one to the District Attorney is there are 80 counties in Colorado? How many counties? 62? How many others have felony teams? Is there a Felony Team Central someplace in the state?

Logan: [Session 3 - 01:04:22] I can't speak to the other counties. I know we have a felony response team, but whether or not other counties have done that, I don't know. Now as far as the higher level of prosecution, that would probably be a better question for Dan and his staff, but I can tell you one thing, and that is that what we found in our response with law enforcement, we have gotten a lot of criticism about that in that we are collaborating with law enforcement to criminalize what people are doing. And certainly we want people to be held accountable for what it is they do as well as law enforcement. But we are able to support the family, the nonoffending parent, a lot better. We are able to provide some services in the family system a lot faster. So from the standpoint of what it is we do, they still have to do their piece of it and we still have to do our piece, but together we can get a lot more information and we can also help move things forward a little bit better as well rather than having two people with two different focuses coming at two different sides.

Commissioner Petit: [Session 3 - 01:05:32] Yes, let me just emphasize, I'm not interested in criminalizing any more aspects of the child protection system than we have right now. On the other hand, there are certain offenses against children that the public has said are felonies and that needs to be enforced.

But let me just ask the district attorney. You, like other district attorneys, are the chief law enforcement in the district. And we heard Karen say that...what was the expression you used? "Hope springs eternal," you said, in terms of the other P.D.s being involved with this thing. There is also the sheriff's office on this end. So I'm just wondering, in terms of your imposition of a requirement to the police departments and the sheriff's office to conduct their business relative to children in a certain way, or are they allowed effectively to freelance it? Is there combined training that goes on that you sign off on, and are there memorandums of understanding between those individual P.D.s and the department? And I guess I would turn to you with respect to prosecutions. I know that you guys have a much higher standard than in civil proceedings because you have "beyond a reasonable doubt." Presumably you would see an improvement in the quality of investigations if there are trained people adhering to certain protocols. So can you respond to that, please?

May: [Session 3 - 01:06:44] Sure. I have already mentioned we are the largest populated community, and I do more felony charges than any. There are 22 elected district attorneys in the state. But I will say this, on the other side of the coin I have more diversion programs than any DA in the state. We have mediation programs where we try to divert people away; we have had different child abuse programs and things like that. But the other answer to that is, yes, when a child dies, we are going to deal with that and we are going to deal with it pretty strongly at that point. Once it becomes a crime, it's a crime and somebody has died. But in our system I do not control the law enforcement agencies. A lot of people see the DA, and my control there is I get to decide what charges are brought. So if we look at something the law enforcement department has done, we can say, "We're not going to file that until you do X, Y, Z." And so that is my way of sort of doing it. I will say, though, in my community we are extremely collaborative, more so than anywhere I know in the state, and it is pretty unique around the country.

We have a lot of programs with the sheriff, the police, and the others where we work together. When a child homicide happens, I have a team that goes out with the Colorado Springs Police Department, or the Sheriff's Office, or Fountain, or any law enforcement agency with them. With the bigger departments we are there because we want to have a unified presence of what we do from the beginning to the end. But for the little departments, quite frankly, some of them want our office to take over the investigation because they just don't see them as much and they don't happen as much.

We work very closely. We don't have any written MOUs in this area, but they know the system, how to bring it out, and how we work together at the scenes. We do a lot of joint trainings together and we do some trainings around the state. In my office, we have a group

that is just dedicated to crimes against kids, and I have got five or six attorneys in there right now, and it is actually my busiest department but it also includes sexual assault. Child abuse is actually the fewer numbers compared to what we get for sexual assault on children or also your child porn and things like that.

We have actually got some pilot programs in our area. Three years ago, I think we started, and we have judges who do the DHS D&N actions when they come in, and then I have a different judge doing the criminal actions. A lot of times the DHS judge might know a lot more than my criminal judge would know, or they had set orders in place that were cross purpose. So now we have a pilot program just in our community where the same judge does both cases. We have had a couple of glitches that have come up there, but again it is trying to deal with the entire family and the entire picture and not just the one criminal aspect of it. Does that answer your question a little bit?

Commissioner Petit: [Session 3 - 01:09:24] Yes, it does. Thank you very much.

May: [Session 3 - 01:09:27] My sheriff would say he is head of law enforcement, but I can arrest him. [*laughing*]

Chairman Sanders: [Session 3 - 01:09:34] Commissioner Covington?

Commissioner Covington: [Session 3 - 01:09:35] I have a question for Jill and probably the fatality people. I work closely with the folks at the National Family Advocacy Office and the Department of Defense in D.C., and I attend their annual fatality summit. And I get calls all the time into the National Center trying to negotiate, people that are trying to review deaths, the military reviews that are required of suspected abuse and neglect, and the local reviews, trying to share information, and they really get bogged down in the problems around information sharing due to different rules. Some places have actually said that they won't share child protective services information with Department of Defense and installations because those are just employers. They think of the military as an employer rather than anything else.

So one of the things I have been tossing around in my head is what recommendations can we make federally to sort of allow better information sharing among the civilian and the military world around protecting kids? I'm curious if that has been a problem for you, or if you ignored some of the restrictions, or if you have gotten around them, and if not if you have your own set of recommendations.

Nugin: [Session 3 - 01:10:48] I hate to sound like everything is wonderful in El Paso County. There is a military team that works the military cases through Department of Human Services, so my responsibility is to do fatality reviews two years after the fatality happens. So Karen's team is going to work with what is kind of like our DHS on the installation, our Department of Behavioral Health and Social Work Services. So those two caseworkers are going to work well

together. So when I need a copy of the autopsy, or if I need those kinds of things, they are routinely part of the record from the team that handled it, and if not then I can call and say, "Hey, I need to look at this," or "I need that for a part of my fatality review." So it is not a big problem for me to do here at Ft. Carson.

May: [Session 3 - 01:11:40] I'll speak up on that real quick. I know when we first started our committee after 2011, I know it was an issue when we asked DHS for the data on that. We couldn't get it through DHS. I think they had to separately go down to the military. When they have a fatality, my office only finds out about it if it happens to be in the paper or they reach out to my office for some of the expertise. I know that is something that the military has gone through in their prosecution. We have them come up and train with our deputies, but when I came into the office six years ago they weren't doing any prosecutions there because all their military were in Afghanistan trying to set up a justice system over there. So we were doing all the prosecutions. Now interestingly, Ft. Carson is an exclusive base. If you read the sexual assault things going on at the Air Force Academy, we have actually reviewed some of those because I have concurrent jurisdiction, so we get to review them. Ft. Carson has exclusive jurisdiction, so we don't get to see that unless they want to share it with us, which sometimes happens and sometimes doesn't.

Commissioner Dreyfus: [Session 3 - 01:13:48] I have wanted to ask this question but I wanted to wait until we had people from county government. My question is about county-administered states. We sit in a country where the majority of our states are state-administered child welfare systems. I have actually been the administrator of both, one, of Wisconsin, 72 counties, and Washington state, which is state administered.

My question is that today we have heard things like the state has made the decision to go to centralized intake. We heard earlier that there is a lot of inconsistency of the quality of the MOUs, county by county, across the state. And I just want to ask this question of counties and not someone from the state. When you think about 64 different county agencies all responsible for child welfare, all having county boards of commissioners and different approaches, help me with that. I think about a federal government who tends to think of things from a fed-to-state relationship not fed-to-county, and I'm just wresting with that in my own mind.

Logan: [Session 3 - 01:14:01] Well, I have never worked for a state-run system; we are county-administered, state-supervised. So our state offers us a lot of support in the things that we do as far as the training that we are providing and are provided, as well as some standards like the training academy and things that, across the state, regardless of caseworker in Mesa County versus caseworker in El Paso or Teller or whatever, they still have the same requirements, they still have the same educational requirements, they still have the same training requirements and things like that. What you need to be clear on in a county and a state like this, and I think Colorado is a really good way to look at that, is in El Paso County, you have heard about some of the really unique dynamics in El Paso County; five military

bases in one county. And you can go to tons of other counties in the state of Colorado and come across 5, 10, or 1,000 military members in the whole county. So it is very different what we do in El Paso County than what they do in Denver County, or Arapahoe County, or Mesa County, or Durango, or any of those other places, because we get to look at what our systems have, what we have available to us. We get to look at what our community offers to us, how we can collaborate together and do some of those things, which I would be concerned if it was decided just at a state level. That would be problematic because would you ever really be able to appreciate the differences between 60 plus counties in a state versus being run in the same similar way.

Now the state hotline is not taking over the intake portion of it. They are going to be available as a support to the county hotline. So we will still all each have our own county hotlines. The state is going to help and support us and provide us the extra technical expertise to answer the same calls and provide additional support for people that don't know that Colorado Springs is El Paso County, because we do get people that call us thinking we are in Texas, and we are not. But they are going to add that as an added support on top of, it's not in replacement of. And so I think it is really important to know that each county has very unique differences, and most often those counties know what those differences are and how to deal with them.

Chairman Sanders: [Session 3 - 01:16:23] So thank you very much. This is very enlightening and exciting to hear about the work in El Paso County. Thank you very much.

Logan: [Session 3 - 01:16:27] I have my list of recommendations. I am just going to leave them for you, and then this is also a multidisciplinary guideline that we use in our county that you can have for yourself as well.

Chairman Sanders: [Session 3 - 01:16:38] Thank you very much.

Commissioner Covington: [Session 3 - 01:16:40] Can I just say I wish every county was like El Paso in terms of how they work together. God, our work would be easy.

Chairman Sanders: [Session 3 - 01:16:54] So we are going to go ahead with the next panel. We have Kendra Dunn, Mark Kling, Linda Mikow, Donna Parrish, and Grace Sage Musser. If they could go ahead and come on up to the table for presentation. As the transition is occurring we have had the opportunity today to hear about the structure within Colorado and a number of presentations that have focused on the process. So we are going to ask the last couple of panels to really focus on the results and their recommendations. Ms. Dunn?

Kendra Dunn: [Session 3 - 01:17:43] Good afternoon, my name is Kendra Dunn. I am the Child Maltreatment Prevention Director at the Office of Early Childhood at the Colorado Department of Human Services. Thank you for the opportunity to speak before the Commission today.

I had planned on answering some of the questions that were addressed earlier about the Office of Early Childhood. I am not going to do that in the interest of time, but if you have them you can ask me later.

I would like to highlight the Child Maltreatment Prevention Unit that has been created to consolidate efforts in the state. I am going to just, from a very high level, tell you what programs those are, and I want to talk about one of them in particular, the Colorado Community Response Program, and then I am going to let Mark Kling talk about the other.

The Child Maltreatment Prevention Unit pulls together two streams of federal funding and two streams of state funding. The federal funding is our Promoting Safe and Stable Families funding and our Community-Based Child Abuse Prevention funding.

For those of you not familiar with the Promoting Safe and Stable Families funding, it funds four types of activities: family support, family preservation, family unit reunification, and adoption support. So it is working on that whole spectrum of families that are known to the system, as well as families that are not.

Our Community-Based Child Abuse Prevention funding works entirely on supporting families from a primary and secondary prevention focus, so families that are not known to the child welfare system. We use that funding primarily to support our Family Resource Center Program, which Mark Kling will talk to you about.

The two state streams of funding that we use for the unit are a divorce docket fee that funds our Colorado Children's Trust Fund. For the past decade or so we have used that funding to support parent education, using evidence-based curriculums like the Nurturing Parenting Program that you heard of.

The second stream of state funding is new and was mentioned this morning. It came out of the governor's 2.0 plan and is the only program that is housed in the Office of Early Childhood Support from that child welfare plan.

The Colorado Community Response Program is a pilot program that helps families do goal setting, financial literacy, but most importantly has a certain amount of flexible funding that can be used to help families proactively alleviate stressors. We are in the second year of a three-year pilot, and it is $1.7 million that has been invested in that pilot. We are very excited about some of the initial outcomes that are being shown. Our formal evaluation is actually launching in November so I don't have results yet, but I will tell one quick story to kind of explain how this looks a little bit different than maybe some of the things that have been done in the past.

For instance, there was a father in the county who got referred to our child abuse reporting hotline for educational neglect. It was screened out, but the child was not making it to school. So instead of just closing the report and being done with it, the family was contacted and they were offered voluntary services through Colorado Community Response. When the home visit happened and they were talking to the father about what was happening, the father explained that he had been taking his child to school on a bicycle and the bicycle had been stolen because of the neighborhood they lived in. The Colorado Community Response flexible funding allowed us to work with that father and to purchase a new bike. The father matched that investment by buying a new helmet and lock, and the child gets to school on time every day.

So there is some value to having flexible funding, and I just want to point that out because in our world it is not something we get a lot of, but it seems to be alleviating problems further upstream, at a point where helping to resolve them is a little simpler. Because of his participation in the program, he also received the financial literacy training and some family goal setting and some other things to help support him, and was connected to other resources in his community, like the Family Resource Center. So it was an opportunity for us to do some of that social connectedness piece as well as meeting a very specific, concrete need.

I have three recommendations. Our first recommendation is that we really need to figure out how to put the supports where the families are. Nationally, we know that over 80 percent of children get a preventive or well-child visit, so that we know pediatric care, whether it is in a private practice or a clinic, is an opportunity to engage parents in additional support and connection, and we feel like that is a very underutilized resource. We realize there is a lot of change going on in the health care industry with the Affordable Healthcare Act, and we are not necessarily recommending that it always be the pediatrician, but we understand that office is a touch point.

So I wanted to tell you that I know you have heard a lot about other home visiting programs, like Nurse-Family Partnership, that we use in the state that we funded with state funding as well as with our MIECHV funding. But I wanted to highlight one other evidence-based program called Healthy Steps because it is implemented in pediatric primary care settings, so we were able to use our MIECHV funding to support it. We feel like this pediatric, primary care setting is the first formal system children encounter, and it is a highly trusted one by parents. What is nice is that Healthy Steps is designed to be a universal program, recognizing that even the most capable and well-equipped parents need a hand now and then, especially at a moment of transition, like the birth of a new child. Because of funding limitations, the programs in Colorado typically target low-income families, but with that being said the cost of implementing a program like Healthy Steps is significantly lower than Nurse-Family Partnership and so it is an important one in the continuum because it might be able to be used with families that aren't quite as high a risk because of the cost. Families are offered the program with the very first infant well-child visit, visits with the Healthy Steps specialist continuing in conjunction with well-child visits and are augmented with home visits until the

child's third birthday, so we know we have that duration. The program emphasizes a close relationship between health care professionals and parents in addressing the physical, emotional, and intellectual growth and development of children from birth to age 3, and it supports the parents in learning about early childhood health and development to enhance their success as parents. It also can provide linkages and referrals to community resources.

Secondly, in terms of where parents are, we know that in Colorado more than 60 percent of children are being cared for by friends, families, and neighbors, so as a state we have started to, both in our community-based organizations and at the state level, grapple with how best to identify and support these community members caring for children in order to help bolster their ability to support parents and to access resources needed to provide high-quality care. So I don't have an answer for you yet, but I will tell you that we believe it is an important part of the solution.

My second recommendation is a need to do more than just fund effective programs. There has been a lot conversation because we are obviously focusing on evidence-based around programming. But I want to acknowledge that we really focus on the prevention spectrum designed by the Prevention Institute in the Oakland area. There are six necessary strategies to prevent anything, and they have to all happen simultaneously. So I just want to mention that we really try to focus on that, not only providing direct services to families but changing community norms and environments to encourage collaboration across systems.

Chairman Sanders: [Session 3 - 01:25:45] Ms. Dunn, we are going to have to ask you to wrap up.

Dunn: [Session 3 - 01:25:50] Okay, great. I will leave it there. Thanks.

Chairman Sanders: [Session 3 - 01:26:00] Mr. Kling? I believe you are here substituting for Brenda McChesney.

Mark Kling: [Session 3 - 01:26:06] Yes, I am. Thank you. My name is Mark Kling. I am Executive Director of the Family Resource Center Association. Brenda and her two young children are ill today, so we thought they should stay home and I should come. I'm glad to be here. Thank you for having me. I have been the head of FRCA since 2008, and prior to that I practiced law for a number of years in the corporate world.

I am going to start right off with my recommendations and kind of roll into some explanations about FRCA as I do that. FRCA offers comprehensive, coordinated services to families in 24 locations throughout the state of Colorado. We use evidence-based programs, we use a dual-generation approach to work with both parents and children, and we practice prevention-based services, and as you might understand, we think that is a very effective model and we have the numbers to prove it, so my recommendations follow that model.

So I would suggest my first recommendation is giving more support to entities and programs that offer comprehensive, coordinated, dual-generation approaches in the prevention area. We find that to be effective. We track outcomes and we analyze those outcomes and report out on those outcomes, and we believe that is a very cost-efficient kind of big bang for the buck expenditure of public resources.

Secondly, my second recommendation is to continue to select evidence- and research-based programs with proven outcomes that are analyzed, in our case, by a third party. We don't analyze our own outcomes; we have a third party do that for us. We think that is a better model.

We have implemented national standards, the quality standards of family strengthening and support. We are also in the process of proving up our Family Resource Center model by utilizing Ph.D.-level resources to prove that up and make it evidence- and research-based. We are about two thirds the way through that three-year project. We use a Colorado Family Support assessment, where we intake families and track them over time. Our case managers that we call family development workers work with the families over time to provide them the services that they want and this is prevention-based. We don't tell them what they want, we don't tell them what they need, we help them get to where they want to go with their families and we work with them to do that.

Finally, or the third bullet would be make sure that those resources are focused on prevention. Prevention has a very cost-effective model. I have read some statistics that show for every dollar spent on prevention you save $12 off into the future. That being said, we don't see a lot of money going to prevention. We see that we have to fight for those type of comprehensive, coordinated models, such as our own. Most entities, both private and public, want to pay for a program, a specific program. They don't want to pay for the infrastructure; they don't want to pay for the system. Well, some money needs to go to the system. Those look like general operating dollars. They might look like capacity-building dollars, but they don't look like narrow program-funding streams that we then have to blend and braid, but no one is paying to keep the rent and pay the salaries for the case managers and etcetera. So we need some money for that.

Fortunately, the Office of Early Childhood is trying to help us do that, which is my final recommendation. My fourth recommendation is cluster like-minded prevention-based providers together, give them the support for the increased collaboration. We all know that we should be collaborating. In a perfect world we would just do that. Guess what? That costs money. Most of us are so focused on our everyday world and our take on that it is really hard to say, "Well in my spare time, of which I have none, I'm going to go out and collaborate with others." So actually creating systems where entities are getting paid to collaborate is very helpful. We find that the recent reorganization here in Colorado of a number of prevention-based agencies to be housed in the Office of Early Childhood and to be managed together has

been excellent. It has caused increased collaboration and we think efforts like that are very important.

Thank you.

Chairman Sanders: [Session 3 - 01:31:06] Thank you very much. Ms. Mikow?

Linda Mikow: [Session 3 - 01:31:15] Good afternoon. I am Linda Mikow, a forensic interviewer at Ralston House, which is a children's advocacy center. Thank you for the opportunity to be here today and to talk with you.

A children's advocacy center is a child-friendly place where children and teenagers come for a forensic interview when there has been a concern or an allegation that a child has been a victim of a crime, or a witness to a crime, or has some exposure or some knowledge about some abuse crime or something going on in the home.

They are referred by law enforcement, social services, and the district attorney's office. Kids as young as 2 are verbal enough to try to talk with, up to 18 years of age, and the advocacy center is a place that often looks like a home. It is child-friendly. It is not having them go to the police department, or social services, or being out on their front lawn after a D.V. incident, or in their home or bedroom. It is neutral, and it is designed to put kids at ease and have them be comfortable so that we can try to talk with them and find out what kinds of things have happened in this home, what they know, and what their knowledge base is. We want them to be comfortable. We don't want to re-traumatize them, we want to decrease their anxiety about what may be happening so that we can try to gather information from them.

This is done by forensic interviewers who are trained to talk to kids in a way of just having a conversation with them and doing that where they are asking open-ended questions, non-leading questions and not giving them information or answering sentences for them, but letting them talk and providing the children and teenagers with the opportunity for us to hear what they have to say.

Now in these cases of domestic violence, there are certainly many times where children are known victims and witnesses. In those investigations, children often are referred for a forensic interview. A forensic interview is one piece of the investigation. A lot of times there are domestic violence incidents where the report is that the children weren't home, they didn't see what happened, they haven't been around, they have been at the other parent's house, and they are not going to know about this incident. But the recommendation and what is considered best practice is that those kids as well, when there is domestic violence going on in that home, they are interviewed, because they may be able to provide information about what led up to that incident and then maybe they weren't at home; they were at school, at a friend's house, staying away for a week at another relative's house when the

battering was occurring. When they came back home, they can talk about other family dynamics and things that were said and interactions in the home. If they just weren't around at all for any of the peripherals of that domestic violence incident, they can provide historical information. Those kids can talk about the dynamics in the home, the interactions and what kinds of things are said. We know that domestic violence can be impulsive and it can also be calculated, and kids can talk about what are the conversations that are being said and what happens when parents aren't getting along and when there is conflict, when someone is mad at someone.

That information can lead to trying to identify what are some of the high-risk factors in this family? What are some things that can happen for intervention and prevention? In these cases where the kids weren't a victim, weren't a witness as reported, when they are referred for a forensic interview, then social services will be notified and can get involved, or the information gained from that interview from law enforcement can be forwarded to social services so they can know, "Here is what these kids are saying." We know they weren't, in this immediate incident, a victim or witness, but they have got this historical information. We know kids are neglected, they are emotionally neglected, and their needs aren't met by parents that aren't available because of this battering that is going on. We know kids are physically abused and sexually abused in domestic violence incidents. The problem is that there is not time for law enforcement to always bring these cases over. They are busy, they are overloaded, and they are overwhelmed. For one child to be interviewed, the process can take about two hours. Not that the interview takes that long, but just the process of having them come in, get settled, talk with them, and talk with the caretaker that brings them in. That is precious time in their day, because they have other things they need to do if they don't think, in this case, these kids are victims or witnesses. So that is a barrier that we need to get over, is to try to allow for that resource and time so that those kids can come in and be interviewed and their voices can be heard, and we can prevent future child fatalities.

Thank you.

Chairman Sanders: [Session 3 - 01:35:56] Ms. Parrish?

Donna Parrish: [Session 3 - 01:36:01] Good afternoon, and thanks for having me today. I probably don't need this microphone because my voice tends to carry, but I'll use it anyway. I am here to basically tell you a couple of different things and to provide you with a few points to think about as you walk away from Colorado this evening.

The first is I just want to share a little bit of data. I know the researchers gave you a really big, comprehensive overview, but I just want to break it down just a little further. 85 percent of child fatalities were comprised of 38 percent of white victims, 31 percent of African-American victims, and 15 percent of Hispanic victims, and the rest were others. But when you compare those numbers to population-based data, the picture starts to look a little different,

being that Pacific Islander and African-Americans at 4.9 percent and 4.67 percent per 100,000 make up the highest rates, when you compare that to 1.6 percent of white victims.

So what I want to say to you today is to me, when I hear that sort of number, it is startling. And for me the issue requires urgency and financial resources. All outcomes need to be tracked and looked at through a "race equity" lens. So we do a really good job in terms of providing outcome data, and I'm always the person that raises my hand in this state and says, "Have you looked at that data through a race equity lens, and broken down that data and that number to say do all children, no matter race or place, fare the same or equally as good as other children?"

The other thing that I want to say is that the research agenda should focus on both resiliency and strengths. One of the things that a lot of research has been based in are low-income populations, and I think that only tells part of the story. We need to broaden our scope and take more of a multidimensional look at other families that are functioning that aren't necessarily impoverished.

The other thing that I would challenge our system to think about is that sameness does not equal fairness. Somehow we tend to think that if we are providing all families the same thing, that they all should fare the same. What I have come to say to you is that I, as an African-American parent, may not receive the same things to increase my parental capacity simply because I went to the same parenting class. We need to really look at how we bridge the cultural divide and how we really use our resources and leverage our resources to really operationalize what things like "community engaged" and "family involved" really look like. So I come here today to say to you that difference does matter, and our policies and our practices need to reflect that.

The other thing that I want to leave you to think about is that our current prevention strategies lack the rigor of cultural responsiveness, and that assessments are designed particularly around parenting to dominant-model thinking and parenting, and we have to cast our net a little further and a little wider. Dictating non-culturally relevant parenting practices may put families at higher risk, actually.

I am here to tell you, because I have been on the front line, we fear that which we do not understand. So we have to take pause to really examine if what we are seeing is really what we think we are seeing, or are we really just looking at something and because we don't understand it, it then becomes pathologized.

The other thing that I want to say, and I just have a few more points, is that we must recognize strengths across color lines, and we have to change our lens and our language for true cross-cultural engagement. Focusing on social determinants of health, in my mind, is really where the work starts and where it ends. Our children have to be parented to handle the current harsh realities of our world, and so if we are going to use programs like home

visitors and have workers go into homes, we may want to leverage the expertise of cultural brokers in order to do that in a way that is culturally proficient and relevant to our families that we are serving.

The last thing that I will leave you with … maybe two things, one of them being we need a technical assistance network for disparity reduction in child welfare. It has looked this way for far too long. The urgency is now.

The last thing that I will say is that we have to develop a balanced approach to target and tailor interventions to address the issues at hand that build on strengths and also solve the problem. So to me it is not about doing something in addition, it is about enhancing how we do the work.

Thank you.

Chairman Sanders: [Session 3 - 01:40:37] Thank you, and Grace Sage Musser. I'm sure I destroyed that.

Grace Sage Musser: [Session 3 - 01:40:46] Yes. But thank you. [*laughing*]

Chairman Sanders: [Session 3 - 01:40:48] You could have at least said, "You got close." [*laughing*]

Sage Musser: [Session 3 - 01:40:53] See, I was raised in a reservation school, and they taught us phonetics, and it is "Musser." I have five themes, and then I have a few recommendations and remarks to make that Donna already made. I want to amplify and give voice to the American Indian and Alaska Native population, and not "other."

The first theme is American Indians and Alaska Natives living in urban settings face numerous issues, both economically and psychosocially, and I think we don't have a social justice system that really meets that need, and I really would like a social justice system that would talk about child abuse and neglect. Then we would be talking on a level that would operationalize into action as opposed to, unfortunately, being here in 2014 and hearing this all of my life, which has been long.

The second piece of that is historical trauma, and I think as long as we have been around, American Indians and Alaska Natives have been the reason why we are such a large population. For example, in the Denver metro area, this is a relocation city. A Relocation Act of 1854 that was passed where my parents as well as many other parents were forced off the reservation, promised jobs in a metro area, or if not jobs, training. Then they either had to leave their children behind because there was no housing, there was no transportation and there was a real lack or loss of identity with no support structure. Those are things that are necessary if we, indeed, choose to eliminate child abuse and neglect. We have yet to fashion

that kind of a broader network for the "other" population, let alone American Indians and Alaska Natives.

Theme two: Child welfare and other systems don't often necessarily, as Donna spoke about briefly, classify racially and accurately the population group that they are seeing. How are we to then collect data that is accurate and efficient and processed in a way that really helps us focus on what we need to, in that deep analysis, employ as informed programs. Documented disparities exist across the board for all people of color and certainly children of color. The theme for Alaska Native and American Indian families is they face many obstacles in not only receiving services but utilizing the services, kind of the knowledge and the skill sets that you just learn by being in the system. You learn how to access the system and then you learn how to get your way through it. I often think that is a skill set we believe everybody has, but I can assure you the population group that we provide services to do not have that. One thing is they are really a cultural community that is based on community and relationships.

So one of my recommendations, and I'm going to skip the last theme, is to build relationships and to build trust by engaging in a real dialogue with the community of people that might be around us and we don't even know because they have been so invisible for so long. Policies do not indicate, in my mind, that we have ever had a voice, let alone a seat at the table, and if we have had a seat it has been one seat and it has been on a token basis. We need to focus on improving that, especially when it comes to child welfare and especially when it comes to Indian child welfare.

We need to develop a shared understanding of the challenges, but also a shared understanding of strengths. When is it that I ever heard in my life when I walked into an office something other than, "What's wrong with you?" Well nothing, really. But what is right with me would have been really helpful. So we would like to ask our families, "What is working, and how can we make that work better? What do we have to put in place that will really amplify that ability to be able to have that work better?"

We also need to develop immediate and long-term strategies. We think too much about "here." That is where our thinking stops. We need to think "out there": What about our children? What about when they become the policymakers? What about when they become the people who need the skill sets to sit at a table like this, to be a Commissioner and sit and listen to this? What do we expect? What do we anticipate? How can we put that in place now?

We need to strengthen our collaborations by talking to one another and by knowing that we do sit in communities, and we are valuable members, and I own and am accountable for things that work and don't work as much as anybody else is, and I have to step up and say when things aren't working, "What can I do?"

Thank you.

Chairman Sanders: [Session 3 - 01:46:16]Thank you. So we will open up to Commissioners to see if there are any questions. Commissioner Martin.

Commissioner Martin: [Session 3 - 01:46:22] First of all, again, thank you very much for the information you have been able to share with this Commission. I have a question, and I want you to understand before I ask the question that I do believe wholeheartedly that culture is vitally important. It doesn't matter to me whose culture we are talking about; every one of us has a culture, right? And so the issue of culture I put very high on the importance list. But what I want to know is how does culture impact abuse and neglect fatalities? So does anyone know of programs that have emphasized, that have utilized, that have focused on culture that have actually been able to show, or utilize systems and programs that have been able to show, a reduction in abuse and neglect fatalities?

Parrish: [Session 3 - 01:47:18] The Healthy Black Babies program—and I was going to try to figure out where it was from. I think you actually have this report in your packet, it is called "Being Black Is Not a Risk Factor," and in this particular packet it talks about two or three really nicely designed programs that are tailored to mitigate disparate outcomes and to ensure safety. The Healthy Black Babies program is one of those programs. So that is the first one that I can think of from the top of my head. And to that point, Commissioner Martin, the other thing that I want to say is, for me the system is really concerned about compliance-based. And for me, if we are really going to aim towards the issue of increasing parental capacity, which will mean keeping your child and family safe, it has to be a way that is culturally relevant and culturally proficient in order for me to really not just show up and be compliant but to really take something away.

Sage Musser: [Session 3 - 01:48:18] And we have two programs that we use on a regular basis. The first one is called Healthy Families program, and what that helps parents do is to get together and really see that they aren't alone and that they aren't isolated. So that automatically builds a community, and the structure around that is to help them talk about the emotions and facilitate the historical trauma and the secondary trauma that they bring to the table when they are parenting their children. When it is a matter of housing, putting food on the table, transportation, health care needs, that is a lot on your plate when you can't find a job because you don't have the skills. So we really find the Healthy Families program very successful.

The second program that I really like a lot is called Life Skills Program, and again it just builds skill sets that I think we all believe that everybody has. But I think one of the skill sets that I see lacking in many populations is the ability to problem-solve. Prior to taking this position, I was a federal mediator with the Department of Justice, and one of the things that communities share is they all know what the issues are but they don't necessarily know how to resolve those issues in a way that everybody is brought to the table universally. I think that is one of the things that this Life Skills Program does for families. We really help them build that problem solving so that they are not racing to the emergency room at the hospital, but

rather racing to a network of support groups that they have incorporated with the Healthy Families and Life Skills.

Chairman Sanders: [Session 3 - 01:50:02] Commissioner Zimmerman.

Commissioner Zimmerman: [Session 3 - 01:50:04] Yes, I have sort of a two-fold question to everybody. I hear a lot of "evidence-based." The work that I do is also evidence-based, but sort of taking those evidence-based models and making them applicable in usually rural reservation tribal communities. So we don't have a lot of Ph.D.s in our rural reservation communities, and there is also this dialogue happening in Indian country around practice-based evidence. The young man earlier this morning talked about the remedies. Sometimes the remedies to what is ailing in American Indian families might be thought of as spiritual, so depression, or anxiety, or even substance abuse isn't necessarily a DSM-V diagnosis, rather it is a cultural and a spiritual illness that requires a spiritual remedy.

So when I am thinking about that and thinking about how do we incorporate culture, but also getting agencies and/or systems ready to implement an evidence-based or even a practice-based evidence model is what we struggle with. It is like we have got the great idea, we have the answer, now let us come into your system and totally remodel it and put a whole new scaffolding up. There is that sort of "How do you do that?"

Then the other is this idea around practice-based evidence for any community of color. We are working across the country where there are tribal people that are living in Minneapolis and Fresno who are experiencing the same sort of racial inequities that American Indians and African-Americans have for decades. So what would that look like? What are the practice-based evidence in tribal communities and African-American communities? And then how do you take these evidence-based models and put them in systems that may not be ready for them, including communities, particularly rural communities? Did I make even a remote bit of sense with those questions?

Kling: [Session 3 - 01:52:20] I would like to mention at least something to tackle at least part of that question. We have 24 family resource centers across the state of Colorado, from urban areas, to resort areas, to rural areas. We even have what we call "frontier" areas that are right next to the Utah border in the middle of nowhere. It is important that each of our 24 centers can use a common tool. So I think what is important is when we are selecting an evidence-based program for training—and we have one, our Quality Standards of Family Support—that it has a big cultural component in it taking into account training for cultural competence. That being said, Denver Indian Family Research Center is one of our members. We also have centers that are mostly African-American centers, that are mostly Latino, because they are all separate 501(c)3's serving the population they believe that they want to serve. So we had to pick something that had that level of cultural competence in the training for it.

The other approach I would say is the family strengthening approach, where it is strength-based not deficit-based, where you truly believe that families have strengths, and we can build on those strengths and work with families to develop a plan, and where they are developing a plan for their own lives and for their children's lives. It is a dual-generation plan that will break the chain of intergenerational poverty forever, hopefully. But it is that we listen, that we respect those individuals and families. And more importantly, our family development workers are trained in those skills. They are trained in motivational interviewing. They are trained in a number of different programs where they gain those skills.

Sage Musser: [Session 3 - 01:54:38] I'm sorry, I just wanted to add also Dee BigFoot's trauma-focused CBT. She has gone out throughout Oklahoma and throughout all of Indian country down there and has really established relationships that then she has been able to implement the TF-CBT program very successfully, and we are getting trained in that program next week. So I am really excited to bring that program back here to Denver and hopefully move that forward.

Commissioner Rubin: [Session 3 - 01:55:16] I'm going to address my question to Mr. Kling and a little bit to Ms. Dunn here. I want you to unpack, and I think for the help of the Commission with very different expertise, what you mean by "dual-generation" programs. And to be more specific, I want you to talk a little bit about, you know, some people would say, "Is that family therapy, and how do you get that funded?" What are the funding challenges in pursuing that type of strategy? How is that differentiated from, like, infant home visitation, and how are those discussions about which programs for which families played out at a local level? I think that was where Ms. Dunn sort of plays into that question.

Kendra Dunn: [Session 3 - 01:55:59] When we talk about "dual generation," we are really talking about any program that is simultaneously providing a service to a parent and a child at the same time. So that, for instance, could be something like the Nurturing Parenting program, where there is a curriculum for the children that is happening concurrently with the curriculum for the parents. So you are understanding that not only are you trying to work on the issue right at hand here at the present, but that you are also working on strengthening the practices that will happen in a future generation. So anything we can help do for the child will not only help them now but potentially will also help as they grow up and raise children. At least as we talk about it, "dual generation" is a very broad-based theory. Just about every thing or practice, everything we do in the Office of Early Childhood we look at on that level.

You asked a very good question though about how do you match a family with the appropriate program at the local level? The truth is ideally every community would have a range of programs available both with intensity, duration, and cultural competency, and would look at different types of methodologies. But the truth is at each community level you might only have one or two programs, and that is what is available in their community. So when you look at our programming across the state, we have a huge variety and a lot of options, but when you look at an actual community there may be a parenting strategy. So it might be a

parenting class, or a parenting support group, a home visiting program. So that with the exception of the Metro area, they rarely get to kind of go through that process of "Is this the right fit?" They are usually going through the process of "It is there or it is not," which I think just begs the point of our investment, as Mark mentioned, in prevention opportunities and programming. We have not taken even the evidence-based programs; we haven't been able to take any of them to scale to the point where they would all be available in all of our communities.

Chairman Sanders: [Session 3 - 01:58:25] You have any thoughts?

Kling: [Session 3 - 01:58:28] One of my favorite ways to discuss dual-generation is, since we are in the Office of Early Childhood, we work with both children and the parents and the rest of the family. But if one of our centers is doing a program on early childhood, we ask the question, "Well, when that child goes home what is the home situation like?" That is why we do a dual-generation program; we are also outreaching to the parents and the rest of the family so that the entire family becomes more stable, the entire family becomes more self-reliant, and the entire family is reaching its goals. The opposite is also true. If we are providing services to youth and parents, but the young children are not getting their early childhood needs met, eventually that will catch up to that family. They will need to deal with that issue. So that is why we work with the whole family and that is why we have a dual-generation approach. We think it is more successful. We find by working with families over time, and our success rates are pretty good, we can show, with the proper intensity, that families do become much more self-reliant and eventually are not needing our services. Then when the whole family is getting there that is when the cost benefits of it is that we can then let those families go live their lives and serve other families.

Chairman Sanders: [Session 3 - 02:00:02] So we will take one last question, I think Commissioner Rodriguez, and then we will take a short break and come back with our last panel.

Commissioner Rodriguez: [Session 3 - 02:00:10] I wanted to say, first of all I appreciated your comment about the urgency and the intentionality that race equity has to be looked at in this equation. I think the world, by and large, is a more dangerous place for our children who are black and brown, and so the idea that we are not attending to what we can do in their homes is a sobering one for us.

My question is sort of off topic of this panel, since I know the panel is focused on children who are not known. But since I don't want to lose the benefit of having the two of you up here: To what degree is race, or culture, or appropriateness of services through cultural competency considered during a child death review? When you have the hindsight, big-picture question of looking to see whether we did all that we could for a family, because I certainly hear what you are saying, that actually, in some cases, services can be harmful, not even neutral, but harmful to a family if they are being delivered either through a means or by a

person who is really not responsive, or sensitive, or aware at all of the situation of the family in front of them. So I'm curious to know, have you seen race or ethnicity or culture considered, if at all, when looking back after a child dies? And do you have any recommendations? Secondly, I think I understand some of the practice recommendations and the funding recommendations, but if you also have any policy recommendations?

Parrish: [Session 3 - 02:01:48] I am not at that table and I hate to put anyone on the spot, but I see that Mark is still here. Do you guys do any of that when you are doing the child fatality review, because I'm not at the table so I have no idea.

Commissioner Rodriguez: [Session 3 - 02:00:10] I'll hold the question then. Do you have any thoughts about it?

Parrish: [Session 3 - 02:02:07] Yes, I would say that it is very important, and I think that in most systems it is really taboo to have the "R" rated conversation, like no one wants to say "race." So the melting pot thing is actually a more harmful phenomenon. If it is not a question that has been asked, it has to be. We have to start having conversations about difference, because difference really does matter, and if we really are aiming, like I said earlier, to increase parental capacity, that is really truly meeting someone where they are at, figuring out who they are and how they navigate through the world, and how they care and where they learned that, and what is prevented early, I think, is possible. So if it is not there it should be.

Sage Musser: [Session 3 - 02:02:48] If I were going to make a recommendation about policy, I think we need to have those voices at the table.

Chairman Sanders: [Session 3 - 02:02:58] Well, thank you very much to this panel. Again we learned quite a bit and it was helpful to hear of some of the effective prevention strategies, so thank you. We will take a 10-minute break and come back and wrap up with the last panel.

[Break]

Chairman Sanders: [Session 4 - 00:00:00] So Ms. Rosemond and Dr. Wells win the perseverance award for today since they get a couple of shots at this. We have the last panel really focused on those who are … on strategies for identifying families with an elevated risk of child maltreatment fatality and for intervening to reduce this risk. We have Paige Rosemond, Stephanie Villafuerte, Judge Kathy Delgado, and Dr. Kathryn Wells.

Rosemond: [Session 4 - 00:01:10] Good afternoon. I will limit my remarks to results and recommendations, so we will be fast. During today's earlier panel I referenced our collaboration with CSU in determining the reliability and validity of our new safety and risk assessment tools. In their report, they asked the reader to keep in mind that human beings have substantial difficulty in predicting other humans' behavior. In addition, CSU went on to

say in no instance should such assessment completely replace such informed judgment. Rather, additional resources should be invested in training and in developing critical thinking skills for caseworkers in order to complement the use of such an assessment. I want to highlight these aspects of the report as we discuss the efforts to prescribe child welfare involvement to label a family as having a high risk for fatal child maltreatment if certain factors exist. Will this achieve our desired reduction of child fatalities?

It is also important to remember our profession's fundamental belief that individuals, families, and systems are capable of change. Our initial involvement with a family must be comprehensive, rigorous, and include sustainable support planning upon our exit.

As referenced in our state profile, we have made many changes to our child fatality review process. We want to continue to assess the quality and impact of our process. Colorado's statute was modified in 2011, formalizing the CFRT process; in 2012, defining egregious incidents and including those in our review; and in 2013, extending prior involvement to three years. We also moved the child fatality review process from the Division of Child Welfare to the Administrative Review Division to serve as an independent … and reporting expectations to provide consistent guidance to counties in the event of an egregious near-fatal or fatal incident of child maltreatment. We also gather data, explore trends, and utilize that information to inform many of the changes I have already cited. But there are also challenges in generalizing these observations, given the small sample size.

It is also a challenge to compare potential trends in Colorado to national trends, due to the varying definitions of abuse and neglect. Specific to Colorado, support is needed and research on these outcomes, as well as the appropriate determination and responsible use of fatal child maltreatment and etiological risk factors.

We also would like to request support of flexible funding to promote government and community collaborative practice to prevent initial and subsequent child welfare involvements. As Colorado's former IV-E Waiver administrator, I witnessed counties' innovative strategies to prevent out-of-home placements. Funding needs to be refocused to support preventing and support involvement, and when involved, maintaining children safely in their home.

Thank you.

Chairman Sanders: [Session 4 - 00:04:15] Thank you. Stephanie Villafuerte, Executive Director of Rocky Mountain Children's Law Center.

Stephanie Villafuerte: [Session 4 - 00:04:22] Yes, thank you, and thank you all for inviting me to be here today. It is a pleasure to know that there are people as impassioned as I am when it comes to the issue of child abuse fatalities, so I appreciate the opportunity.

I have spent years of my career dealing with child maltreatment issues. I have worked as a criminal prosecutor in which I dealt with child homicides for over a decade. I have worked as a child welfare policy analyst for a governor's office, and in addition I currently serve as the executive director of the Children's Law Center.

The Children's Law Center is a 35-year-old organization that is dedicated to direct legal representation for abused and neglected children, as well as public policy advocacy. Specifically, we serve as court-appointed guardians ad litem for children who make their way into the child welfare system.

In addition to my work at the Law Center, I also currently serve on the Colorado Department of Human Services Child Fatality Review Board, and it is within that context that I address all of you here today.

I have three recommendations, and I'm going to highlight all three. Very first one, we need to create an independent child medical examiner system. CAPTA needs to require all states to employ a chief medical examiner with expertise in forensic pathology and child abuse deaths to review all child death cases. Currently, there is no federal law that requires an independent medical examiner in child death cases. If you are in places like Colorado, as over half the states are, we have an elected coroner system as opposed to an ME system.

In Colorado, we have 64 different county coroners with no requirement of a medical degree. They only need a high school diploma and eventually, and I say "eventually," 20 hours of on-the-scene training. As a result, we have individuals with little to no medical expertise and no experience in child abuse and neglect making findings in our child fatalities cases. Over half the states in this country have similar problems. There are no mandatory standards for autopsies, there is an absence of oversight into the performance of coroners and medical examiners, and there is no standardized training or accreditation.

Child death cases, as all of you know, are highly specialized. Children are not killed in the same obvious ways that adults are. These injuries are often hidden beneath the surface. Indeed, experts often have to look for very subtle signs of trauma—a difference in eye pressure, subdural bleeding—things that are not apparent to the untrained person.

We have specialized doctors called pediatricians who handle children while they are alive. I would argue that it stands to reason we should also have specialists who handle children's issues during their death. As a member of the child fatality review team, it is not uncommon at all for us to wait a year for a coroner's report. It is not uncommon also for these reports to be inconclusive as to the cause of death. This impacts human services agencies to be able to problem-solve around these deaths, including how do we deal with surviving children in these families? How do we come to conclusive results in these cases and know what sort of treatment and services we need to provide, if we don't even know how the child at hand died?

In conclusion, we are not going to abolish the coroner's system in this state or this country any time soon. Indeed, in Colorado we tried that in 2011, to make serious changes, and politically it was highly unpopular. But what I would argue is that the federal government does have the power to put into CAPTA a provision which requires independence that gets us away from the elected political system and also requires that there be a medical examiner in general to oversee these cases per state.

My second recommendation is to mandate autopsies for child deaths occurring in children within a certain age. Federal legislation lacks specific provisions for automatic autopsy of child fatalities. Research shows that in our state, child deaths are most common for children under age 5, and Colorado has no laws that mandate autopsies at all. Half the states in our country have age limits; the other half do not. We need these autopsies so that we can establish accurate cause of death, and to provide a database for research and education, and to give human service professionals information to act in the best way they can for surviving children.

Finally, with one minute to go, I will tell you CAPTA should require all states to have a Birth Match program. I know from reading the minutes of this Commission that you have received substantial information on these programs, but I will tell you, as guardians ad litem for these children, it is very common for us to see mothers who have pending child welfare cases or who have had their parental rights terminated give birth to new children. They give birth in new jurisdictions and new hospitals, and we are unable to track them to ensure they are getting continuing services or getting new ones. I would urge this Commission to also consider putting that type of program into CAPTA for states to comply with.

Thank you.

Chairman Sanders: [Session 4 - 00:09:26] Thank you. Judge Delgado.

Judge Kathy Delgado: [Session 4 - 00:09:30] Good afternoon, everyone. My name is Kathy Delgado. I am a district court judge in the 17th Judicial District, which is Adams and Broomfield Counties. I will tell you a little bit about myself. I have been on the bench for about 12 years. I, like Stephanie, was a prosecutor for about 13 years, handling sexual assault, domestic violence, and child abuse cases before I was appointed to the bench.

One of the things that I worked on when I was a prosecutor was to strengthen the child abuse laws in our state. I felt very strongly that for children who are witnessing domestic violence, that was an act of domestic violence, and that statute was added several years ago.

When I came to the juvenile court in 2006, I started off as a lead judge. In 2005, our Court Improvement Program entered into a contract with the National Council of Juvenile and Family Court Judges' Permanency Planning Department to establish three model courts in

Colorado. Adams County was one of those courts. You have heard a lot about El Paso County today, who also does a fabulous job. They were one of the courts, and then Denver County. And our job was really to be agents of change. At the conclusion of the contract, and based on the success achieved through the model court programs, the Court Improvement Program then established a plan to implement model courts or best practice courts in all 22 judicial districts. I did provide Cheryl with a document regarding those best practice courts.

Over the past five years, each judicial district has worked collaboratively with their Best Practice Court Teams. The Best Practice Court Teams include social service representatives, law enforcement, school, medical, substance abuse providers, respondent parent counsel, guardians ad litem, and CASAs. Some of the Best Practice Court Teams actually have mentor parents—parents who have actually been involved in the dependency and neglect system—to help them with the projects they are working on.

The CIP Executive Committee has approved and allocated funds over the past several years to bring the best practice court teams together every April for a convening. It is our opportunity for further training, team building, and for sharing our best practices across the state. Through our relationship with the National Council, we recognize the importance of training for juvenile court judges. The State Court Administrator's Office here, and through our Judicial Education Department, along with CIP, has supported an annual Dependency and Neglect Institute. We have done that for the last five years, and I'm really excited that next year I will be the dean of the institute. One of the things that we hear from the judges who have attended over the past five years is that it is the best training that they have ever attended as judges. My goal has been, from Day 1, I want to debunk the attitude that juvenile courts are "kiddy court." I want judges who are well trained, who are passionate, and who want to be juvenile judges. From my own experience over the past 12 years, having handled every rotation, it is the most important docket that I have ever handled. It is also the most difficult docket that I have ever handled, just based on the needs and the issues that the parents and the children present to us.

As a result of the collaboration that we have also had with Casey Family Programs, we have had some great individuals like Susan Weiss and Susan Kelly, who I think are both retired now. They have really helped us develop what we have formed, a Judicial Permanency Advisory Group. This is a group of passionate judges who are leading the work of reducing congregate care and promoting and enhancing judicial leadership skills. For the past three years we have had a special one-day training in advance of our annual judicial conference, and this year we had 60 judges attend.

It is my belief that, just like we need well-trained social service workers, we need well-trained judicial officers who are able to recognize the needs of the families. You heard Donna Parrish talk about the treatment plans. If we are spending more time in court with these families and having to allocate enough time for the hearings, we don't have to have the

"cookie cutter" approach to treatment plans, we can actually have a treatment plan that meets the needs of the families.

I am also a huge fan of the "one family, one judge." If a family is going through a criminal prosecution, a divorce, and a juvenile case, to have one judge that understands what is going on with this family, I think, is critical.

The other thing that I am very passionate about is hearing the voice of children. We have been promoting the idea that children need to come to court when it is appropriate. Some of them might consider it work. I could not do my job without actually seeing the child and talking to the child. I have found in my experience that the children, once the judge is engaged with them, will tell you things about what is happening not only in their homes but in their foster homes. Transparency is critical.

I guess I have run out of time. It does go fast.

Chairman Sanders: [Session 4 - 00:15:05] Go ahead, Dr. Wells.

Dr. Wells: [Session 4 - 00:15:09] Good afternoon, and it does go really fast, and I promise to not have a bunch of slides up. I'm really going to limit my comments, and thank you, Mr. Chairman and Commissioners, for allowing me to speak one more time.

As a clinician, as someone who had practiced general pediatrics in a small town for five years and then chose to go down the child abuse and fellowship training path, and now am really on the front lines and working closely with investigators daily, I have a tremendous amount of respect for those folks I work with, both through the legal system and the child welfare system. They do very hard jobs. But I have continued to have interest in systems and policy work and feel very strongly that we need to remove our silos and our barriers. There is so much change and so much opportunity, both on the professional level but also for families as based in relationship. Relationship happens when we work together.

So I am going to base my comments on two general recommendations. I'm going to give you specific details, but really those recommendations are around networks of health care systems, those networks having a relationship with this issue and the professionals that deal with this issue, and then information sharing.

Broadly, health care providers get involved with children that are at risk for fatalities and are already known to the system in three ways. One, they identify them and then they are responsible for reporting. That requires adequate training. I can tell you that in all of our health care training systems there is no requirement for child abuse and neglect identification training. It is not a required process for emergency medicine physicians or pediatricians, it is an optional elective.

I think we need to continue to work in our educational systems to try to make it more of a part of the curriculum, but we have a ways to go. Even if we are going to have those E.R. doctors be able to identify those injuries that we hopefully are going to be able to track, if we have a better system, they have to be able to identify them as being related to abuse or neglect first.

Then they need to know when to report and how to report. One of the things that we found in Colorado during our public awareness campaign around the hotline is that most don't know how to do this. 79 percent of mandatory reporters knew that they needed to report—79 percent, not 100 percent. Only about half of those interviewed knew *how* to do that. So that really gave way to some efforts around a mandatory reporter training in Colorado, and I think you have heard some things about that earlier today, which is very exciting. The challenge is it is not required for health care providers. I told my hospital where I work, "This would be great training for all the folks that see kids." They said, "That's great, but we already have 20 trainings a year." In my opinion, one recommendation is this should be a mandatory training for all health care providers that see children across the country.

Secondarily: the reporting system, the hotline and how that happens. I was fortunate enough to be a part of the Child Welfare Action Committee that made some recommendations, many of which we are seeing the results of today, including the ombudsman system and the hotline. But again, and really remembering how important it is, I look at that first piece of information like a 9-1-1 operator system: if you don't get the right information at the intake, you are not going to know what to do with it afterwards. So that really is very important, but then there needs to be information feedback.

If I am a health care provider and I make a report but I never hear back, what happens then? What happens to me as the reporting party and other mandatory reporters? Now I understand confidentiality, and I'm not saying that everything should come back to a mandatory reporter. One of the recommendations we made, though, is those mandatory reporters that have ongoing relationship with that child and report in their capacity as a professional need something back. If I am the general pediatrician and I never hear back that child should not be with dad, and they show up in my office with dad, how am I to know, as a partner in this network of efforts, to let somebody know? So what happens when we don't hear back is we start to distrust the system. The PROS study that was done in 2008 of pediatricians said 27 percent of pediatricians who knew that this was abuse, or thought it was very likely to be abuse, did not report it, One of the reasons is a distrust in the system. I'm not saying that is acceptable, but I am saying the distrust comes from lack of relationship and lack of hearing anything back.

So that is the next piece that is important, I think, with information sharing and confidentiality. We talk about HIPAA; we talk about all these things. I understand the importance of confidentiality, but I think that I would urge this Commission to talk with the federal government about ways to get past those as we have done with FERPA rules on sharing

information: both children that are in custody of human services but also those kids that are at risk.

Secondarily, we get involved in the system when there is a child welfare investigation. I will tell you there are no standards about when those investigations and those things that are even related to an injury, or related to medical neglect, or failure to thrive, and there is no standard about when a medical provider is a part of that investigation. Some folks have employed nurses being a part of that conversation.

So two things: Number one, it is a capacity issue. Child welfare workers are overwhelmed to even make that call. Secondarily, there may not even be those medical providers available. So I would propose a network of health care providers that have training, knowledge, and understanding of these issues. That does not have to be a child abuse pediatrician. It does not even necessarily have to be a pediatrician, but we seek throughout the state, we find out who those individuals are, and they become our touch points for questions around child abuse and neglect, for needs of kids in foster care, and for needs of kids that are at risk of being in out-of-home placement but are not quite there yet and how we provide their ongoing health care needs. I think that if we don't have those people that have those skills and expertise, reimburse them in the way that they can continue to do that work, give them support and training, I think it is going to be very difficult to do the kind of work that needs to be done with a partnership with the health care system.

So that is the last piece, is really developing those regional providers, those contacts, and then having some sort of oversight, something such as a Child Welfare Medical Director. I know that has been recommended elsewhere, but someone that can oversee that process.

Thank you very much for the opportunity, and I hope you enjoy Colorado.

Chairman Sanders: [Session 4 - 00:21:11] Thank you. Questions from Commissioner Petit?

Commissioner Petit: [Session 4 - 00:21:18] I have a question for Judge Delgado.

First, with regards to the purpose of this particular piece, which was children known to the system and what could you do to intercept a particular problem, let me mention two things to you: One is there are peer-reviewed reports, one in the U.S. and one in Canada, that say that a child is at 50 to 100 times greater risk of being killed by an unrelated male in the home than a related male in the home. Let's say that is true for a moment. Would something like that be built into a casework protocol that says, "If we have an open CPS case, the child is living with her mother and some guy starts coming in, would you know or would you seek information about whether there is a criminal record on that individual?"

Judge Delgado: [Session 4 - 00:22:11] Yes. We do criminal background checks on any adult in the home. Any time there is a change of circumstances we also are responsible for

completing a new safety and risk assessment, and we consider both primary and secondary caregivers in both of those tools.

Commissioner Petit: [Session 4 - 00:22:26] So would those criminal records be dropped into a file, so that if the worker changes or the person or the family moves, would it be included and embedded within the official record?

Judge Delgado: [Session 4 - 00:22:37] Both in our electronic and paper.

Commissioner Petit: [Session 4 - 00:22:39] It would. Okay. Here is a question for you and the judge, in a situation where the court says, "I want the department to retain custody of this child, legal responsibility, but I'm placing the child back to its home." And the department objects. The department says, "We agree that the child should remain in our custody; we don't think the child is safe if the child returns home." What would happen in that kind of situation where you have declared something? Does it ever happen that the department appeals that decision? And when they do appeal the decision, to whom do they appeal it and is it ever overturned?

Judge Delgado: [Session 4 - 00:23:18] The only experience I've had is where I refused to terminate parental rights, and it was appealed, and quite frankly, in that case, the reason I did not grant the termination of parental rights is because I found that the department had not exercised reasonable efforts. It was a domestic violence case in which there was total victim blaming. The perpetrator of the assault on the child was sent to prison in the criminal courts; the mother was doing everything in her power to safely parent that child. There was an appeal to the Colorado Court of Appeals, and my decision was affirmed. Subsequently, when the case came back, there was a new caseworker who had a different kind of attitude about what the court had ordered, as well as had a better understanding of the dynamics of domestic violence, and that child was safely returned to her mother, and she has been there safely and lived in a great home for the last five years. So I would say that in that situation, if there was an appeal it would go to a higher court. I don't think that necessarily happens in too many cases.

Commissioner Petit: [Session 4 - 00:24:34] Well yes, in many cases that I have run into, the department is intimidated by the court and does not want to appeal the decision for fear of subsequent activities. I am just wondering, Paige, in this particular jurisdiction, does it ever happen you appeal a judge's decision?

Rosemond: [Session 4 - 00:24:53] It is difficult for me to answer that question at the state level because we wouldn't be involved in those appeals. It would be the local county jurisdictions.

Commissioner Petit: [Session 4 - 00:25:00] There was somebody here from the representative department, say the county attorney. Is she here?

Judge Delgado: [Session 4 - 00:25:06] I think most of the appeals happen when there has been a termination of parental rights.

Commissioner Petit: [Session 4 - 00:25:12] But not of the department's decision to not have the child …

Judge Delgado: [Session 4 - 00:25:16] I mean, I have never had that experience, and I certainly can't speak for the other 21 judicial districts, but I don't think that the county departments are afraid to file appeals, and I think they would do that if they feel that the court has not followed the law.

Commissioner Petit: [Session 4 - 00:25:33] Well in this case it is not following the law, it is an opinion by the department that says, "We don't believe the child is safe at home. We want to keep custody and we want the child in a foster home," and the judge says, "No, I think this child will be safe at home." So I don't think it is a legal question at that point, it's a judgment as to where the child should be.

Judge Delgado: [Session 4 - 00:25:51] It's a judgment. It is a judgment.

Commissioner Petit: [Session 4 - 00:25:53] Right, I understand that, and then the process of appeal is also a judgment, and I'm just wondering if it has happened. It doesn't sound like it happens here, so…

Judge Delgado: [Session 4 - 00:25:59] Right. And one of the things that we have done in this state is expedite the appeal process in juvenile and domestic relations cases, again so that a lot of times in a criminal court or in civil courts the appeals can go on for several years and we recognize that length of time doesn't work well with establishing permanency for children, so we have done that by statute.

Chairman Sanders: [Session 4 - 00:26:25] Commissioner Dreyfus?

Commissioner Dreyfus: [Session 4 - 00:26:27] Thank you. Stephanie, I have a question for you, and then Dr. Wells, one for you.

I loved your thinking around an independent medical examiner highly specialized in child welfare. It has been something I have been thinking about too, as we have been going around the country. I want to just drill down a little bit more on what your vision is around that.

For instance, would you envision that to be a person at the state level? Would you envision that to be somebody that works for that person at the state level but is located around regions? I think you said "all deaths" when you talked about mandating autopsies for deaths of children under a certain age. Let's just say it is either a certain age or it is where it is

viewed to have been a preventable death. Do you envision those autopsies being conducted by that trained, independent medical examiner, correct?

Villafuerte: [Session 4 - 00:27:28] Correct. What I would envision would be, again, as you stated, somebody highly placed at the state level, lodged in either Public Health or Human Services, if you will, and then creating sort of a second-tier system of medical examiners throughout the state. So that is a list of people, and knowing that it is difficult to employ medical examiners, it could also be physicians with certain specialized training as well. Create a team of people that are available to that person to call and say, "We have this set of cases now that need to be reviewed," that type of thing.

Commissioner Dreyfus: [Session 4 - 00:28:01] And they could go out on the investigations, and participate in court, and whatever.

Villafuerte: [Session 4 - 00:28:04] Correct.

Commissioner Dreyfus: [Session 4 - 00:28:07] I really think there is something there. Dr Wells, I recently served on a legislative task force in Wisconsin on mandatory reporters, and one of the things we pushed on, and it was partially implemented in legislation, was to put the burden on the mandatory reporter in terms of maintaining their competencies as a condition of licensing.

I know that not all mandated reporters have to be licensed, but many of them do. I want to know what your thoughts would be about that, because I am with you about the burden on mandated reporters should not be the burden on the Human Services Department. I appreciate them creating a curriculum, but the burden of maintaining competencies and in your mandated reporter responsibilities. I want to know what you thought about that, if that were a condition of licensing.

Dr. Wells: [Session 4 - 00:29:03] I personally support that. I think that obviously we have lots of trainings, lots of things we have to do, and lots of expectations, but I think that until we can say that if I am seeing kids that I don't have some basic knowledge or understanding of my mandate, and I agree with you, I think it is great that the state did that. They did it in collaboration with the Kempe Center, so it was a nice collaborative project, and I have actually taken it, even though I'm a child abuse pediatrician. I think it is a great training. I think that would be a way to sort of instill and make sure that those folks know—like I said, when you see those numbers, that 50 percent of folks didn't know even how to report, let alone what they should report.

Commissioner Dreyfus: [Session 4 - 00:29:40] Then the other thing you said shouldn't be lost on the Commission is now we are talking about schools of medicine, now we are talking about law schools, and we are talking about education schools, and where mandated

reporters come from as far as their education background, and the importance of that as well.

Dr. Wells: [Session 4 - 00:29:59] Absolutely. Thanks.

Chairman Sanders: [Session 4 - 00:30:00] Commissioner Rubin?

Commissioner Rubin: [Session 4 - 00:30:04] Thanks a lot. You know, Stephanie, I was struck by just how direct your testimony was. It was very, very helpful. I want to continue and unpack it a little bit more, because I think you made a lot of very concrete recommendations and also articulated that we talk about the relative importance of the count, and getting it right versus sort of leveraging our expertise on prevention services and trying to reduce fatalities. But you articulated the intersection about these surviving siblings, and that leads to a question about timeliness, which I didn't hear in your recommendations. Commissioner Covington, you can weigh in as well, too. I know sometimes it takes time to get results, but I'm also familiar that in public systems when there is lack of urgency, there is a lack of urgency. Is there a timeliness recommendation here about how long authorities should have to be able to investigate a case and assimilate the materials?

Villafuerte: [Session 4 - 00:31:02] Absolutely. I think timeliness is critical, and part of what we see is that there is this lag. For example, in our child fatality review process we have these timelines when reports have to be issued, for example, there is a district attorney exception in which they can block it if there is an ongoing prosecution. In 2013, I think we had 17 blocked reports. So when you have these types of exceptions built into the law, talk about timeliness. There are still reports, if you look at our 2013 log, that we have not released because there are still D.A. holds pending criminal prosecution. That is a fine example of where timeliness breaks down, and again we don't have results.

Certainly, when you are dealing with coroners and medical examinations, absolutely. I think that there should be some sort of a mandate and protocols, which again do not exist anywhere in this country, about what the expectations are when a child dies; like who handles that, how they should be accredited, how quickly they should be looking at it, and then what do they do with the information.

I think it is absolutely critical to try and put some boundaries around this issue.

Chairman Sanders: [Session 4 - 00:32:14] Commissioner Covington?

Commissioner Covington: [Session 4 - 00:32:19] I really appreciated your pretty succinct and to-the-point recommendations too, Stephanie. I'm going to change the subject just a little because you didn't address it, and I meant to ask it of Mr. Mackert too. It was related to fatality reviews. When he was describing Colorado, there are two parallel systems; the public health piece, and then there is the cases that are known to the system. He talked about it

being an independent review, but it is housed with the Department of Social Services. So I found that to be a little bit odd, to be considered independent but still within the agency.

So I am wondering, as an outsider, how you feel about the independence of reviews that are housed within the agency?

Villafuerte: [Session 4 - 00:33:01] That's a very good question. I personally feel that we have a team that is very independent. People are very clear about their thoughts on issues. Because it is put in the ARD, Administrative Review Division, I believe that it created a little bit more distance than it had before, and that was a relatively new development in the past year. Because ARD is typically entrusted with those functions, if you will, and investigations it feels better to me. Again, there has been a lot of free-flowing thought on that. I think it is important to remember that because it is a human service team, it necessarily is staffed with those individuals because that is the eye towards the review, right? It is, "Has there been policy and procedure violations," etcetera.

So to answer your question, because it is placed in the ARD division versus where it had been previously, I believe there is the appropriate level of independence, but again, I think that varies from department to department.

Chairman Sanders: [Session 4 - 00:34:09] I had a question for Ms. Rosemond. We heard the example of the work being done in El Paso County that sounded promising, and it sounded like a comprehensive effort. I believe we have ascertained that there are 64 counties in Colorado, so how would the state office take a practice or set or practices like El Paso County and get that spread across 63 other counties? What is the mechanism that you would use?

Rosemond: [Session 4 - 00:34:42] Through our Colorado practice model we have a committee called the Promising Practices Workgroup, where counties can bring these promising practices forward, and then if the committee decides the validity of the practice and then promotes its replication in other counties. We do have members of the state that also sit on the committee and support the replication of these practices after they have gone through the process to determine that they are promising practices.

Chairman Sanders: [Session 4 - 00:35:12] Exactly how does that happen? Let's say a decision is made, so now the entity has said, "We want to do this in other counties." What role would the state play? What would counties do? How would the practice actually be spread, and have you seen it as an effective mechanism for doing that?

Rosemond: [Session 4 - 00:35:30] Yes, we definitely have. This is a continuous quality improvement effort, so it is something that we ensure is a rigorous effort to ensure that it is quality practice and that it is replicable. We have done this with a number of our efforts through the IV-E Waiver as well, in utilizing different models for family engagement meetings. The state supports the training. It definitely is a state-supervised, county-administered

system, so while we play a role in the supervision and the replication of the practices, it is often county decisions as to whether or not this is the best fit for their community. It is a balance that we play as the state supervisors. If it is something that we feel rises to the level of becoming rules, such as our enhanced screening and RED team practices, we provide the trainings and then we incorporate it into our rule as an expectation.

So if we were to see that some of these efforts in El Paso, or see something that would rise to the level to be part of policy, then we would play a role in assessing the appropriateness of it becoming policy and then move forward to assist with providing statewide training, and then including it in our rule.

Chairman Sanders: [Session 4 - 00:36:45] Does that suggest that it is through rule, policy, and training … that those are the ways that you spread practices across the state and that a worker in Arapahoe County versus Denver County is going to get the same training and will be reviewing the same policy, etc.?

Rosemond: [Session 4 - 00:37:04] Yes, that is the strategy that we support and that we are continuing to try to improve upon. This has also been evident in our differential response expansion from pilot to hopefully progressing to more county involvement. So in a number of areas, we are trying to emulate that expectation.

Chairman Sanders: [Session 4 - 00:37:20] Thank you. Commissioner Petit?

Commissioner Petit: [Session 4 - 00:37:24] A question for the judge again, and for Paige. Is there an issue of any type with criminal courts being backed up and not a trial going forward with an individual who also is involved with a case in your courts, and where an individual is not incarcerated but is waiting to be tried and yet he has access to a child? Is that an issue here?

Judge Delgado: [Session 4 - 00:37:51] Sadly, I have a case like that I'm dealing with right now, where I'm in the criminal court right now and I rotated into that court about a year ago. The child, a 6-month-old, passed away from child abuse that was ruled as a homicide. The dependency and neglect case was filed, and it took the coroner and the district attorney an incredible amount of time to make a decision. When the case was ultimately filed by the district attorney's office, the department had been working with the family for some time. I found out that the children had been returned to the parents by the juvenile court, and the criminal cases were pending in my division, which obviously troubles me greatly. I refused to take a plea bargain in the case where the parents would have had just probation, because I just felt that a jury needed to make a decision in terms of the criminal charges. That's the first time in my 12 years as a judge or my 13 years as a prosecutor that I have ever had that experience, and quite honestly I think it has a lot to do, again, with training. Unfortunately, in most of our judicial districts, judges rotate out of the Juvenile Division every two years, and I think that is a huge issue. And despite the fact that we have worked very diligently to

train judges over the last several years, we still get judges in juvenile that don't have the skills. Just based on their prior experience, they have difficulty dealing with the families and with children. I think that is an issue not only in Colorado, but really across the country with the rotation of judges, and that is something that I wish we could mandate. That is something I have asked from the National Council in terms of is there something, some policy or paper that you could send out, in terms of how long should a judge stay in a Juvenile Division?

Now in the criminal courts, I see a lot of our juveniles, our kids who were brought up in the system and who are now graduating into the adult criminal courts, and just to see the struggles that they face as emancipated foster youth is very difficult. I mean there is just a whole gamut of issues that I think could be addressed. Unfortunately, I have had two youth that I had overseen their cases when I was in juvenile that were doing well. They emancipated, they had permanency with families, and they ended up with one of them being recently charged with child abuse resulting in death, and the other young man was found guilty of child abuse resulting in death, and I don't think that years ago we were really working with children who have been raised in the system, who have encountered their own abuse, to deal with their trauma. The training that we just did for judges two weeks ago was how to be a trauma-informed judge and to have a trauma-informed courtroom. It was really a powerful way to teach judges how we deal with these kids and with the parents, which I think is necessary, because we do see these families and our children, our youth grow up and enter into the criminal system.

Rosemond: [Session 4 - 00:41:55] We do struggle with the timeliness of prosecution, district attorneys making these determinations as to whether or not to charge. As you may know, we have 30 days to complete an assessment, with one allowable extension by a supervisor extending it to no more than 60 days. Often, 60 days is not long enough for some of these decisions to be made. We have a goal of 90 percent. Sometimes we believe that this 10 percent allows for those circumstances when timely prosecution does become an issue, but we really charge counties in working within their local jurisdictions to ensure that there is timeliness of law enforcement investigations and D.A. determinations, as far as prosecution.

Chairman Sanders: [Session 4 - 00:42:47] We will take one last question. Commissioner Rodriguez?

Commissioner Rodriguez: [Session 4 - 00:42:52] My question is for you, Judge Delgado. I know child welfare sort of a trend is having more resource parents, foster parents, and kinship caregivers working closely with birth families on the case pointing around reunification. It has been my experience that many of those caregivers have much more contact and sort of stronger relationships with some of the birth families than even the caseworker or the attorney. As a result, some end up with information about the birth family, risk factors, supports that the families need. I think sometimes they are not disclosing to the department or the court because they fear that they are going to be looked at as sort of not a

good partner if they are providing information that might be contrary to what the case-claimed goal is.

I'm curious if you have any means or mechanism in your court reports or in your court of caregivers of children being able to share information about the progress of birth families or their assessments of the type of support and services that families need.

Judge Delgado: [Session 4 - 00:44:00] Absolutely. I welcome foster parents, kin, and providers, but I think what is also very important is the appointment of a CASA, which provides an additional set of eyes and ears, that goes in and visits with these kids and with these families pretty frequently. Most of our CASAs in the 17th Judicial District meet weekly with families and kids, so they can see what is going on and they see the people that are in the home. I can't tell you how many times I have learned from a CASA that someone, a new boyfriend or a new girlfriend, is in the picture that we wouldn't have known about but for the fact that the CASA just happened to mention it, and we were able to run a criminal history and to amend the treatment plan so that individual could not be around the child.

I think having a court where you are respectful to everyone that is there, and allowing everybody to have an opportunity to speak, and showing that the judge cares, and listens, and wants as much information as possible in order to make the right decision for the family is vital. Just having enough time in your hearing so that you are not doing 20 hearings in half an hour, and I know that is a problem for a lot of the large jurisdictions; we just don't have the time and the number of judges. But that is a huge factor.

Chairman Sanders: [Session 4 - 00:45:28] Well, I think, again, we are wanting to thank you for the great recommendations, very focused and succinct. Thank you very much, and thanks to all of the presenters who I think did a great job today in presenting us with thoughtful, informative presentations. Thanks to the audience who is here in person and who joined us by phone and by webinar.

Any of the other Commissioners want to say anything as we wrap up? So we will reconvene tomorrow morning at 8:00 in Executive Session for the Commission, and then reconvene as a full body at 8:30 here, and I think in this room again, and it will be an open meeting, although the agenda is purely Commission deliberations, but people can join by phone, by webinar, or in person, and the information is on our website.

We are adjourned for today. Thank you.

Day 2: SEPTEMBER 23, 2014

Reggie Bicha: [Session 5 - 00::20] ...in the Child Welfare Plan we call Keeping Kids Safe and Families Healthy. And we've been making changes very quickly in Colorado, at both the state and local levels. We are one of only two states in the country to add a reporting and state review of egregious incidents to state statutes. This law exceeds federal CAPTA requirements on fatality and near fatalities and is intended for us to learn from extreme situations that do not result in death or near death. And we continue to revise our laws as much as possible to both protect the confidentiality of the children and families we serve, while increasing transparency and accountability to the public.

We've done so at the direction of our governor, who's prioritized these issues, and with the support of our state legislature that has significantly invested in our kids. Today I have several recommendations to present to you based upon my more than 20 years of child welfare experience. And I ask you to consider incorporating them into your final recommendations.

First of all, applied training. Some lessons are best learned in practice. For example, police officers all go to police academies. Nurses and physicians receive training that is applied and coached to prepare them to perform their duties. When medical professionals are trained on new procedures, they're required to apply what they've learned before using it on patients in their practice. Now most states that I'm familiar with teach child welfare practice, including how to do an assessment, interviewing skills, and conducting safety and risk assessments in classroom environments. Professional development of child welfare workers really needs to go beyond the classroom to include in-the-field experience. And should include trained coaches who can directly observe, teach, and evaluate approaches used by caseworkers to ensure that learning life-saving skills and knowledge are sufficiently transferred and applied from the classroom into the field. Colorado's Child Welfare Training Academy is in the first phase of developing such a coaching pilot for our state.

Secondly, I would encourage you to take a position to provide new funding for and revise federal regulations for Statewide Automated Child Welfare Information Systems, or commonly known as SACWIS systems. Colorado's SACWIS system, we call it Trails, is the best 1983 technology money can buy. It was built around 15 years ago, using technology that is literally from the mid-1980s. Commissioner Dreyfus, our Trails system is built, developed in Wisconsin, some 15-20 years ago. To put that into perspective, we were still using rotary phones at the time this technology was designed. The original creation of the SACWIS had about three primary purposes. It had to include billing and payment. It had to meet federal recording requirements, and it was also to be a case management system. Our caseworkers in Colorado are entering information into a database that truly is best suited for an accountant. The case management functionality, which was best at the time that the system was created, creates almost a distraction from keeping kids safe. A recent Colorado child welfare county workload study conducted by our office by our state auditor, just a few months ago, found that case support services amounted to the single largest category of time spent for our caseworkers,

representing about 36 percent of all time recorded. Case support services included any activities that do not directly benefit a specific case or crime, and this included documenting in our Trails system.

Folks, it's time to modernize America's SACWIS systems. Getting caseworkers technology that is supportive of the work that we need them to do and how they do the work to keep kids safe and families healthy and decreases the extreme burden of documentation through outdated tools would go a long way to helping us keep children in America safe.

Third, accurately capture quality of practice in CFSRs and CQI activities. Our Administrative Review Division, which does our continuous quality improvement, audits the accuracy of documentation in case records. Quality improvement systems in child welfare are not required to monitor or evaluate the practice that occurs in our state or throughout our country. For instance, in both states that I've worked, the CQI team provides a review of the case record. They can tell me if the worker documented or planned properly for what the record contained. But we have no way of knowing whether or not the worker gathered all the necessary information while they were out in the field. So if I'm out working with the family and I'm assessing something and I totally missed domestic violence issues, and I go back and write it up and I never point out that there were domestic violence, our CQI and our CFSR process, the federal process, is never going to capture the fact that the caseworker missed domestic violence in the home. If we want to be certain that children are safe from abuse and neglect, our oversight system should be required and supported to go beyond the record [*recording skipped*].

Fourth, let's diversify the workforce. In the United States, child protective services are performed almost exclusively by social workers or similarly trained professionals, often referred to as caseworkers. They are in the field with little support or an extra set of eyes. I can't tell you as a caseworker myself doing child abuse and neglect investigations, in rural Wisconsin at the time, going out into the boonies of Monroe County, Wisconsin, where I was working by myself, without another caseworker or supervisor or some other person to help me gather and collect information and to analyze it properly. I fear sometimes what I might have missed in my own practice. If we wish to keep children safe and to ensure their well-being, I believe we need to diversify the workforce beyond independent caseworkers. Two things here: even the very best trained and best supervised caseworkers cannot be experts in all things that children in our system need. Caseworkers generally do not have the medical training sufficient to fully assess injuries, monitor or evaluate medications, or to identify developmental delays in children. Caseworkers don't have the knowledge of educational requirements, especially when the majority of children in our foster care system have special education needs. Even when a caseworker does everything that we expect him or her to do, because most caseworkers lack the medical and educational expertise that other professions can provide and because they are only one person, bad consequences can come to children.

I'd like to show you a quick example. When I was the Secretary in Wisconsin I oversaw the Bureau of Milwaukee Child Welfare. It's a very public case. It's a part of the record. *Milwaukee Journal Sentinel* covered it well. It was a young child named Christopher Thomas. Christopher was placed in protective custody by the bureau and was living with his aunt and uncle at the time. Christopher was an infant, and he had an older sister, age 2 or 3 at the time. Sadly, the aunt killed Christopher following months of abuse. We went back and looked at the case record. The caseworker did everything we'd expect the caseworker to do. She went out on a monthly basis. She documented that she saw both of the children. She interviewed the aunt and uncle who were providing care, but she wasn't a nurse. So what she never did was to take Christopher out of his aunt's hands. Take him out of his blanket where he was swaddled, and check his body. If she had, and if she had been trained—or better yet, if we had a nurse in the field with her doing that visit with her—we would have seen that he was being physically abused by his aunt. She walked into the other room and noticed that his older sister was watching television and kind of talked to her from across the way. Now she probably should have gone up and sat down with her and interviewed her more and consulted with her. But again, if we had had a nurse who was there with her observing that child, we would have seen that those children were injured and they would be alive today. Christopher would be alive today; his sister is.

Let's establish a national change in practice by developing, funding, and supporting multidisciplinary teams for every child in foster care.

And lastly, it's time for federal finance reform to child welfare. Colorado is one of 22 states currently implementing Child Welfare Waiver Demonstrations. We know the results of these waivers even before we begin them. Previous waivers have fully demonstrated that states who participate, more children are safe, they spend less time in out-of-home care, and they achieve permanency much sooner when federal funding fully aligns with these priorities. It's time for us to stop waiving federal law and to start creating federal funding that supports states to get kids the right services at the right place, at the right time.

With that, I thank you for the opportunity to share my thoughts and ideas with you. Again, welcome to Colorado, we are really honored that you chose this jurisdiction to meet and to hear from us, and I'm happy to answer any questions that any of you may have.

Chairman Sanders: [Session 5 - 00:10:40] Thank you, Secretary Bicha. Commissioner Rubin.

Commissioner Rubin: [Session 5 - 00:10:45] Secretary I want to thank you very much, and we hear from a lot of folks across the country that to me, a sign of a great public servant and someone who is at your level in terms of your service in your state, and still have that frontline experience, in our remarks is really remarkable, and so I commend you on that. Some terrific recommendations there. I think it really helped to crystallize a lot of what we hear across the country. One thing I didn't hear you talk about, and we're sort of grappling with … where does predictive analytics fit into the conversation? And I'd like to hear from

someone who's not here just to support it, but someone who is probably incorporating the advice they are hearing from others about the value of predictive analytics in government case work.

Secretary Bicha: [Session 5 - 00:11:29] Thank you Commissioner Rubin for your question. It's an excellent question. So in Colorado we've created a program that we call C-STAT. It's a performance management system. We have 130 measures across our department that look at outcomes or key outputs that the science tells us should lead to the outcomes that we want for the people we serve. I tell you that to say that we've had this for about 3 years and it lines up with our CFSR measures and other requirements for child welfare. We've done a great job at looking at past information about kids and families that we serve and trying to change our system so that we get better outcomes out front. But we're really on the forefront of engaging with experts across the country. We've had conversations with Excelsior and Deloitte and others … you have a bit more, it seems like the IT world is really leading the way in this predictive analytics idea. We're trying to figure out how we can incorporate it into the work that we do at the Colorado Department of Human Services.

I think there are two factors. One is gathering information in our systems and trying to predicatively analyze it to give caseworkers more information. The other thing that I think about, particularly if we rebuild SACWIS systems and remodel it, could we have IT scan a record and alert a caseworker that these three factors appear in your case. You might not see it because you are busy day to day, but the computer can analyze it faster than our brain can and can say to the caseworker's supervisor, "Hey heads-up. There's something going on with this case that you may want to address." I think we absolutely have to pursue predictive analytics, but I think we're on the cusp of what that might look like and I hope that the Commission can learn from other experts across the country and provide some strong recommendations. And if you need a place to pilot them I have a great state here in Colorado that would love to help you out.

Chairman Sanders: [Session 5 - 00:13:29] Commissioner Covington.

Commissioner Covington: [Session 5 - 00:13:31] Thank you, Director. I want to tell you we really enjoyed and appreciated that you encouraged your staff to attend yesterday, and many of them presented to us and we really appreciate that. It was nice hearing about all good things happening in Colorado. I had two questions based on your remarks. You were talking about, "We're not doing a really good job monitoring case practice." How do you get to that? I mean you're doing assessments in the field. You're doing safety assessments, physical assessments, you can look at the quality of those. How do you actually...because I know when we review a death of a child we often find problems with practice. Whether it's because of training, or limited resources, or whatever it is. How do you create a system that can really make that work in terms of monitoring what's happening out in the field? I'm having a hard time getting my hands around how you do it.

Secretary Bicha: [Session 5 - 00:14:26] Thank you Commissioner. First of all it was kind of cute that you said that, "I let my staff be here," as if I have control. They all said that they wanted to be here, and I'm glad that they took the time to speak with you. So a couple of things that I think about—and again, I'm a social worker, so I observe things from a practice perspective, and I know there are people that are way smarter than me who can tell you how better to evaluate and analyze the system. But what I do know is that what if we had people who in the right settings could go out with caseworkers and just sit back and observe the practice that's going on. We've come a long way in the last 20 years. When I first started out as a caseworker, we didn't have anybody in Monroe County who evaluated case records and came out. If something horrible happened, then maybe somebody from the state or the feds would come out and look. The fact that we have in America today a routine system at both the state, local level, and the federal level to continuously review cases and improve practice was a huge step forward, and we should recognize the progress we've already made.

What I'm suggesting is that we go a step further and not just rely solely on what is documented, or in my concern, what is *not* documented in the record, and figure out a way that we can truly go out and observe practice to learn what practice is like in a jurisdiction beyond what the caseworker tells us. I wish I had a better answer for you about what specifically that looks like. What I envision are experts who are simply going out and evaluating and watching and observing and documenting the interactions and providing that over 50-100 cases in a state, and coming with some conclusions about the type of practice that's going on. Who is the caseworker interviewing? Why are they interviewing them? What information are they gathering, and how are they using that information? Who did they choose not to interview and why? What actions did they take in which order? All of that sort of stuff I think would be really fruitful for us to know about to inform practice, to inform policy, and to inform funding.

Chairman Sanders: [Session 5 - 00:16:37] Commissioner Dreyfus.

Commissioner Dreyfus: [Session 5 - 00:16:39] Thank you very much Secretary Bicha. I'm so proud of you. You are just truly a national leader in so many ways, so I'm just really fortunate. I just want to stay on the issue of...I love the idea of bringing fidelity into case practice and the way you're talking about it reminds me a lot of motivational interviewing. The evidence-based approach of motivational interviewing, where there is actually a coaching that goes on but then every six months you are being reevaluated on whether or not you are retaining those competencies to the fidelity of the model. I think there is something there that is really doable. I think it's great.

So yesterday we heard from Dr. Gary Melton from the Kempe Center. And one of the things that we're kind of grappling with as a Commission, and I know that you and I have had this conversation before, that as public sector leaders I think we did ourselves a disservice when we said that this thing that we call child welfare begins and ends with child protective services. The welfare of Colorado's children is a much larger shared responsibility, and CPS is

a piece of it, but it is not all of it. We are trying to get our arms around how much of our focus is right here to eliminate fatalities from abuse and neglect and how much of it needs to take this broader view. So yesterday I heard from the folks that were here. There seems to be a lot of interagency collaboration here, leaders who are working well together. I certainly got that with your public health folks that were here. But listening to Dr. Melton, he's really talking about community. And I guess I just want to ask you as with the governor talking about Safe Children, Healthy Families and thinking that how do we just focus on the individual family without the context of the place within which they are living and raising their kids. How is Colorado thinking about that work at the Kempe Center in this interconnection between CPS and what is this larger system that ensures the welfare of kids?

Secretary Bicha: [Session 5 - 00:18:51] Thank you Commissioner. Your comments at the beginning were very nice. When I was a baby social worker I seriously would watch Susan flutter around the state of Wisconsin and watch her move systems that had not been moved in decades. I often thought, "I wonder if I could do that?" So hearing your feedback is personally very gratifying. Thank you.

We have a saying in Colorado, "Children should not have to experience abuse and neglect before they or their families get the help that they need." It gets back to predictive analytics and other factors. We have to identify families before abuse and neglect happens and sure as heck need to identify and support families before a fatality occurs.

In our state we've done a couple of things. We've created an Office of Early Childhood. We talk about the Office of Early Childhood, about helping parents help their kids get ready for kindergarten. But when we say that, we define that. We have what's called the Colorado Framework, Early Childhood Framework, and there are four domains. That children have early learning experiences. They know their letters, shapes, numbers and so forth to be ready for kindergarten. But it's also about making sure that children are healthy and including in being healthy is free from abuse and neglect. It's about making sure that children are emotionally and socially prepared to enter kindergarten. Again we know that children who experience abuse and neglect are less likely to be emotionally and socially prepared. It's also about making certain that families have the right support at the right time to help deliver on those other three items.

The other thing that we have done in that same spirit is we are doing a much better job of connecting prevention with intervention. It used to be the philosophy that prevention was over here and intervention was over here. Right? I never understood that, because when I was doing direct practice I would serve on primary prevention agency boards like family resource centers and so forth, and then I would be doing practice and I'd always hear from the primary prevention people, "Well we're keeping kids from abuse and neglect." Yeah, but the families you're serving aren't the families that I'm serving over on this side. So what we've done in Colorado is to very formally connect the dots. So that we are piloting three efforts: One is

called the Nurse-Family Partnership Augmentation. The second one is called SafeCare Colorado and the third one is called Community Response Program.

These three pilots our counties can choose to develop. There is state funding that goes out to them. They must connect with a nonprofit or private partner in the community. So it's not just government building something but rather a community partnership. It specifically targets families who are reported to CPS but appropriately screened out. Because we know the families who are reported to CPS, the threshold to conduct an initial assessment or a child abuse investigation may not meet the legal criteria for us to conduct that investigation, but it doesn't mean that there aren't needs in that family. And we believe that if we can engage with those families earlier on a voluntary basis, assess their needs with them and get them the right supports, that we'll be in a better position to diminish challenges in the family that could erupt over time into a child being abused or neglected.

As I said, we are piloting these initiatives. We want to test that theory to see if indeed it does make a difference in our state. Those are a couple of things that we're doing. SafeCare Colorado specifically is in partnership with the Kempe Center as our lead agency at the state to help us bring these services across the state. I don't know if that answered your question Commissioner, but those are some things that we're doing in our state to make those connections.

Chairman Sanders: [Session 5 - 00:22:54] Commissioner Martin.

Commissioner Martin: [Session 5 - 00:22:55] First of all thank you so very much for coming in this morning. It is remarkable the work that is being done in Colorado, just thinking about the collaboration that is being engaged in amongst the different offices and the government and private partnerships. My question really pertains to your third recommendation regarding accurately capturing the actual practice that's being done out in the field.

As a judge, one of the things that I often tell the social workers who come into my room, I try to remind them that they are my eyes and ears when they go and visit my children in the homes, and that what I'm looking for in terms of testimony is, what's going on in the home. And so please don't take my comment and question wrong, but sometimes I think my social workers forget to think. So they fill out the forms that are required, but as we talked about on the story coming in, they forget then that if in fact all the letters that are sent are coming back undeliverable, to ask the kid where the dad lives.

So if it's true that the difference between a near fatality and a fatality is the degree of the risk or the number of risk factors, then what I'm trying to find out from your position, I understand that social workers have to be accountable and I understand that they have to fill out forms, but what I need them to do is think beyond the form. Think about what's behind the form, so that when something like this happens in the field they can say, "Well okay, if that doesn't work let me ask mom. Let me ask the kid." I am not saying this is isolated to

social workers: judges, all of us do it. Okay? So what I'm trying to find out is if I'm really going to prevent a fatality, I need us all to think. So I am asking you, is this what you're talking about, accurately reflect the practice that's really going on?

Secretary Bicha: [Session 5 - 00:25:11] Thank you Commissioner, and I don't know about the rest of you, when she said, "I'm a judge," did anybody else just kind of sit up in their chair a little bit more? You know, I assume you are all familiar with Attention Deficit Disorder. We used to think Attention Deficit Disorder was about kids not being able to focus. They couldn't think. Now we know Attention Deficit Disorder is the opposite to an extreme. It's that they focus on everything all at once and therefore they can't focus on one thing at a time. Commissioner what I think about when you ask the question is, it's not that caseworkers can't think, it's because, in my view, the system that we have in our country expects them to think about everything all the time. Don't drop any balls. Fill out that form. Make sure you saw your kid. If that child has an illness, make sure they get to the doctor, they have the right medication. "Did you assess the family? Did you find where dad is living? Dad didn't tell you he's living in the right place, but did you make a referral to Medicaid?" They have to think about everything all the time. And I think what happens is because we have a system that isn't a team of people who support kids in foster care, because I not only have to think about all those things but I also have to think about things outside of my scope of practice. Like my child who has diabetes, and I have to make sure they are on the right medication and that the foster parent is giving them the right medication and then I have to know whether or not the medication is not working so I can get back, even though I know nothing about diabetes or medical care. I think that that's the bigger challenge than the others.

If we could come up with a system, in my view, I'd at least like to pilot this to prove me wrong. If we could come up with a system that had a team of professionals who all were committed to the success of that child and family, and the caseworker then could be freed up to focus on the form and the information that you need and to understand why that form is important beyond filling it out and feeding a computer system. I used to have to go to IEP meetings, judge. I'm a social worker. Got an MSW, focus on child welfare. I know. You start getting in there in a room full of principals and teachers and McKinney-Vento, and this diagnosis and that … how am I going to advocate? But what if we had an educational expert on our team who could go sit in that IEP and really advocate and better educational outcomes, so that I as a caseworker could be focused on following up with dad and following up on the safety assessment, and getting you the information that you need. I think that we would be in a much more powerful position to keep kids safe.

Commissioner Martin: [Session 5 - 00:28:09] So I'm a judge who attends IEPs too, and I have no idea what I'm doing in there. So are you talking about like an MST type of program for child welfare?

Secretary Bicha: [Session 5 - 00:28:20] Yes. I am proposing something along that line. My very first job out of my undergraduate was in residential treatment, worked at YSU Academy.

I was a caseworker at the residential treatment center, and when my child was sick, I literally walked down the hall and asked the nurse to come and evaluate him. When we had an IEP meeting, we had a principal who was on staff because we had an in-school program, and they knew all that stuff and they could help educate and support me, and we were all rowing in the same direction. Right? Then I went out and did practice in a county agency, and I didn't have any of those supports, and the expectations for me were amped up. Even more when that child was in residential treatment. That's what I'm talking about.

Chairman Sanders: [Session 5 - 00:29:09] I know we have several other Commissioners with questions, but I'm going to get my question in right now, because I usually don't. So Secretary Bicha, having worked in a couple of states, I know you are really familiar with this issue, but there are state-to-state differences in definition of abuse, of neglect, of foster care, of kinship care … differences in the standard of proof whether abuse or neglect occurred. Differences in definition for the fatality due to abuse and neglect, and as you know going from Wisconsin to Colorado, differences in practice.

Several of your recommendations seem to suggest moving toward a more standardized practice. Talking about training, for example, that could be supported in some different ways, or looking at quality assurance differently. Can you say a little about your thinking about what role the federal government has in kind of defining what practice should look like, mandating states to do certain things versus how much of that should be accepted as state-to-state differences?

Secretary Bicha: [Session 5 - 00:30:18] Thank you Commissioner Sanders. You know one of the questions that I was often asked when I had the great privilege of moving to Colorado, is: "It must be way different here." The answer to that question is, in many ways it's different and in a whole lot of ways it's exactly the same. If I am a 2-year-old child who's being sexually abused by my stepfather, my challenges and needs are very similar whether I live in Eau Claire, Wisconsin or I live in Durango, Colorado. Each state is required to fulfill federal obligations with limited federal dollars. All of us have the same obligations. We might have different state plans, we might call things differently, and so to me the differences are really the stuff in the middle that we choose to create. But the kid's needs and the family's needs are very similar, regardless of wherever they live in the country, in my view, and the federal expectations are very similar.

Here's what we know, is that, I believe it was the Adoption and Safe Families Act put in new federal requirements that directed states to create continuous quality improvement systems. Required states to develop child welfare training academies. Required states to have other infrastructure in place all across the country to improve our systems for kids. And states, every one of them responded like never before to meet that federal expectation. I don't think that federal government is always the best to tell us what the solution is, but I do think the federal government is helpful at pointing us in the direction, encouraging us what's working well across the country, and creating resources and supports for people to try new

ideas at the state and local level, like some of the ideas I proposed this morning. I hope, Commissioner, that this Commission takes these ideas and others from here and across the country and challenges our system both at the federal, state, and local levels to try new and innovative solutions to get better results for kids in our country.

Chairman Sanders: [Session 5 - 00:32:36] Commissioner Ayoub.

Commissioner Ayoub: [Session 5 - 00:32:40] I failed to ask a follow-up question yesterday of someone who is connected to you all, so I'm going to see if you can help me out. We're always looking for best practices on what really eliminates a fatality, and in some of the other states we've gone to when we've heard that there's been a decrease in fatalities, as we dig into it, we find out that it is more of a procedural reason, a counting reason. The District attorney yesterday said that you've had a decrease, if I understood right, that there were no fatalities this year until very recently there was one. But I didn't hear what they attributed that to, other than there's a group that meets a lot. Do you have any information on that?

Secretary Bicha: [Session 5 - 00:33:31] Thank you for your question, Commissioner. I'm afraid I can't speak specifically to the fatality that may have occurred in El Paso County. The way that our system works in Colorado is they have a requirement to inform the state. They have at the local level the responsibility to investigate the fatality and determine if it was due to abuse and neglect, and if the finding was due to abuse and neglect, the fatality was, then they have to report that again to the state, and our Child Fatality Review Team then conducts a comprehensive review of that case.

Commissioner Ayoub: [Session 5 - 00:34:03] I was asking about the decrease not that one fatality.

Secretary Bicha: [Session 5 - 00:34:08] I'm sorry. Again, not familiar with El Paso County's numbers. I know that they have a growing number of fatalities due to abuse and neglect in that community, and it's been extraordinarily impressive, as I'm sure you heard yesterday, how that community came together and said, "Not one more," and brought everybody to the table to find some pretty incredible solutions.

Chairman Sanders: [Session 5 - 00:34:38] Commissioner Covington.

Commissioner Covington: [Session 5 - 00:34:41] I have this visual of everybody waving as you talked about, "stop the waiving." So if the waiver goes away, you don't have to do waivers anymore. How would you want funding structured? And are there certain ways you would like to see federal funding come in for specific issues?

Secretary Bicha: [Session 5 - 00:35:002] Thank you Commissioner. So if you ask one state leader the answer, you'll get one state leader's perspective on that. Although I think there is growing consensus around this. Here is what we know, is that title IV-E reimburses for poor

children who are in out-of-home care. It does not reimburse for poor or un-poor children who are unsafe and for which we must provide safety. We now have decades of research that tells us if we can keep kids safely in their own families, even if they're not the ideal families, those children are better off than if we place them in out-of-home care. We have federal requirements that tell us, "provide reasonable efforts to prevent placement, provide reasonable efforts to get kids back home," but the federal funding that is an entitlement isn't connected to those very important priorities that the federal government gives us and is not connected to decades of research that tells us what's best for kids. Nor does it recognize the fact that whether or not a child is safe or unsafe should have no connection to whether or not they are poor based upon a 1996 definition of poor. What we are really talking about is reimbursed for extreme poverty by 2014 definition.

What I'm suggesting is that the federal government provide funding to states that is intended to keep children who are unsafe, safe and allow states the flexibility to use those funds, like we are in Colorado, either on the front end for prevention services, safety services, for kin relatives, so we can keep kids with kin, or for out-of-home care when that's absolutely necessary. Just continuing to fund a system that is based on extremely poor kids and only in out-of-home care is a system that shouldn't be sustained in our country. Is that helpful?

Chairman Sanders: [Session 5 - 00:37:08] Commissioner Rodriguez.

Commissioner Rodriguez: [Session 5 - 00:37:12] Thank you for your time with us this morning. I had a follow-up question on your recommendation around practice audits. I think that's actually a fascinating idea, because typically when there's really a breakdown and a child's needs are completely unattended, I don't think that it is actually the absence of a form being completed or data being entered into a SACWIS system that went wrong. I think it's much more what Judge Martin mentioned around sort of lacks in judgment or caseworkers attending more to procedural requirements as opposed to doing the real business of social work. So I think that there would be a lot to be gained from practice audits, and I think I have a similar question to that as a matter of standards, which is, when you envision practice audits being done, are you envisioning those happening … sort of the feds coming in and auditing states? Or are you envisioning sort of a self-monitoring system where states or local jurisdictions do their own quality improvement planning? Can you just talk more about what your vision is around that type of audit?

Secretary Bicha: [Session 5 - 00:38:20] Sure, thank you Commissioner Rodriguez. Both/and, I would say. I don't know that anyone has figured this out. If they have, and you know, I would like to know more about it so that we could try it in Colorado. Once the federal government comes in once...we are currently doing a state audit right now, the Office of the State Auditor is looking at everything in our child welfare system right now. Once the state auditor comes in, it's all after the fact. What we need to do is a system, if we want to eliminate child abuse and neglect fatalities, is get ahead of the fact. And so I say that to say I would propose as a first start, creating some funds that went to states and maybe to

academic institutions and others who can experiment with what this evaluation of case practice would look like. Let's figure it out, and then figure out … and then over time promote that as a way of doing business across the country. We need to get ahead of the curve, and so I would suggest that we do it at local or state levels first so that we can get better at it and identify kids sooner as opposed to every...if we start at the federal level and it becomes a part of the CFSR, now it's every seven years or something that they come in, that's too late.

The other thing that I want really want to emphasize, and I'm pleased that you're interested in the auditing work or the continuous quality improvement practice, but I really feel strongly, again trying to get ahead of the curve, imagine a physician who is a surgeon and learns a new piece of technology. And he goes and it's one of those laparoscopic things, right, and he's got the machines, and you're not actually cutting people. Right? And we learn it in a classroom but then he never tries it with the patient. He never has an expert there to teach that physician how to properly conduct the surgery in a way that is safe. That is what we do today for child welfare caseworkers. We send them, in Colorado, to six to eight weeks of training in a classroom. We do some web-based stuff, and then we send them out in the field. And we wish them the best and hopefully their supervisors are spending some time, and they're working with senior peers in the agency, and so forth. What if we had a child welfare system that took the classroom theory and then went out in the field with them and applied that practice with them for a period of time. And they really understood how to interview. And they really got what information to gather and what information is noise, and can synthesize that in a way that was helpful at helping us kids keep safe. If we could do those two things, I think we could really change our child welfare system in this country.

Commissioner Rodriguez: [Session 5 - 00:41:08] Right, and I just wanted to comment that one of the things that we've heard in your state as well as some of the other states is we've heard from families and from children who have been in the system, and I think the practice audits and the applied sort of field training are really a valuable opportunity to give caseworkers the opportunity to actually ask their client, did this work? Give me feedback on how I did, on how to improve my own practice, which never happens on a systemic sort of basis and there's no feedback loop. It only happens when we have meetings like this, and we sort of ask people to do "Monday morning quarterbacking," and so I think that's a fabulous way of integrating that perspective.

Chairman Sanders: [Session 5 - 00:41:55] Commissioner Dreyfus, did you have a follow-up to this?

Commissioner Dreyfus: [Session 5 - 00:41:58] I just love this idea. Do you see any reason why this couldn't get incorporated into current IV-E training partnerships with universities?

Secretary Bicha: [Session 5 - 00:42:09] Other than funding support and sort of technical assistance about how would you develop and do it, I think would be two things that would be very helpful to states or at least helpful to our state.

Chairman Sanders: [Session 5 - 00:42:20] Commissioner Rubin.

Commissioner Rubin: [Session 5 - 00:42:23] Secretary, as the only physician on this panel, you give us too much credit. We have a saying in medicine when I went to medical school, "see one, do one, teach one," so I'm not sure seeing one procedure, and then doing it, and then teaching it to a medical student after you is a really good method of quality improvement for us. But anyway, I appreciate the comments about the medical team. I think Commissioner Martin has really initiated a conversation around, how do you ensure quality and what the best approach is, and the unintended consequences and false traps of things we do. So a colleague of mine, co-director Kathleen Noonan, wrote an article that not a lot of people read in the Law Review talking about standards- versus rules-based practice. And in that, she says there's a false trap of check boxes, of we're going to standardize case practice by having people check boxes on a piece of paper to ensure that they actually fulfill the requirements of a home visit. All right? What happens is they are staring at a sheet and they're checking the boxes and they're not asking the questions about domestic violence or taking a look at the kid or talking to the kid. And so in that, she said the most successful practices are the ones where the standards are set in the quality improvement system, and the most promising example of that is like quality service reviews, where people acknowledge we can't see everything with limited resources but we can actually take representative cases, go deep on it, and learn in the continuous quality improvement environment whether we're meeting certain standards, and it provides the opportunity in a couple of ways and I wanted you to comment on these.

Number one, should there be standards in terms of, what are the elements of standard-based practice? Multidisciplinary teams, certain acknowledgment about talking to the children, family teaming … all the stuff that comes out of child welfare practice that then allows the states and local municipalities to set up how they're going to address those standards and how they do quality improvement around those standards. I think from a matter of policy, how do we incentivize, should we be rewarding states based on standards rather than specific check boxes. And how that would look in terms of the way we think of health care right now, which is having some level of risk, the states take on some level of risk, the more they achieve standards, the potential for incentivized funding actually increases.

Secretary Bicha: [Session 5 - 00:45:09] That's a good question Commissioner, and in all honesty I would love to have more time to process, but my quick answer is again a both/and. You bring up some good points about the checklist. At the same time, I would argue an airline pilot. The whole system is designed around a checklist. To make sure before every take-off, before every landing, every step is checked. I think the difference between the two is back to the answer I gave the judge. A pilot has time to go through the checklist before he takes off.

Caseworkers often don't have the time to go through the checklist in a meaningful way because they are thinking about two other cases that they've got to get out on, and they've got that report for the judge, and I've got to get back over here, and that's what I think becomes a distraction with the checklist and it becomes an action that I fulfill as opposed to a truly meaningful tool that helps me slow down, be thoughtful, and fully analyze the information.

Commissioner Dreyfus: [Session 5 - 00:46:07] Just a comment, follow-up, and then I also think a big difference is kids and families are not airplanes, and I think we often times use that analogy so often, that they are so much more complex than an airplane.

Secretary Bicha: [Session 5 - 00:46:22] Indeed.

Chairman Sanders: [Session 5 - 00:46:24] Commissioner Bevan, I think you were trying to get in. [Pause] Any other questions from Commissioners? Well, Secretary Bicha thank you very much.

Secretary Bicha: [Session 5 - 00:46:42] My pleasure. Thank you for the opportunity. Welcome to Colorado.

Chairman Sanders: [Session 5 - 00:46:50] Thank you. So we will continue right now with the public agenda since we have announced some specific times, and we'll continue with the case reviews. We're scheduled for a break at noon. What we will do is take that break earlier and reconvene and complete our executive session item then, but for right now probably for the next hour or so we'll continue with the public session agenda. And whoever is on the phone, it will be helpful if you mute it to make sure we're not getting any background noise. Commissioner Rubin along with Commissioner Petit.

Commissioner Rubin: [Session 5 - 00:47:38] I'm going to allow Commissioner Petit to do his case first and then I'll jump into mine. So Commissioner Petit you want to talk about the case you want to talk about?

Commissioner Covington: [Session 5 - 00:47:47] Can I ask a question, because we saw this on the agenda but we didn't get any information as Commissioners on what this is on the agenda for?

Commissioner Rubin: [Session 5 - 00:47:54] What I have been asking for, for a few months, just to let you know, just kind of...I call the "use cases." I think they're very helpful to folks who...you know, when I talk about the connection to health, I wanted to provide the Commissioners with just very constructive cases. Not to be totalistic about it. I wanted you to understand the complexity of where the health issues and the Medicaid issues might be to these cases. It's mostly helpful for you to sort of see when I mention a quality measures program, "Why is Dave mentioning a quality measures program?" Like what does that have

anything to do with what we're talking about. I think these cases will illustrate some potential ways into some of our work, and I think Commissioner Petit actually after ... we had a call between the last meeting, and he had a very informative case that I actually think is very valuable and thinking about a question we should be asking at every meeting. So Commissioner Petit, why don't you do your case because it's more germane to the stuff we've already done.

Commissioner Petit: [Session 5 - 00:49:05] Okay, we have people on the phone. So I'll go forward with this thing. First of all, I don't know how many of you have read this report already, but it's about a real case that took place in Maine a number of years ago, but there's nothing about it that you wouldn't see happening someplace right now in child welfare operations around the country. And it's an excerpt of what I've distributed to you previously, and I think staff made a copy today, is a section within a chapter that Teri Covington and I did for the Children's Bureau that was published last year. So that's the story. I thought a lot of yesterday touched upon this particular theme. What I'd like to be able to do in the few minutes that I have, and I'm going to go through this more quickly than I would like. This particular case ... I sometimes have done day-long workshops on it. You can do a whole book on it. You can do a whole life on it. So let me just start with this particular framing of this thing.

Between now and the next 12 months, there's going to be 2,500 more kids, or probably closer to 4,000 more kids, who die. And a bunch of them are going to be in the exact same situation that Mary Taylor was in, which is, everybody knows about her case and still she slips through the cracks, and we're not able to surround the child with the support that she needs or her family needs in order for her not to be killed. This particular case, what I think it illustrates so well is the competition, is the word that I use, or the conflict between the civil proceedings and the criminal proceedings. There are two things that are going on, and they have different standards of evidence and proof.

One is a reasonable doubt and the other one is preponderance of the evidence basically, and they come into conflict with each other. Right? But both of them are necessary to protect children in this kind of a situation. Where Mr. Taylor had broken bones in two previous wives and current wife and several previous children. Broken bones, and the deal was how could you protect this child who now was abused herself? This little girl had been abused herself. And if you take a look at the report, all the different players that are in it, broadly speaking: child protection system, which includes nonmandated organizations but basically emergency room people didn't call a doctor, private physician didn't call CPS, hospital emergency room didn't contact CPS. You've got a prosecutor, you've got defense attorneys, you have judges, you have child protection workers, and they're all involved with this particular case. And what ended up happening, and I raised this question to Judge Delgado, is that what really triggered the downward spiral on this thing is when the courts said over the objection of the department—I'm not blaming the courts, I'm just saying this is what happened. One of the missteps that took place is the department said, "This child is living in a very dangerous

element with Mr. Taylor, or he has access to the home. He's not living at home but he has access to the home." When the review came where the child should go, the decision was made by the court to return the child home and to keep the child in custody of the department, of which I was the commissioner. The department did not want to have the responsibility for seeing the child in her home because they thought it was 7/24 kind of a situation. So they failed to repeal the judge's decision. The child returned home and was subsequently killed by Mr. Taylor.

There were seven opportunities, trial dates, set to bring him to justice for the two previous wives he was accused of having broken bones and subsequent children. Seven times the defense attorney petitioned the court for a change in the schedule of the date. Seven times the district attorney did not object to the postponements. Seven times, the judge said, "Okay, if you are all in agreement we'll postpone this case." So seven times he could have been brought to trial, likely convicted, and serve jail time. All this time he's still in and out of the household with Mary Taylor on this thing. So you have a DA in this case that was afraid of the judge, because the DA was a part-time DA, he also ran a private practice but he was also a half-time district attorney and he had a lot of business that went before the court. So they said, "Let's just let the judge do what … we'll let this happen." So the point of this is if you go into all of this stuff you see that over a several-year period is signal, after signal, after signal that this child was in a dangerous situation, and when the protective mantle of the state was pulled together to provide her with security, all the laws necessary to protect that kid existed, they just simply weren't implemented and executed in the proper way.

So where you have the civil proceedings could have protected Mary by keeping her in foster care or making a field placement, they didn't remove her. She was now still in the home. So one way to protect her was to remove her from the perpetrator, but she wasn't removed from the perpetrator; she was left at home.

A second way to protect the child would be to remove perpetrator from the child. That was the criminal justice system. And the two of them just kept passing it back and forth, passing it back and forth, and the department is just sitting in the middle kind of watching this thing and being quite passive about it, and the doctors who knew about the family, and the police who knew about the family, everybody was just essentially assuming that someone else was dealing with this, and it wasn't the kind of vehicle that I heard yesterday for the first time in all of our forums that we've heard this terrific presentation about this felony team and can I just say... I'm going to say this later when we get into the heart of, I don't mean now. I'm going to turn it over to David. A way to frame all this because I see this constant tension with everyone that's participating in this whole process about lower-grade kind of situations that may escalate into an abusive and neglectful situation. And situations that are right now hot-button red situations, which you need to protect that child. So I was toying with the idea of that CPS, that then maybe there ought to be a contact of CDS introduced into this, which is Child Development Services. Because a lot of this is about family and children and how to

parent properly and so forth, and it keeps running smack into the other procedures that we have for the CPS.

There's more to this case. There's more nuances, more subtlety. David has some stuff that I think he should present. I feel like what's in here, much of it has now been exposed over the last few meetings that we've had, in which we are all seeing this for ourselves and it's in one place. I don't really want to go page by page on it. What I want to simply say is that we know who thousands of these children are that are at the greatest risk around the country, and unless there is a vehicle that brings multidisciplinary resources that government and nongovernmental forces have, the children that we know are in deep trouble. We're going to continue to see so many just slip through the cracks and die. I don't want to get into what the prescription is at this point. We've been hearing some of it. Some of it we're going to have to formulate ourselves. Some of it David, I'm hoping when we get into the discussion of a plan today, that we will task our staff with getting information of just how some of this work is being done or not being done, which is one of the things we've heard yesterday and the day before: this stuff is not being done. You keep hearing me ask questions about MOUs, etcetera, or training, etcetera, and you keep saying, well most of them are, or some of them are, or quite a few of them are, but not all of them are. And that's how come kids are slipping through.

So that's the Mary Taylor case. I will just tell you, one of the outcomes of this thing was that the governor of our state used her situation as a focal point in his state-of-the-state address. He ended up convening all of the parties with legal responsibilities for the care and protection of children. So all the groups that you are all familiar with. He said, "I want you to meet in my cabinet room every two weeks until you resolve how this could have been different." He asked me to chair it, and the people around the table—the fiduciary committee, the appropriations committee, the district attorneys, the prosecutor—all of them were in the room at the same time. They were legally charged with doing this. So just note there were many things that came out. I'll just note one. As I listened yesterday to Judge Delgado about the situation in Maine, the criminal courts, I don't know if this is still true, the criminal courts said, "All cases involving children as victims shall leap forward ahead of the entire criminal docket, except for homicide cases." Not homicide involving children, just somebody else, you know two people having fought and killed each other. But the point on that is that it reduced the amount of time that the dual status, the kid and the family being in both courts, and all the dangers that that implies, by nine months.

It was a nine-month shaving of the time in which kids' cases would be heard, which meant it was immediately *[Inaudible-background* noise] about where the cases would, because as Judge Martin knows, the criminal trials essentially are going to trump the other kinds of considerations. Because as a homicide, people can go to prison, and then you have defense attorneys that are trying to score a particular position and all of that. And so anyway, I'm going to stop there and turn it over to David.

Chairman Sanders: [Session 5 - 00:59:01] Actually, Commissioner Martin.

Commissioner Martin: [Session 5 - 00:59:03] So I think it's very important, and I appreciate you bringing Mary Taylor's story to us, but there are a lot of answers if you will that are floating. So from the fiduciary standpoint, this whole concept of a family court. So there's one prosecutor's office that deals with the criminal procedure as well as the child protection case. So that the idea is to bring the criminal courtroom, the criminal case, the child protection case, the domestic case, any family case before one magistrate, one judge, so you have all the issues before one body. So there are a multitude of ways that jurisdictions are trying to look at this, and I think that the thing that I would ask the Commissioners to remember about the lesson from Mary's story is that there may be an opportunity for us to recommend to the feds that when these types of situations present themselves, when there's a criminal matter, when there's a child protection family matter, or a child custody matter, mandate—and I don't know in what vehicle you do it through, Medicaid, IV-E, whatever—but mandate somehow that there has to be collaboration between the courts and make the court a focal point and requiring people to come to the table and talk about it. So this happens day in and day out, and I do agree that this is an issue that we should at least think about when we're talking about the work of our Commission.

Commissioner Petit: [Session 5 - 01:00:32] And I want to be careful to say that I'm not at this point prescribing anything. There is stuff that's implicit in here, but I think this is a discussion we have to have in terms of the immediate child now in immediate danger kind of situation. That's not the same as the swimming. It's not the same as the cars. It's not the same as the sleep issue. All important. I'm not saying anything about anything. But I'm saying there are kids right now that we know right now, the issue is how do we coordinate, as the judge has just described, so that the kid is surrounded and protected. That's all.

Chairman Sanders: [Session 5 - 01:01:03] Commissioner Rubin.

Commissioner Rubin: [Session 5 - 01:01:05] So as I spoke to Commissioner Petit and I shared my cases, which are much more around kids not under the child welfare system, what struck me about this case is I feel like many of us have had a case just like that, and I described the case to Commissioner Petit when I was in training. That we were in multidisciplinary teams, and usually there are attributes about the case, a coercive parent who knows how to work the system in some ways. Just do enough to kind of keep, I see Commissioner Martin bowing her head. There are certain elements about the kids you worry about dying. There is a sense of responsibility for what's going on, and there's coerciveness about it, and what you have is you end up having that a child is removed. And it's the sibling who's not removed, or the baby not yet born. And we sit around multidisciplinary teams and we say, "That mom is going to kill that baby," and that happened to me. What struck me about that case is when we talk about our solutions to reducing child and abuse neglect fatalities and then talk about the medical cases right now in here. We can think of more...how proximal to the event do you want to get. Like sometimes data can help inform prevention programs, etc., but the connection to

preventing an actual death is a little bit more ... so you have to think through, "Will that actually reduce at a population level," etc. And then there are these extreme proximal events, and as a researcher I think sometimes it's useful to look at the cases and just use common sense. When everyone is raising an alarm in a multidisciplinary team about a child who is still alive, and that child is going to die, what is the whistle-blower response at the local level? And I think that's a question we should ask, and think about are there fundamental recommendations when a professional or a group of professionals raise the alarm about a child very proximately at risk that leads to a higher level of reviewing. And so that's what I heard in the case because I know every day in a lot of these cases those were those type of cases, someone said that kid was going to die.

Commissioner Covington: [Session 5 - 01:03:18] How many times does somebody goes and picks up the telephone to somebody from DHS and they make a phone call right there? When you're having a case review, it becomes so apparent the other kids are at serious risk.

Commissioner Rubin: [Session 5 - 01:03:31] That's why that question to Stephanie Villafuerte yesterday about she created the urgency around the actual death reviews because of the other children in the home. So it rang true from Commissioner Petit's story and from Mary Taylor's case.

Commissioner Petit: [Session 5 - 01:03:46] If I can just say on that the idea of predictive risk and danger, there are different ways of looking at that, and this is something that we're going to be talking about I hope in terms of what this Philadelphia situation will present. I will argue that right now the single most predictive thing, on the children that we do know, except we know them, they are already in our scope of vision. They are already being dealt with in one fashion or another. They are the kids at most risk, and there is a large number of them that we can identify in every one of the 3,000/4,000 child welfare offices that exist around the country. They almost all have a case in which they can say, "This is a kid that is in extraordinary danger."

Commissioner Dreyfus: [Session 5 - 01:04:33] I had shared with all of you when I met with a child protection center in Wisconsin, I just went and sat down about this whole topic. They identify, and there's 10 factors that they use in identifying hot-button cases. So again, these are the cases based on 10 factors, and there is a multidisciplinary team that gets the case and gets on the phone, and every month they review those cases with the caseworker, the supervisor, and the doctors ... everybody is sitting, just like a multidisciplinary death review, they are looking at it on hot-button cases and the factors that are used to flag those cases, and then the procedure that will be used in reviewing those cases so that once somebody says, "this child is going to be killed," there is immediate action that can be brought to bear. So I just bring that up to you because I recently shared that, and I hope you all saw it.

Commissioner Rubin: [Session 5 - 01:05:34] Yeah, and I think the question for us is going to be, is there a matter of national policy here in terms of helping local communities. What are

the standards for setting around these cases? There are a whole huge number of them, and if we can help states and local authorities think about how to elevate a response when everyone in the community is saying this kid is going to die.

Chairman Sanders: [Session 5 - 01:05:57] I would just quickly add, and it seems it would be helpful to go into your case, but just struck by the comments that you're in a meeting and identified that this child is going to die and you call the agency because child protection agencies are really designed to respond to an incident and prove that that incident occurred, yes or no.

Commissioner Rubin: [Session 5 - 01:06:18] Well, in this case, everyone was doing their job, and so we would talk about this case and it would continue through our multidisciplinary team. What happened was mom wouldn't be there when they came. She was bright. I mean, she had a really savvy lawyer who was working the case for keeping people away. She was doing just enough to evade the system while everyone was actually doing their jobs, and the kid died anyway.

Chairman Sanders: [Session 5 - 01:06:43] And it seems that, that question, what the purpose is for the services, is a big one that I think is potentially a policy question.

Commissioner Rubin: [Session 5 - 01:06:057] Anyway something for us to think about and a question I think we should ask our local authorities in terms of how they view the whistle-blower cases.

Commissioner Petit: [Session 5 - 01:07:08] ...something than a whistle-blower language. I suggest something like five-alarm fire. The "whistle blower" implies wrongdoing and alerting people to the fact that somebody is hiding something. I just would modify it a little bit.

Commissioner Martin: [Session 5 - 01:07:21] So don't misunderstand my comment. I am all in favor of protecting children and I know the exact case you're talking about. I have a zillion of them. Right, which is pathetic, but I do. We have mothers who know the systems so they don't go to the interagency meetings, they don't go to the family conferencing meetings, they don't go to the mediation, but they go to one doctor appointment and then they miss the next three follow-ups. You know, the whole gamut, right. But there's such a thing as due process for the parents as well. And as much as I want to say let's be in the meeting, let's call the hotline and send a worker out, a DCP worker tomorrow and grab the kid, we still have to talk about whether or not … we have to balance that, and we have to figure out a way that protects our child but also provides an opportunity. Because what's going to happen is, what happens in Cooke County. We have statutory language that says if the kid is severely abused or killed, their sibs are like prose abused. Right? We can go in and get those kids, and I have to caution people there still has to be some nexus to assume or to anticipate, well we say that and that's what the law is, I'm not sure we're following one in the courtroom though. Because what we do, we get emotionally involved in the death, and we automatically assume

mom's going to do the same thing to the sib and so, I'm just saying let's think about how we're going to ensure that we're really looking at the factors for that sib before we dive in and start taking kids. Because that's what happens when we start having parenting teams. Girls were getting pregnant in foster care and we assumed because they are in foster they can't take care of their newborn. And I'm just saying let's, I don't disagree, I'm just saying let's take a breath and think about what risk factors specifically pertain to the sibs.

Commissioner Petit: [Session 5 - 01:09:29] So let me ask you on that very question, because that is a key question. We had a little girl that had a mentally ill father and a very severely mentally disabled mother, and after seeking some help they ended up putting the child in an oven and she was baked to death. She died. It was the single worst case in the history in the state of Maine. We couldn't get off the front pages for weeks. We kept calling press conferences one after the other. The legislature said at that point that when there is a killing of a sibling in which somebody has been convicted that that automatically terminates rights to any other children in the household. There is a presumption on it that says we are not going through the extended process. The prima facie evidence is, we kill one child, we're not going to take the risk on killing another child. I don't know what the law is in Illinois; that's the law in Maine. I don't know what the law is nationally, and I'm not arguing one way or another for the moment, but that's the kind of stuff we get tasked with to say, find out how much of this is going on, how much of an issue is it. We survey judges, we survey child ... whatever it is on this. Right? So you've raised a major issue that you feel strongly about. For me, and this is a legal issue as well, when you err, this is the message that we always send out to our people. When you err, you err on the side of the child.

Commissioner Martin: [Session 5 - 01:10:48] Okay, I don't mind if it's a rebuttable presumption. But if it's irrefutable presumption, I have some strong issues with that. So I presume without knowing the law in Maine it's a rebuttable presumption.

Commissioner Petit: [Session 5 - 01:11:02] It probably is.

Commissioner Martin: [Session 5 - 01:11:02] Okay. Then I have no problem with that. I don't have a problem with that. All I'm suggesting is it can't be automatic. We have to look at the risk factors, because what happens is, and I don't want to belabor the point, but what happens is, what I keep saying, when we take a kid out of a home, that kid does not go back. It's moving Mount Everest twice.

Commissioner Petit: [Session 5 - 01:11:11] It's an atomic bomb dropping in the household.

Commissioner Martin: [Session 5 - 01:11:15] And maybe the child shouldn't go back, but we need to make a factual determination if that child should be in that situation. That's all I'm saying.

Commissioner Petit: [Session 5 - 01:11:32] And at the same time, the child is not left in a dangerous situation while the due process goes forward, respecting the rights of all the individuals. It needs to be also this effort that is guaranteeing child safety during that period.

Commissioner Martin: [Session 5 - 01:11:46] And I don't mind if we have a multidisciplinary staffing about that sib and talk about the specific risk factors for that sib and make a determination in a unified matter to present to a court to make an order. I don't have a problem with that. But I do think it's imperative that we not make assumptions. Because what happens? I will tell you right now. What happens in my courtroom ... in Illinois we had this horrifically dirty home case where there were 14 people living in a one-bedroom apartment with like eight adults, and kids were sleeping on floors with feces, I mean, horrific. We called it the "Keystone case." Every time a worker comes in my courtroom and says, "Judge, it's a dirty home case" everybody in the courtroom has seen those pictures, so we all envision the Keystone case, and we make presumptions about the new case in front of us. And that's what I'm asking this Commission to understand at a practical level on the ground what that translates into. All I'm saying, let's just keep in mind that we have to account for those things but that does not mean that we can't find and put in procedures and recommend procedures that afford us the opportunity to take a breath and really talk about these and give us the time to do that right then and there.

Commissioner Rubin: [Session 5 - 01:13:10] And there you see all the value of doing these cases because they get right into the thorny issues because you're raising the right issues. Some elements of the case I had in fellowship, the child didn't die. The sentinel child did not die. That child had severe nonfatal injuries, including severe burns at 18 months and multiple healing rib fractures. That child was removed. Mother blamed it on the sibling, who by the way had a brain tumor, who was about 9 or 10 years old. Created a lot of confusion in the case. All right? The other element here is it was a newborn baby. So waiting for that next court case. So maybe the response for due process is, as part of this red-button system, there has to be a way to expedite it in front of the court. I think we just need to think about, can we protect due process but at the same time protect the child when the red-button goes off. And I think it's worthwhile asking that, maybe there are local communities who have really developed nice ways of thinking about both sides of the issue.

Commissioner Rodriguez: [Session 5 - 01:14:14] But I also think it's important to go back to David's point about, we're still thinking about it under the construct of the existing CPS system and it being attached to an incident or behavior and the parent proving that they've rectified whatever the initial incident was for removal where, for me, I'm challenged in thinking about what you guys are describing under that construct. Because when you have parents, like the case that you're talking about, who chronically—they may be able to correct the initial situation and satisfy the court conditions, however, everybody knows that child is still at risk and in danger. I can think about both of the solutions that you are talking about if we change the function of what the child protection system is. For me it's sort of trying to

think of both things at once. I don't think our existing system actually, even with what you are describing allows protection.

Commissioner Dreyfus: [Session 5 - 01:15:18] But I don't think it changed the CPS function. I think the problem, this is fascinating. This is great conversation, and I just want to go on record in saying, I think we as a Commission have got to have recommendations on the red-button cases. So I really appreciate this being brought up. I don't think it's a question of CPS here in terms of...I think part of our problem is it's what Reggie was telling us, we ask them to be all things to all people at all times. On these CPS red-button cases, I don't know that they're the lead. I don't know that they should be the lead. What I'm talking about from the Child Protection Center in Wisconsin, they are presenting the case, but they are not ultimately the decision maker based upon how that multidisciplinary review process is going to be met. I think what you're bringing up though is then, "Okay, what happens after that?" I like this idea of expediting presentation to the court. Right? So I do think we're asking CPS to sometimes be way out over their skis, on what their role and function would be. They have a role, but I don't think they are the ultimate decision maker.

Commissioner Rodriguez: [Session 5 - 01:16:42] I guess what I'm saying is, under this scenario, even if there was an expedited presentation to the court, with due process in there, there's a good possibility those parents could correct whatever the initial incident was and satisfy the conditions of the court. Go to parenting classes. Go to counseling. Minimally, not fully. Like exactly what you described and still get their children back. Even though everybody knows whatever the chronic underlying conditions, in this case, the serious mental disability and the mental illness, hadn't been corrected.

Commissioner Martin: [Session 5 - 01:17:16] But let's think of the court differently. Okay? Currently the court is set up for criminal and civil cases where there are two sides. Families don't have two sides. Families are multidimensional. There are issues that are good for mom and issues that aren't so good for mom. So why don't we take a mediation setting, where it's not a trial setting. What I'm talking about a staffing where the information is not evidence, it's information to the court so we can make a decision about what's best for the child, and the court codifies that decision. Yes, Pat, you're really out of the box. But we're talking about getting information to the people who need the information to make a change in the child's life. So if we own the world, let's think bigger than what the court looks like today.

Commissioner Rodriguez: [Session 5 - 01:18:08] I totally appreciate that because the way the existing court system is set up right now, it's whether you win. Whether their lawyer wins their case and mom gets their child back, which that almost has no relationship to what's good for the child because you lawyer it in court.

Commissioner Martin: [Session 5 - 01:18:25] So let's think about family custody cases and setting a forum that is not your traditional Judge Judy trial. Okay?

Commissioner Petit: [Session 5 - 01:18:36] So if I had my way on it, most of the cases would not end up in a court situation. That they would be intercepted way earlier in time so that we don't need to go through this mind-bending exercise on how do you resolve these conflicting needs. In this particular case I'm talking about, the child in the oven, the governor said, "Michael, goddammit how many kids are there? Take them out of these homes right now. I am so tired of this. It's terrible." I said, "Governor we have several thousands of children that look like this family situation, and the last time we had a death was four years ago." So for four years we've been dealing with families that look like this and they didn't kill anybody. Besides I don't know how many people want to take on all these kids into their own homes in foster care, because that was one of his solutions. Just get them out of there and put them in foster care. Several thousand children put in foster care? So from what you're saying I agree with you completely. This is a discussion that has not taken place nationally in decades. If ever. So I think part of this for me, the accident of geography. We are not just interested in the states where they do this right, we're interested in the states where they don't do this right. So again in terms of the tasking and our need to organize material that we can use to assert something, that's what I'm hoping comes out of today and the 23rd in Vermont. Is to say, these are the things that we want the staff to work on. David, I think they are all part of the plan, but we need to be specific about what we want.

Commissioner Dreyfus: [Session 5 - 01:20:05] I also want to add I think there's an opportunity for us as a Commission, and I'm not saying it has to be a subcommittee, but as we identify these areas, as we're sitting here today, we don't know the answer to this issue, but we know it's important. Right? So I appreciate tasking staff, but I think if we put it on the table...we each have expertise. None of us are on this Commission because we don't have our own area of expertise and experience. Well maybe there are a couple Commission members that get tasked to work with staff on developing recommendations for the red-button. You hear what I'm saying? I just think this is a great example of the inner-working between staff and the expertise of various Commission members that can be brought to bear on them bringing us draft recommendations that keeps moving.

Commissioner Petit: [Session 5 - 01:20:43] So Susan, there's a 50-state survey and we say, this is what we'd like for it to look like. This is what we're asking for. Produce a draft, let us take a look at it.

Commissioner Dreyfus: [Session 5 - 01:20:56] I like the idea of the Commission members being in a room with staff versus this group.

Commissioner Rubin: [Session 5 - 01:21:02] Well it's been advance planning for when people come to testify before the Commission. For example, I think every local panel, like El Paso yesterday, should be prepared to answer questions: What happens when you have a red-button case? What do you do? What should we be doing? Right? And let the interdisciplinary group comment, and if they know they're going to get that question in advance, and the staff has prepared for it, they've had time to think about it, maybe internally deliberate and

provide some recommendations, etc. As I go into the Medicaid cases the, right now, that sort of illustrates what Commissioner Dreyfus is talking about. I think that there might be some value...particularly as you go into systems outside of child welfare or child protective services, that have traditionally not thought about this issue as deeply. We are going to have to do a lot more advance work with them to allow them to deliberate about the intersection of these cases. So by the time they come before the Commission, we are getting a very productive session.

Chairman Sanders: [Session 5 - 01:22:07] Commissioner Rubin, before you go. A couple of things. I would suggest that we get into the case piece, because I think it would be helpful for us to leave this discussion with some organization about how we are going to move forward, and I think Commissioner Dreyfus just raised the issue of the Commissioner expertise. I think we should do that piece of the agenda after the presentation, so that we can do some thinking about, are there areas that we want to begin to focus on. Put Commissioners and staff together to move forward. So I'd like to make sure we have something concrete.

Commissioner Rubin: [Session 5 - 01:22:49] So let me talk a little bit about the medical side. This is sort of from the perspective of heath care. Again, looking at very proximal, concrete ways in which we can prevent kids from slipping through the cracks. So this is not unlike many low-income moms that might be seen in a public health clinic or in a pediatric practice. Child has Medicaid coverage. Mom was late to prenatal care. Did not complete high school. She's a single mother, and she has a low-birth weight infant who was born at 32 weeks. The data would suggest all risk factors for this child's well-being. So if we go to the next slide. In scenario 1, everything turns out reasonably well, which we acknowledge and it gets back to Commissioner Martin's point is, most of the time everything turns out okay. She has a supportive mother. She obtains employment. She does visit the pediatrician regularly. The child is not perfect. Receives early intervention services, is school ready by age 5, but has some decline in school performance and all the problems we see in terms of kids getting through school, etc. And this is a reminder to us to think about the consequence on the false positive. I think that should always be in our mind. It gets to your question about due process, etc., that most of the time these kids do okay and with that regular visit to the pediatrician, someone has their eyes on the kid. They can assure that the kid is doing okay.

Next slide. Let's vary this. You may see this on a death review team. Child has only three visits to the pediatrician. Last at 8 months of age. Is diagnosed with failure to thrive at 8 months. Meaning the child is below the fifth percentile for expected weight. The pediatrician asks the family to come back in six to eight weeks for a weight check, makes some recommendations about calories, and the child never comes back. Dies at two and a half years of age, weighing 18 lbs. And the question that I usually ask when I do this in front of public health advisors, "How could we have prevented this kid from slipping through the cracks?"

Commissioner Martin: [Session 5 - 01:25:15] So my question is, why didn't the pediatrician then call the hotline?

Commissioner Rubin: [Session 5 - 01:25:20] That's exactly the way most people will respond. Maybe the pediatrician tried to call the family and left a message at home, but you have to remember that pediatrician works in practice with 20,000 covered lives. So in a very busy ambulatory practice, unless you put a sticky that says, "This is the kid I'm going to worry about," it's on the parents to bring that kid back. But what's changing in health care reform is there is a whole push around accountability and quality measurement in kids. And I can tell you that a lot of the quality measures aren't obvious. They look at immunization practice. They look at, right now as far as they've gone on the obesity epidemic is, do we measure body mass index on kids. Not whether we reduce it, because it's a question on whether we can even do that or influence that. And then there are a lot of extraneous measures. No one to my knowledge has talked about the issues of protecting children as part of a quality measuring and a response to failure to thrive. If in fact, as part of the Quality Measures Program within the Medicaid program, which is really hot right now, what happens is if quality measures are defined and those standards are sent down to the managed care organizations that are actually contracting with these health systems and doctors' offices, and they start paying out bonuses or incentives based on demonstrating that they followed up on kids like this, my health system will respond by putting in the decision prompts to make sure that kid doesn't slip through the cracks. Not everyone, but again this is about tightening the threads on that quilt and there are mechanisms that are built into the way Medicaid is structuring our discussion about quality that we may be able to take advantage of to ensure this doesn't happen.

Commissioner Dreyfus: [Session 5 - 01:27:08] Just remind everybody when we had that meeting with the congressional staff, I wasn't there in person so I'm not sure who the congressional staffer was, but I brought up Medicaid and the need for us to influence Medicaid policy, and there was an immediate pushback on that. But I just remind people, this would be a good thing for staff to do, what number of children in the child welfare system were born under Medicaid? And I will tell you, it will be the vast majority of them. So this idea that we're going to deal with this without going out and influencing the other systems that surround these families is why we're still talking about this issue after how many federal commissions have existed on this topic. So I just want to remind everybody what that reaction was, but I just couldn't agree with you more. If we don't influence Medicaid policy prior to the birth of children, and in those first years, we're not going to get there.

Commissioner Martin: [Session 5 - 01:28:04] So David I don't want you to think that I'm picking on you.

Commissioner Rubin: [Session 5 - 01:28:15] Go for it, pick on me. I like being picked on. There's plenty to go after.

Commissioner Martin: [Session 5 - 01:28:19] I'm not trying to do that. But I would ask you to still consider that in Cooke County I don't have one coke baby from any hospital other than Cooke County. So what happens at Northwestern, the one hospital that sits on the Gold Coast behind Neiman Marcus or Needless Mark-off, whichever way you call it, and there's a young girl that comes in underweight delivering with no prenatal care and that child goes home, but the one at Cooke County they call and do a "tox" on her. So I see Medicaid, I get that, but how about the Blue Cross/Blue Shield ones, okay? And then my other question to you is when I have...

Commissioner Rubin: [Session 5 - 01:29:04] I want to follow up with you because when Medicaid sets policies around quality measures, the commercial payers usually follow. Same thing with Medicare and ...

Commissioner Martin: [Session 5 - 01:29:10] Is that a mandate?

Commissioner Rubin: [Session 5 - 01:29:12] They're all contracting on quality measures. What's lacking is specific definitions of what the pediatric quality measures are going to look like, and they're trying to develop that. And so there will be trickle-down to the commercial plans, and I think we also have to think about, there are kids who are just small. So we want to be careful that we don't make those families miserable as we try to ... but at the same time, I think we can have a thoughtful conversation with the Medicaid folks about what this would look like and get some feedback from physicians in practice of what would make sense and would not be over the line.

Commissioner Petit: [Session 5 - 01:29:47] But other things are available under the new Medicaid plan. Actually under Medicaid previously, if that state exercised that option, but it's all the home visiting stuff, the nurse visiting. All the on-calls on treatment. All the mental health treatment that is built into Medicaid if the state wants to exercise those options. So in some cases, you have push back on it. Well at some point we'll push back. There's going to be a push-back debate as to how far all this goes. There will be conflict among federal versus state. The federal government can just say each state plan has to look like this. It doesn't, because it gets into conflict with different jurisdictions, division of federal versus state kind of responsibilities. But the fact that congressional staff … I mean it's always good that they respect and listen to what people have to say, but that doesn't a legislature make.

Commissioner Dreyfus: [Session 5 - 01:30:30] I just remember going through in Washington state when we were just cutting everything that was not nailed down, and going through the horrific experience of having to cut Medicaid. And those things that were the mandatory things we had to cover in Medicaid for the federal government were left untouched. Right? So I think that's probably where that conversation needs to be had. Is whether or not there's not the need for some additional mandated coverage for the federal government in state plans. I mean that's just how it works. Right?

Commissioner Rubin: [Session 5 - 01:31:02] Let me take you through a couple of other quick cases just to show you the other elements of intersection. And this was brought up at yesterday's meeting. And then we can have a long conversation. It's just—go ahead.

Commissioner Rodriguez: [Session 5 - 01:31:11] If that pediatrician had actually made the call at that point to CPS and the intake worker got the call, what typically happens? What is the circle? How would a CPS worker ever be able to distinguish between small babies' failure to thrive due to neglect without there already being...I mean, I understand when there's a collaborative relationship with public health or you have a physician on the team. But absent that …

Commissioner Rubin: [Session 5 - 01:31:48] Well, if you have more skin in the game and you're actually managing what you measure, which is, did the kid come back, we tried to make a couple of contacts … at a certain point I think most health systems would then report the child because they can't get the...and at least you have someone going into the home and doing a full assessment. It doesn't mean every kid is going to be removed, but I think there's an opportunity for intervention far before that child does. I'm not saying expedite it or whatever; I think there was a lot of opportunity in that type of case for initiated response if you're managing what you measure.

Commissioner Rodriguez: [Session 5 - 01:32:21] But there's no requirement that they then call in a medical consultation on a case like that. It would be the worker's decision about whether they want us to do ...

Commissioner Rubin: [Session 5 - 01:32:30] Well that's a great question because I think that...most of the time, and I think the issue of child welfare medical directors and how we support the sort of interdisciplinary aspects and the growth of that expertise to child protective services is an important part of that conversation. Because when that case comes in, there should be a medical unit in the child protective services, and a lot of large cities are actually developing those units to have that internal expertise, to say do we need to worry, do we not need to worry.

Commissioner Dreyfus: [Session 5 - 01:33:03] I think far before that, not just a screened decision. So yeah, the pediatrician calls in, but does it get screened in? And what we found when we were working with the Harvard Center on the Developing Child, and I had them come in and I had them look at all our child welfare policies as related to young children. Right? A couple of things that they told us to do: Number one, screening in all calls on children under the age of 2, even if it was just about getting preventive services in, if we're getting calls. And mandatory screening if a pediatrician is calling us. You could all say there are other ways to go at it, and we're making it more complicated than I just presented to you for the sake of time. But all I'm saying is, you're making an assumption too that this has been screened in, and I always struggled when mandated reporters call in, especially pediatricians,

on young ones, I always fail to understand why wouldn't we be screening that in and going out.

Commissioner Petit: [Session 5 - 01:33:58] Well it could be because of caseload size and the workers already have training issues that exist. Every jurisdiction is going to have a different capability in terms of responding to this thing. Some of them respond immediately. They send people out and they take care of it. And others it's like, they're triaging. If they're in a position where they could ... some jurisdictions, there's almost 100 percent response rate to a filed report. And other jurisdictions that we've been in is 10 or 15 percent. Eighty-five percent triage out of the system on this thing. So a lot of this, which we haven't really spent much time yet, is what is the capability of the child protection agency? And it's very uneven state to state.

Commissioner Rubin: [Session 5 - 01:34:38] Well, let me roll through this. There's a couple of versions that will ... The next scenario. Scenario 3. This child has five visits to different emergency rooms for injuries, and this gets to Dr. Wolk's testimony yesterday, because he said some important things relative to this case. ED visits were never reported to the primary care doctors. The primary care doctor had no idea he had had five different injuries in five different emergency departments. All right? Had some no-shows to primary care, which happens a lot. Had some vaccine delay, which happens a lot. Dies at 18 months due to an abusive head injury. I can tell you, having done evaluations of injuries within home visitation programs that are receiving Medicaid claims, that there are Medicaid claims that demonstrate multiple injuries to children in the first year of life. Yet I know of no surveillance system right now that takes advantage of that information. To either ask or require, because this is not what the primary doctor can measure, because if they are not coming to my health system I wouldn't know about it. This gets to a higher level of Medicaid organization. In terms of public health tracking and the intersection to health care reform, just so you guys know, is Dr. Wolk mentioned something called the health information exchange in Colorado.

And just so you know what that is, the idea is that as all these health systems are building their electronic health records, and Medicaid is getting its claims, that there's going to be a cloud where when a child shows up in the emergency department, in this case they're thinking mostly of adults with congestive heart failure and all the different medications they're on, but we really haven't defined what a health information exchange looks like for children. When you think about the value of that, certainly there are kids with complex medical conditions and have the same types of issues of coordinating care, like adults, but for kids it becomes a real question, not only whether we know about all the emergency department visits for injuries, so that we might be able to react when that child came to MY emergency department. That opens up the whole question about information sharing, whether child welfare-related data should be part of the health information exchange so that people will be knowledgeable about potential risks to the child when that child is seen. I'm not saying that is what it should be, but it raises the questions of what you want in an HIE, which is health information exchange, for kids.

Commissioner Martin: [Session 5 - 01:37:03] So right now, we talk about Pat going to different pharmacies to get Oxycodone or whatever you guys call those things now. We can track if I'm using prescriptions to go from CVS to Walgreen's to Costco to fill out pain meds or codone. I don't see why we can't do that for kids, because the infrastructure is in place. Right? That doesn't even require DCF. I don't disagree that DCF information should be available, but that wouldn't even require it; it's just a matter of putting in some cloud IT thing.

Commissioner Rubin: [Session 5 - 01:37:52] That's right. What I'm suggesting is we need to understand Medicaid. They know this HIE issue like intimately. I'm not sure they thought entirely through the issue for what it looks like for children, and we can influence these parallel processes going on that have direct relevancy to providing for safety for kids outside the child protective services system.

Commissioner Martin: [Session 5 - 01:38:11] And the only thing, again, I don't want to be the push-back all the time, but I also want us to remember that that doesn't mean automatically DCFS comes in and takes the kid. What that means is that the kids get some eyes on him or her and we make an evaluation of the risk.

Commissioner Rubin: [Session 5 - 01:38:34] There are different levels of response. You might imagine if it was the managed care organization that said this kid had five injuries, they call, just the primary care doctor, "Do you know about this?" There are different steps far before you actually report that kid. We can talk about the response, but I think we need to engage the Medicaid program to understand for that kind of discussion. Because I think, you can have from a community level, it could be a public health team. It doesn't necessarily have to be DCF. I'm more interested, can I get some eyes on that child to make sure the kid is okay.

Commissioner Martin: [Session 5 - 01:39:07] I don't mean to be difficult about it, but we know what the law is but we don't follow the law, and that's my problem. So if we have the platform to put forth some of these types of recommendations, I think it's imperative upon us to also make certain, we remind people that when you do respond, there are laws in place that require an assessment. Because when we assume that's said, that's when we stop following.

Commissioner Rubin: [Session 5 - 01:39:36] I've got one more scenario, and then we can keep talking through and move on.

Commissioner Petit: [Session 5 - 01:39:44] We're focusing right now on the medical, but this is true, also, the mental health side, it's true with education. It's true in a number of different platforms. Mental disabled. So I think looking at this from the perspective of medical communities is very useful, but there's also a need to look at this from these other

pieces, which again all screams for a multisystems response and approach to how we address these issues.

Commissioner Rubin: [Session 5 - 01:40:08] I'm going to back out. Hold on here. Let me vary this slightly, which is to tell you that you have a kid here now instead of the multiple injury scenario, is you have a child who is in a public health response, is the recipient of home visiting services and yet dies after receiving for some period of time home visiting services, prenatal infant and home visitation. And mother drops out after pregnancy, and then the child dies at 8 to 10 months of life from an abusive head injury. Here is the case where we initiated a public health response, we had a child in a home visiting program, and if you go to the next slide, I think what this illustrates to me is about that sort of building stronger communities and connecting programs. This is the result of an analysis that we did at PolicyLab that actually looked at the effects of the home visiting programs across the state of Pennsylvania to look at whether they were being successful on injury prevention.

What it actually found kind of intuitively is that children in the home visiting programs had higher rates of overall injuries. Most of those were superficial injuries, and it may be because nurses were in the home and they told the moms, but these were emergency department visits. So they weren't just primary care visits. But across all the outcomes, there was always an up-tick in favor of the injuries in the nurse visiting group. When we got to drill down, even though there was no statistical differences in injuries, we didn't see the big program effects the trials had demonstrated in the perfect situation. So when we actually asked about a couple of the abusive head traumas that occurred among home visiting kids, what did we find out? We found out that mom had gone back to work and who took care of the child? And so if you know anything about Pennsylvania, the child care subsidy issues in Pennsylvania are a disaster right now. And so this shows that we are initiating a public health response with these other programs as well too. Without that sense of how these programs connect, the context of community and whether there is child care or the other services that wrap around these programs becomes very germane to us thinking about our prevention models. I worry that we're setting programs up to fail unless we think about community context. Raise issues of these other systems—not just home visiting but child care and WIC—and think about how they connect together to kind of prevent a child from slipping through the cracks.

Commissioner Covington: [Session 5 - 01:42:48] When you look at this table, though, you can't make the assumption. I mean there's another assumption you could make, which is that the mothers are being more attentive to their kids and they're seeking help when their kids get hurt.

Commissioner Rubin: [Session 5 - 01:42:58] Absolutely. The superficial injuries I don't worry about, because I think you're right, Commissioner Covington. Those are mostly bruises and lacerations. You're right, there's a good message there too, but the skeletal fractures and the abuse injuries and what we call the severe hospitalization, the high-risk injuries,

those are abusive head traumas. That's not about, those are the ones we worry about. I call those like central line infections for kids in home visiting programs.

Chairman Sanders: [Session 5 - 01:43:27] I want to make a comment, because I think that's what complicates this so much in thinking about this part around surveillance and intervention and who intervenes, and the notion, which I agree with, that more eyes is always helpful. But I'd go back to what Emily Putnam-Hornstein presented and looking at the re-referral rate for infants, and regardless of the intervention it was between 55 and 70 percent. So we really have to think about kind of what we're doing even once the intervention has occurred and once the recognition that there's an issue has occurred, and think about those things together.

Commissioner Rubin: [Session 5 - 01:44:12] Dr. Olds made a good recommendation, and it sort of slipped through there, I'm not sure if people caught him talking. MIECHV, which is the funding for the home visiting program, and how they've been...and he didn't expand on this too much about the community advisory boards, which was a reference to the need for communities and to incentivize communities to really develop the infrastructure around these programs to make them successful. And he said in the states where they have not done that, they've had more problems. So I think there is an opportunity, think about it: the other problem with retention, we saw only 20 to 30 percent of the women staying on beyond birth, and unless you incentivize these women that there is a continuum, that if you stay engaged with the program we're going to give you access to these child care services, the Head Start, and create the pathway to kindergarten. What you have is a lot of dropout because they don't see where this leads to, and so that's my worry. That's my personal opinion. That's not based on data, but I think there's a way to think about strengthening community responses. Whether that means more expectations around community advisory boards or community development for these types of programs … that could be a direction we might want to go in.

Commissioner Martin: [Session 5 - 01:45:26] So one of the things … a little knowledge is dangerous at times. And so in Cooke County, we have some pediatricians that come and give us baseline information about bruises. They do a series on bruises for us, a series on fractures. And I'm asking, whether or not those superficial injuries and some of the bruises, they talk about bruises on babies' faces that people typically overlook, but when you have a child that is not mobile and they are experiencing bruises on the face, that should be a red flag for us. So my question to you is, those superficial injuries: are those superficial in your assessment, or did someone else determine that they were superficial?

Commissioner Rubin: [Session 5 - 01:46:12] They were just codes for like hematomas and lacerations. You can't make that differential here, and I don't want us to... You're right, some of those could be concerning injuries, but I think more where Commissioner Covington, my interpretation to superficial injuries is that you could raise, is supervision the same in these homes because the moms are being asked to do a variety of things. I think you have to accept that a lot of this is, you've got nurses in the home. They are teaching parents how to

utilize the health care systems. They are teaching them better response and being more proactive. I'm going to be there. What I worry about more is the fact that we have any abusive head traumas in a home-visited kid.

Commissioner Martin: [Session 5 - 01:46:57] So my point was just are we missing some of those superficials that become issues. So that's my point.

Commissioner Rubin: [Session 5 - 01:47:07] Maybe. That's maybe. I can't say that from that data.

Commissioner Dreyfus: [Session 5 - 01:47:08] I want to make two points, because I think Dave this is fabulous, but there's two points I hope we take from this. One, Commissioner Ayoub, to your earlier question to Reggie Bicha about El Paso that I want to comment on. I think the first thing is we live right now in a country when you look at Medicaid, I'll bet when we even look at the standards sitting underneath superficial injuries where we are using adult standards in a children's world. This came to me very clearly a few weeks ago in our child welfare refinancing proposal that Reggie was mentioning, because we're in partnership with the Alliance, APHSA, and NOSAC in a child welfare refinancing proposal. We called for separate children's behavioral health standards in our country because we are using adult standards, a medical-necessity lens, in applying Medicaid in children's behavioral health. What we've been hit with is from CMS and SAMHSA, an absolute "We do not believe that there should be separate standards for populations." I personally disagree with that, but I just think it's important it doesn't get lost on the Commission, this notion that, and to Judge, your point of superficial injuries, I appreciate that if that's my 32-year-old son, but it's sure a lot different for my 1-year-old grandson. We are using often times in these systems, we don't have unique children's standards. So I just want to make that point.

The second thing is about community capacity. I think what El Paso was telling us yesterday, and I love your question to Reggie Bicha, because it isn't a question where you could say, they implemented this program and therefore it made this result. This is where a community has come together and said, we're going to own the same issue together; we're going to share accountability for the issue; we're each going to change how we do our work, and we're going to collectively come to the table different. It's hard to programatize that into an evidence-based program model, but it's what we learned in Washington state with our Adverse Childhood Experiences. David you know this. We had 15 years of longitudinal data through the state behavioral risk factors survey funded by the Gates Foundation, where we could show that communities that had certain community capacities, they were coming together across systems. There was leadership. There was shared knowledge going on in the community. It's this collective impact notion. We actually saw over 15 years in those counties a decline in their ACE scores through the surface. So there's something about this cross-system work that you can't put in a box of a program. It's a different way on how systems are interacting and being with one other. I don't think we can get to where we want to go without being clear about that. So this issue of community capacity doesn't happen just

because good people are thinking good thoughts. It's invested in and it's created. It doesn't just happen otherwise; it just happens with one leader for a couple of years, that leader leaves, and everything goes back to the way things were. So I just wanted to make that comment on that.

Commissioner Petit: [Session 5 - 01:50:18] Chairman David if I can just raise this issue of, this conversation is all very interesting and all the information and issues being raised are interesting, but we don't have that much more time, and I'm wondering, you might have addressed this when I had stepped out, but how do we talk about what happens next? What are the issues we think are most important and the certain data that we want to start collecting. I think beginning of the formulation of a strategy and what are …

Chairman Sanders: [Session 5 - 01:50:49] I think that after this is complete we want to go around and at least get a sense of some of the expertise, in addition to the conversation we just had around Medicaid that we had as Commissioners. And then I think we want to go into a set of questions that we can collectively say, "These are some things we know that collectively we want to look at," and that becomes our next step. I think the questions that have been laid out as part of a work plan can be a starting point, but there are a lot of other ways to think about it.

Commissioner Rubin: [Session 5 - 01:51:21] Well I was going to suggest, Commissioner Petit, I was going to suggest that instead of us continuing to discuss through this, that this was my recommendation back to the Commissioners was to send ... and I thought of Commissioner Dreyfus for this because of her experience in Medicaid, to go and start doing some advance work with the CMS folks to think about where they think the intersections are, so by the time they come before the Commission, that they've had a chance to deliberate on these issues. And that's where I think we can do some advance work before we come to a public meeting.

Commissioner Petit: [Session 5 - 01:51:51] I agree. I will just note that we're talking about a very, very big thing, which is how our culture takes care of its children. And there are a lot of strings into that, and so approaching a systematic kind of a way. And I think we do have a plan, and the question is, how do we respond to that plan? Do we like the plan that David has outlined or not, what we need add to it and so forth. We don't get to do this part of it very often, and one of the issues has been, how do the Commission members as a whole put input into this? And that's what I think, I hope, the next couple of hours is going to allow us to do.

Chairman Sanders: [Session 5 - 01:52:30] I think it would be helpful if we spend at least a few minutes giving the opportunity for each of the Commissioners … and I think Susan raised it, but kind of a little about your own background and areas specifically that you're interested in and contributed. And I'll give a couple of examples. I know Teri has said several times that this question that's come up about child fatality reviews and the citizen panels. You have years of history on that and can talk about things like that. I think we just heard the examples of Medicaid, and we know some of the things that Judge Martin brings from her experience in

the court. So just because it seems like we don't have to always kind of rely on outside expertise, and it would be helpful to just have a sense of what people can contribute. Then I think we'll take our break. We will convene in Executive Session, then come back and we can talk about the specific questions that are laid out. Commissioner Ayoub, you want to start?

Commissioner Ayoub: [Session 5 - 01:53:39] I think what I feel I bring is my personal experience, my life experience, and then my communication expertise. So I realize that there might not be a direct correlation between sex trafficking and child fatalities when we're thinking about what we need to do to eliminate them, but there is a lot of cross-over that I just want to touch on. Just the violence in general to start with. Then a lot of what is discussed by the people that are coming forward speaking to us is the same conversations we're having in the sex trafficking areas. I'm not sure why, if there's child abuse and it's a pimp that that child is living with, why I don't think it's considered child abuse. Why it has to be what's named the caretaker, even if, in their life, that *is* the caretaker. I realize what I'm talking about … I just want to share it. I understand that it's not what we're going to deal with specifically.

There's also familial trafficking, and I wonder when doctors see kids if they … just like they were saying a lot of times the domestic violence is missed. I think sex trafficking is missed a lot also. There are definitely some survivors that I've met with that have come out since we started talking about this more publicly that had terrible situations like that. One who was trafficked by her father from the time she was 5 years old until she got away at 17, and the times that she had to go to the doctor, she was taken to a doctor who was a trick and who traded out for that. There's others that go to the doctor but they just don't go that deeply, and so as far as a factor that might be something that is recognized, sex trafficking is... if someone is being trafficked, there's a good chance there's going to be violence there. So when it's a child, it would be great to look at that. Pimps as far as not only is the girl or sometimes the boy, the victim, but they have children too. Somebody mentioned it yesterday as far as in domestic abuse, where the perpetrator will use that child as a weapon. Nobody does that more than a pimp. There is no feeling there for that child, and that control is all-important, and that child will be abused or killed or taken away, so many things, to control that victim.

When they talk about PTSD, the trauma-informed training, I loved hearing that because that's what the survivors are pushing for. There are so many well-intentioned people, but there is so much damage that can be done by well-intentioned people. It's almost better to leave children in a situation that they know how to navigate, than to go in with good intentions and not the training. Not the expertise. Even as survivors we say, we need training because we're reliving it every time we retell it. We can't just retell it, we relive it to a point. So people want to say that we'd be the best mentors. Yes, our input is very important, but it still has to be surrounded with that help of the experts because our own trauma can come out when we're trying to help. But definitely nomenclature, words that are used matter to victims. So when I hear about some of the victims, especially in a domestic abuse situation, there is so

much victim blaming, and nobody does victim blaming more than the victims. Just the awareness around that I think can help in this situation.

Another correlation is when we hear from survivors, from the parents and the kids, where one of the first things every one of them has said is, "We're not data" or hear "I'm the data, this face is the data." So I think again, the nomenclature used is important. I would look at the fact that there is that correlation if you identify sex trafficking with juveniles, then there's a good chance that there's abuse going on there too.

The other side, on the communication part, I think that a lot of you are used to speaking to your own. So there's a lot of acronyms. There's a lot of words that are being used also that I might not understand, but I don't think I'm the only one, and I've heard conversations among you that even though you're in this field in some way, you're not in the field all in the same way. So what we're saying isn't always what we're hearing. The message sent isn't always the message received. I think we might want to look at always saying, "Let me tell you what I heard." Judge Martin, I heard you saying this morning that public health means something very specific when the people in it are saying it, and to us it might be more general or just have a whole different idea of it. I mentioned yesterday there's conflicting information, so we bring these experts and we listen to them and another expert conflicts with them. For me especially, we're bringing these experts forward and then even experts on this Commission are saying something different.

For example, I think we mentioned this at dinner last night. I have heard from the time I've been on here several people on the Commission and other experts speaking that it is the boyfriend who is usually the perpetrator. Then the expert yesterday, Dr. Drake very convincingly said that it's the biological parents, more often the women, the mother. So just things like that I think we have to really figure out. We're going to keep hearing information. How do we decide what information we're going forward with? Nobody will ever complain that you made something too clear. Somebody actually apologized for simplifying it. No, please. But nobody will ever say that. Even if you're talking to some people that you think will understand it. The more clear and concise it can be, the better chance there is that they are getting the message you're trying to send.

I fully believe that there are more congressmen and -women that are like me, than are like you. They don't have the expertise, and so just going forward to think about communicating this to Congress, it will help to start getting into practice now of speaking as clearly as possible so that they understand. And communication for me also means the broader public. I think we mentioned it on one of our phone calls. How do we ... because somebody's an advocate, because somebody's around these meetings doesn't mean that they're experts in everything. So how do we communicate, not just clearly, but then how do we get the word out to even more of the public so that they are calling their congressmen. That they are saying, "I support this Commission." No matter what we do, I believe it's going to take more than us. They want to hear from a lot of people, and that they will be paying more attention

than just saying, "Okay let's listen this Commission." How do we start now? It's a short Commission. It's a short timeframe, and that comes really quickly.

Also telling stories. These cases are important because they're stories, and maybe not saying it so clinically. Reggie told stories, and that's what people remember. That's what people connect with. That's what moves people to act. Things have to be repeated a lot, especially when we're new and we're trying to get that message out. In marketing they tell you that somebody has to hear something seven times. So repetition is important. You might say something once that really sets in your mind because it's a specific interest of yours, but others didn't hear that. So that's important.

Then the other thing I would look at in communication here is I would love to hear more, and maybe it's with the staff, about social media. We're not the youngest Commission, and I think that we might want to look at how we're reaching out to the public. I'm probably the oldest one, so I thought I could say that. Senator Cory Booker is a perfect example of somebody that uses social media brilliantly, and there's more and more of the congressmen that are using that. The more we can get it out to the public that way, the more they are aware of it, the more they will get it to their congresspeople too. To me yesterday, there were tweetable moments that you could tweet out and then retweet, and it helps all of us. So there are things that you can tweet out as something that somebody said. It's not us taking a stand, it's saying, "Dr So-and-so said this, what do you think of that?" Then you start getting more input from the public and from other professionals. These hearings are great, but it's a handful of people that we're hearing from, and we're hearing almost the same thing. Is that all we're going to hear, or... I want as many ideas as we can. So a broader outreach to me would be great. And I hope that on our staff that that's one of the things we're considering, is having somebody that knows how to decide what that is, how to tweet something out, how to let us know that... because it's very easy to set it up where it's a retweet. I always put something... when they send me the announcement, I put it on Facebook and say, looking forward to this meeting and telling them when the announcement is. Again, the more we can do that, the better. So anyway, I can help in the communication. I am looking forward to. And I offer you if there is any time that you want some feedback on your presentations or anything that could make them more powerful, I'm available to do that. Thanks.

Chairman Sanders: [Session 5 - 02:05:38] I would just point out that Congress just two weeks ago made it clear that sex trafficking does... there is a responsibility for the child welfare agency, so there's a different kind of alignment now that Congress is very clear about. Commissioner Zimmerman.

Commissioner Zimmerman: [Session 5 - 02:05:55] Good morning. So I am a social worker by profession. I started out working in my tribal community, creating a suicide prevention program for that community that was experiencing a cluster at the time. I left my community after 50 years living there in a rural reservation in Croix to go to the University of Montana to take a position as the director of the Trauma Center, because the work that I was doing

around … whether it was suicide prevention or if it was substance abuse prevention/intervention or any sort of mental health issues, was all related to not just historical trauma but intergenerational trauma and exposure to violence, and children exposed to violence.

So I'm going to use this opportunity to also say that I am here to represent the American Indian contingency and support that, but this is our fifth hearing and we've had a youth and a couple of folks that do direct service, and what I need, I think that this Commission needs, is to really acknowledge there are 566 federally recognized unique tribes. All of them with their unique systems. There are federal laws that are in existence where tribes can be, what they call "280 states," like Minnesota, where the tribes have given over their jurisdiction for criminal and noncriminal accounts. What's the noncriminal? Civil, to the states, but there are those tribes in other states, many other states, who have not. So they have their own tribal courts that sometimes you don't have to be a lawyer, you don't have to have attended law school, all you have to do is pass the bar for their laws, that's it, and so they are deciding child welfare cases all the time. There are data systems that don't exist because there is not funding for it. The Bureau of Indian Affairs, which has the Human Services Department, has the Financial Assistance and Social Services Case Management system, and that's really about managing. If you've heard of Elouise Cobell and the Cobell Settlement, that's about managing individualized Indian monies. Not necessarily case management for child maltreatment.

So the BIA is mostly responsible for, and here's my expertise, I know what I don't know. Here's what I don't know about this work in Indian country and what's being done and what we need to know: I don't know where the data is because the data systems don't exist. I don't know if there are any tribal child fatality teams that exist in Indian country, except for one that's scaffolding up in Navajo Nation, that's one out of 566, and I believe there was a team that no longer exists on the Crow Reservation in Montana. That's it. The children, I have attended CPT meetings on my reservation where we will be talking about a family where a child is enrolled in Wisconsin, a child is enrolled locally, and then there's an unenrolled child, so we have to have state child protection involved, you have to have Wisconsin State Child Protection involved, and then we have to have our tribal or BIA CPS involved. And that's just for one family. That happens a lot. So I think it's really important for us to understand that the data systems don't exist, and part of the recommendations...

I feel like my charge is that when this report goes before Congress, that Congress has a pretty decent picture of what is needed in Indian country. Because CAPTA dollars don't make it to Indian country. According to the National Indian Child Welfare Association, only about one percent of CAPTA dollars have gone to tribes since its inception. That's it. That's not enough. So the other piece is that American Indians represent...they're the second-largest population for victimization in this country, and only about 28 percent of all the crimes are prosecuted against children. Because again of that jurisdiction. So we could go with child abuse to a tribal court, but if the child is murdered, jurisdiction is taken over by the FBI. And then prosecution is done by a U.S. attorney in the state.

So these systems and jurisdictions are incredibly complicated, and we haven't heard that yet. I think it's lovely that we have had them and this is what we do to support families, but more to the question of if we really want to know, we don't even know how many American Indian children have died by maltreatment because there's no mechanism for it. There's no child reviews. The data is in state systems, or it doesn't exist, or it's a federal prosecutorial issue and the tribes don't count it. The tribes don't have to give data to a state system, that sort of thing. So I think we need to hear, and I was thinking about this and I'm thinking, I think we need to hear nationally, on a national level, because again those 566 unique tribes, there is a government-to-government relationship with the federal government, and it's the same with the states. It's government-to-government. And the federal government has a trust responsibility to tribes. In exchange for land, they've exchanged health care and safe housing and education. They have a trust responsibility. This is where we can say, "This is where this needs to happen." But there's no funding to do it. I love the idea of teams, but I'm telling you, I'm working with BIA social service workers who are in systems where there have been supervisory positions that have stayed open for years. When they're happy to have five caseworkers to cover 2 million acres. During sequestration there was one social worker to cover 2 million acres on one reservation. The capacity isn't there for tribes, but we need to be able to document that. We need to hear somebody say that. I can't just say that because I kind of know, because I kind of don't know, really. I don't. I talk with people. I have this anecdotal information, but we need to hear from BIA, we need to hear from Indian Health Service, we have sexual abuse nurses who know how to do...they've made it a national policy across Indian Health Service to be able to examine women who have experienced sexual violence. That's good, and they've done it some with children, but they don't have teams that know how to do a forensic exam of children around maltreatment. Docs come and go every two years, once they get their payoff done. They don't stay in these tribal communities long term.

Commissioner Dreyfus: [Session 5 - 02:13:54] You mentioned a number of national groups. Have any of them created recommendations that we could be looking at?

Commissioner Zimmerman: [Session 5 - 02:14:02] That's a question that I don't know.

Commissioner Martin: [Session 5 - 02:14:06] So I worked with the National Council for a while, and I was one of the people that went to the Hill to testify about the need for federal funding in tribal courts. And the whole result of how that came out … but the point I was trying to make is, there's a leadership council within the National Council that has a bunch of tribal court judges on it. And I'm not saying that they're necessarily an expert on any one given thing, but I do know that they've made some recommendations about how the Council can help advocate for some issues for tribal courts specifically. So it certainly doesn't go to the medical care or education. So that's one place to look and maybe ask questions about other experts.

Commissioner Zimmerman: [Session 5 - 02:14:53] So there's the National Indian Health Board, that's a national organization that represents tribes. There's Bureau of Indian Affairs, IHS. There is the National … NARA, I'm sorry I can't think of what it represents but it's the Native American...something, something Association. And they do a lot of work around child welfare practices also. I think there are voices that we can really access, but I almost feel like it's too late. Because we've been hearing all of the information around data and what exists and the scaffolding and the capacity of communities for five sessions around fatalities. So I hope it's not too late.

Commissioner Martin: [Session 5 - 02:15:36] I disagree. I don't think it's too late. I personally don't think it's too late, and I do agree with you that it is nice to have representation but we also need representation that has information. So I would certainly concur in what you're advocating.

Commissioner Zimmerman: [Session 5 - 02:15:52] So I think that's my area of expertise is in childhood trauma, particularly in American Indian, Alaska Native populations, focusing heavily on the impact of historical and intergenerational trauma and poverty. So that's what I bring to the table. But more than that, I think like Amy and like all of you, I hear your passion every time we meet, and my passion is to not be the token that we heard yesterday but rather to be the voice that at least helps open a door for the other voices to come and let us know. It's going to be difficult because BIA has a history and IHS has a story of being sort of blamed for everything. So those are going to be delicate relationships to develop, or that I have developed, to call on to say, "Come tell us the truth because we're trying to find resources."

Commissioner Covington: [Session 5 - 02:17:01] Comment to that, too. I think what you're really begging for, and I think what I'm begging for too is that we be more strategic and we involve loudly the Commission's voice in planning meetings and site visits and attendees, who the voices are that we want to hear from. You said it clearly, that we haven't heard the right people in terms of the Indian voice.

Commissioner Zimmerman: [Session 5 - 02:17:28] Right. I think this speaks to the executive director position. Is that I've asked repeatedly for NICWA to be at a hearing, and I talked to them last week and said, "So you'll be there?" And they said, "No, we weren't invited." Even though I was told they would be invited and be here at this meeting.

Chairman Sanders: [Session 5 - 02:17:55] Teri.

Commissioner Covington: [Session 5 - 02:17:58] Well I was coming at this really differently. I was just going to tell you what I know. What I mostly know. Where I feel I can be a real resource to the Commission. So the bad news is for the last 20 years I've been on a pretty regular basis hearing stories of kids who die, and I know them far too well. I don't even want to think about how many thousands of stories I've listened to in my past 20 years. This is what I'll say: I really know how kids die. I know the depth of messes that those kids' lives were in

and what got them on their pathway. So that's a resource I can bring. I was watching David put those cases up, and in my head I was thinking of the pages and pages and pages of notes that I would know as the back story to those stories and where all the systems crashes were and where everybody screwed up, or where we just missed, missed, missed multiple opportunities. So that's something I really know. I guess it's a good thing or a bad thing.

But I also really know a lot of about the different types of deaths. So I've heard a lot of talk about the Commission about sudden unexpected infant deaths, the sleep-related deaths. I know that like nobody else in the country. I really do that. I know that back up one side and down the other. And I know child abuse and I know suicides and accidents. So it's just a resource that I can bring to the Commission.

I know how the review processes work. That's what my day job is, is to know how it functions in every state. So I know it in my sleep. You could ask me today about a state and I can give you a full description of what their system looks like. What their strengths are what their weaknesses are and where the huge gaps are across the country and how we could better support that. But I'm a real believer that the review processes can really drive, one thing I haven't heard at all is how can we learn from review findings and recommendations that have been made across the country. So there are 50 states doing these, they're making recommendations all the time around what to do in the areas of abuse and neglect prevention and policy change and what have you. I haven't really thought about that more detailed, but I think at some point we might want to take a look at that because there are a lot of lessons to learn there.

Every time a death review team, a citizen review panel, a state panel, or a local panel … but and they are making often times recommendations. Some of them aren't very good, but there's some real pearls in there if we dig. So they're there, and I think that we haven't even thought about capitalizing on what some of those pearls of wisdom are from around the country on the reviews themselves. So going from that, the other resource that we haven't really talked about is our National Case Reporting System. So we manage the National Child Death Review Case Reporting System that anybody now in the 43 states doing reviews, they enter really comprehensive data into that system. There are 1,700 plus data elements in there. If they enter a case about...I was thinking about it yesterday, we published a little paper that was just teasing out some of the data in there, Vince Palusci and I, that we did in *Child Abuse and Neglect*. It was just a descriptive analysis of the data that we currently have in there. I forget how many child abuse cases we have. We have the whole range in there, of the physical abuse, homicide, murder, the egregious neglect, and then we have all those grey cases. It could have been a drowning. It could have been a fire, whatever it was, but we have all the circumstantial information about those cases. So we have … if the team decides that there was really poor supervision, they'll say that. And then we'll know also if there was drug and alcohol used at the time of the supervision. If the parents were distracted … I mean you name it, we have all that information. So I think we could capitalize on some of that, and I'm

happy to have my staff pull reports as needed for us if you guys are interested in looking at that data in more detail.

The other thing I really know a lot about is child abuse and neglect measurement. We talked about this a lot. We've had all these hearings. Sometimes they drive me nuts, like when they're putting those maps up yesterday, I just about wanted to yell, and I just kept my mouth shut. But I mean, I have real strong feelings about the value of NCANDS versus other systems and how deaths are counted. Mostly because I really know how poorly, well I really, really understand and get the absolute lack of standardization on fatalities in NCANDS. So to compare states and degrade states and to do stuff like that using NCANDS and to put up a map that shows different Stigler's … it just doesn't mean anything. So the measuring piece I would really like to be very proactive. I don't know how we're going to eventually structure this, but we've gotten a lot of stuff about measurement. And I'd really like to have a pretty loud voice in kind of consolidating all of what we've heard. We've actually been doing that for two years through some Casey work that also came together. Some of the work Dr. Schnitzer was presenting on. But I would be happy to try to help the Commissioners make sense of that myriad of stuff that we've had thrown at us in the last five meetings. I really try to keep my biases out of it, but I have some strong feelings on that.

One of the feelings is just really coming to grips with the use of the data. It's important to use the data if you're in law enforcement, if you know what kind of data you're using. Just like it's important if you want to use the data from a CPS perspective versus if you want to use the data from a broader public health perspective. You're looking at different data if you're trying to do those different things. So I think there's a way to make sense of that. And then I did some work through Casey where I did a pretty comprehensive literature review of the public health model and maltreatment. Looking at maltreatment from a broader perspective than a child protection/child welfare issue, but looking at it from a broad public health perspective, so I've got that in my head. And we actually did some publications on that that maybe we can bring to the Commission. I think we had a short version of it published in that wonderful journal that you guys sponsored. But there's a longer version, as well, that goes into it in a lot more detail.

What was the last thing I was going to say? I am a Public Health person. I got my master's in public health. I was a health educator for a little while. My first job was working for the Lame Deer Reservation in Montana, and I've spent most of my life as a ... before I came into this national work … as a rabble-rouser doing very basic community development. Working with teen parents, teen moms, building strengths with teen moms in the city of Flint, I worked in the schools there. We built health clinics for teens. So I come from a real... back in the old days, when I was doing what I call "the real work," which was the on-the-ground, really fun work in communities, before I took this sort of work. That's where I kind of come from.

Chairman Sanders: [Session 5 - 02:26:33] Thanks. Actually I'll be very brief. I think that what I have as a background that may be unique in contributing to this, although I've shared

with some on the panel, is having been a child welfare director in … particularly in a large jurisdiction that experienced a large number of child fatalities with a lot of visibility around them. The second biggest media market, a lot of fatalities, so I have experience in some ways that I think is unique, and was a child welfare director for almost 14 years, a number of years. Then the work that we do now through the foundation I work for, with states as well as the public policies. So I think those are areas I have a lot of familiarity in. Child welfare financing, I certainly feel comfortable with IV-E and title XX and so forth. Some sense of federal policy.

I would just say a couple of things to close on that. That I think the experience teaches me that federal policy is only going to be one mechanism for change, and that we really have to think about how policy translates on the ground. I was sitting here thinking that the Adoption and Safe Families Act was 1996, and the time in care has gone down, which is a good thing, but I believe it is still 23 percent of kids are in care for two years or longer. So it certainly hasn't changed practice in a way that is going to provide a measurably different experience for a lot of people who are in care. There's been a recent increase in the number of youths emancipating from care. Just some concerns about how federal policy translates into on-the-ground practice. I think we need to think that through. That was part of the reason for some of my questions to Reggie, as well as yesterday, is, "How do you actually do that?" And I'm not sure that at this point there's an effective mechanism for doing it across the country, and even within states I think it's a real challenge. I just think we just need to keep thinking about that.

Commissioner Dreyfus: [Session 5 - 02:28:39] So to share one of the things that I thought about when I was listening to you talk about plain talking and communication is, from my experience of having been responsible for child welfare in two different states, I will tell you that I think as a country we have what we believe we know about abuse and neglect of children, and then what really is the reality inside the system. So I go into this having had a bird's eye view of who really are the kids and families in the child welfare system, and it's not what was my Aunt Kate's child welfare system back in the 60's when she was a foster parent in Columbus, Ohio. I don't think there's been, I don't think our policymakers have kept up with the complexity and who really are the kids and families in our system today and what's it really going to take to get this job done.

My background started in county government. I was chief of staff to a county executive, and so my experience is both in a county-operated state of Wisconsin at the county level, as well as in being in an administered state in Washington state. A couple of areas that have been near and dear to my heart is moving the system more to the front end. So more early intervention, in having seen the reform efforts of the market child welfare system when I was child welfare director in Wisconsin, and really figuring out how to make a much deeper investment in getting in earlier and diverting kids from the system when possible for better outcomes.

Another thing I've had a lot of experience in is putting up two different IV-E training systems and two SACWIS systems in two different states. One of my loves is though the cross-system interface. So I found, there was no worse day in my life than coming into work and hearing that a child had died on our watch. I remember one day, it was Memorial Day, I was out in Washington state, took my husband to the airport. I'm driving back and I got a call that a child was in the intensive care unit dying from head trauma from shaking, and I turned my car and I went to the emergency room. I went to the ICU to simply see that baby. And I know that was very troubling to my staff, but there was no worse day for me than when we were, from my perspective, responsible, because ultimately that's where the buck stopped when a child was severely abused or died on our watch. But one of the things I came to learn very quickly, is I could do everything right on the inside, but if I wasn't influencing the other systems around me, Medicaid, health care, education, the other systems around these kids, I wasn't going to be successful. So my leadership got me to really have a much better understanding of this cross-system interface and that this notion of building community capacity, community will, is more than about evidence-based program application.

Lastly I would just say that my work now, working with America's third sector, the nonprofit human serving sector, and you noticed I said human *serving*, not human services, because I'm just passionate about that this sector exist to be more than just providers and programs and services under contract with others, and the larger role we play within community and really bringing that back. So being able to bring the perspective of the folks who are on the ground doing this work day in and day out, either under contract with government or seeing how it translates on the ground. I think it's a unique perspective. I bring that not because I have it personally, but because I now have a network of over 500 organizations nationally with that unique perspective.

Chairman Sanders: [Session 5 - 02:32:50] Actually before you go Judge Martin, Commissioner Bevan is on. Commissioner Bevan.

Commissioner Bevan: [Session 5 - 02:32:59] Yes, I'm on.

Chairman Sanders: [Session 5 - 02:33:00] Go ahead.

Commissioner Bevan: [Session 5 – 02:33:01] I'm sorry I missed it. What are we doing? Are we introducing ourselves? Is that what we are doing?

Chairman Sanders: [Session 5 – 02:33:05] We are talking about specific areas that we can bring to the Commission in our future deliberations.

Commissioner Bevan: [Session 5 - 02:33:16] I'll be brief. I have done post docs and research. I translate research into policy and then of course I've spent 20 years on the Hill. I see both. I can see where the loss of the current laws especially CAPTA, which is my baby and I'm very upset about it, especially on implementation. In terms of some of the things that we

were talking about this morning, about aggravated circumstances and a child who has died and then the issue of the siblings. The disconnect there and the fact that the laws there is the same with CAPTA, so I know the laws really well. I know the funding streams really well, and I know the Hill really well. For example, for Susan that raised the issue, during the briefing with the congressional staffers, when she brought up Medicaid there was no real response. No interest. It wasn't that there's no interest, it's that there is no jurisdiction. The people we were meeting with have no jurisdiction; therefore, they couldn't do anything with it.

So we would have to go to Energy and Commerce or another committee. I know that kind of stuff. And I really do hope that we can consider working in subcommittees so that we can really work with staff and make our contributions a success. I feel the most frustrated about that. Thank you.

Commissioner Dreyfus: [Session 5 - 02:34:59] Cassie this is Susan can I ask you a question because you have this expertise, and I do not. Is there any way that our Commission could say that our report, because it does cut across so many committees of jurisdiction … is there any way for our report to be released and received in that manner? Is there any precedent for that ever to have happened where who we are presenting to is a combined committee of jurisdiction versus this very siloed …

Commissioner Bevan: [Session 5 - 02:35:34] Yeah, sure. You can direct the report to, we are required to address the report to Ways, Means, and Finance, but we're not limited to that. So we could address the report like GAO would do, to several committees of jurisdiction. It doesn't have to be limited to just Ways, Means, and Finance.

Commissioner Covington: [Session 5 - 02:36:04] Susan can I ask you a question. I've been thinking about you a lot in terms of your work with sort of the private sector. Is that how you would define it, the private sector and check the nonprofit? Do you see that there's going to be differences between that and the public sector as we move through this?

Commissioner Dreyfus: [Session 5 - 02:36:22] No, actually I don't. I think what's happening in our country over the last 10 years is the number of nonprofit organizations who are now under contract with their counties or their states and doing this work directly, non-CPS, because CPS is not contracted out anywhere, but all the in-home services, all the out-of-home care services doing these safety assessments in the home. So for instance, Eckerd, who you heard from in Florida, they have a combined caseload in whatever number of states that they are in that is bigger than 14 other states' total caseloads. If you stacked them all up from 1 to 50 states, Eckerd would sit from having a caseload size bigger than 14 other states now. It's not a question of a difference of opinion, it's a difference of experience and a difference of perspective, because there tend to be a lot of these agencies, these multi-human service organizations, so they are looking at this from a housing perspective, from an early childhood development perspective … I think they just bring in a unique perspective. It is never heard of in our country, and something we are very proud of is that the Alliance, with

the American Public Human Services Association and the National Organization of State Associations for Children, who are the state associations for many of these nonprofits that I'm talking about, have come to agreement on a child welfare refinancing proposal that I think speaks a lot to that there is not so much difference. It's just the difference in perspective and experience.

Chairman Sanders: [Session 5 - 02:38:14] Commissioner Martin.

Commissioner Martin: [Session 5 - 02:38:16] Thank you. First of all I say this often and I truly mean it from the depths of my heart, I am truly honored to sit on this Commission with each and every one of you. I've never really had the experience of working with such talented and informative people, and so I really do enjoy it, and I've learned a tremendous amount from the speakers but also from each of you individually.

So of course I'm a judge. I have been the Presiding Judge of the Child Protection Division in Cooke County, which is one of the largest unified court systems in the nation. And we've had the largest caseloads, with L.A. and New York, for a number of years until we started reducing them about a decade ago. So under my tenure, since 2000 when I was appointed. First of all, let me back up. Prior to being a judge, I was a Cooke County public defender and I was in the criminal division. At the time of running for judge, my first election, I was the supervisor of the murder task division [*jump in audio*] the court was … to be honest with you. I kind of knew where it was, but I had never been there. So when I got elected, I assumed I was going to a criminal room. Well unbeknownst to me, I went to a child protection courtroom, and I didn't even know what it was. So I was there for about a year and a half, and then I was transferred to the law division, where I did a lot of medical malpractice cases, legal malpractice cases. And I had a jury out, and my chief called me and said, "Pat, I'm sending you to child protection." Well as I was telling David this morning, in Cooke County, juvenile court was considered like judges' jail. You know like when you did something wrong you went to juvenile court, so I'm thinking, "Son of a beehive. I haven't even been on here long enough to be wrong, and they're sending me back to juvenile court already." So my chief said, "No, I'm sending you back as a presiding judge." Then I said, "Son of a beehive, I've only been on the bench three years, I don't know how to do that." But anyway, so this has truly been a learning experience as I go.

When I was an undergraduate, I went to Middlebury College in Vermont. And we were on a 4-1-4 plan, and the one cloister went to term, and that's why I went there, because I wanted to major in skiing. So I spent one winter semester studying the juvenile court system of Cooke County. My uncle was a judge, and so I wanted to be home for a semester, and he had a friend that was a presiding judge of juvenile court in Cooke County, so I went there and I studied the juvenile court system of Cooke County. Looking back on it, that was the most pathetic example of studying anything. But I ended my paper with what happens to the kids after they leave juvenile court. And when I became presiding judge, that's how I started my tenure. And so I've been very much interested in what happens to my kids when they leave.

So I worked on trying to figure out ways to make the lives of my children better, and so when you talk about ASFA, all of us know that there are three major prongs of the stool for ASFA: safety, permanency, and well-being. But I really do think that we need to talk about a paradigm shift, in that safety cannot be safety without well-being. Permanency cannot be permanency without well-being. Putting a kid in a home and saying, "This is your forever home," and they are not well, is not a good place and a good result for my kids. So the thought is rather than thinking so much in isolation of three different goals, let's talk about it as one goal.

And so in Cooke County, I tell them that I'm not only the judge, I'm the legislature, and I start making up the laws too. So one of the goals in Cooke County is that not one of my children leaves foster care without having an Aunt Kitty. And what I mean by that is a loving adult. And I don't care if it's a drunk uncle, doesn't really have to be a placement, but it has to be someone who calls my kid and says, Happy Birthday, Merry Christmas, calls my kid and says, "What are you doing for summer vacation?" And so what I'm interested in is talking about permanency, safety, and well-being for all of my kids, but especially for my older kids. I need them to do like our families do. No one's family is perfect, and neither is mine. When I was growing up … My mother is from Mississippi, and we would go to Mississippi for family reunions, and from Chicago to Mississippi we were told not to be with Uncle Bubba by ourselves. Right? He's still running moonshine. So the thought is that my parents tried to protect me by teaching me how to protect myself. And that's why, if I've learned one thing, and that is that the state is not necessarily a good parent for my children. And so the thought is if it's humanly possible to keep my children with the family, but help my children learn how to navigate their family when necessary. So what that translates to me is when mom has a drug problem and I can't cure it in 12 months, help my child to understand that when mom's okay that's a good influence. But when mom's not okay, grandma is the person that you rely on to get to school and get dinner.

So let me just go through a couple things of what I think I know, and the first one is that I am no longer interested in pretending to families and children that I know what's best for them. I am tired of looking at programs and saying, well it makes me feel like I'm doing something good so it must be good. I am now in the business of trying to understand what is good for families and children and figuring out how to help them get what is good for them. I guess the thing that you should know is that I've done a lot of judiciary training through the National Council of Juvenile and Family Court Judges, as well as the Supreme Court of Illinois. Most of it has been done on the overrepresentation of minorities in foster care, and biases that judges and the judiciary have on deciding cases, and the issue of older youths and permanency for youth.

I have been involved in changing Supreme Court rules. I've been involved in helping the legislature understand the outcomes and implications of some of their laws. I am very much interested in making certain that everyone realizes no matter how long or how good my

child's experiences in foster care, they still experience trauma. And even when we have a good outcome, we need to address the trauma issues that our children experience. I am also very much interested in understanding and helping child protection systems understand this whole issue of sex trafficking. You will not believe, but that's just now an issue coming to the forefront in our courtrooms, and so many of our children are involved with sex trafficking that we don't even recognize. So that is a big issue for me, and the last thing I am also interested in is immigration. My children coming across borders without parents and what that means for them. What we can do from this moment forward. I am not interested in penalizing anyone for coming over. I'm interested in the future of my children here as they are now. So those are some of my passions. I'm not sure I'm an expert in anything but those are the things I work on.

Commissioner Ayoub: [Session 5 - 02:45:48] Judge Martin you reminded me of the importance of hearing from law enforcement and training law enforcement. There are so many things that happen that they are not looking at, or the way that they approach people. When kids are getting in trouble, a juvenile home I was in, in juvi … I spent a semester and a summer in my sophomore year and another semester and summer in junior year in detention centers, "group homes" if you wish. I was detained. We're acting out. Why aren't they looking at what we're acting out from? I see even the bullying problem. Are they asking those kids what's happening to them in their home? Certainly when an 11-, 12-, 13-year-old girl is being labeled promiscuous, is anybody looking at why that is.

If somebody is going from getting straight A's to getting F's is there anybody asking what that is, instead of just detaining them and putting them away. With these families recently in Nevada, our Attorney General help desk convened a very small group in Las Vegas and a small group in Reno of survivors. And we asked and got a traumatologist to facilitate that. And it was amazing the things that we were able to come up with as recommendations because we were in that safe environment and got out of the trauma victim part of it. And even out of the anger part of it, enough to say, what we experienced from law enforcement, from the child welfare, all the different areas. We were all from a variety of different situations and what recommendations. So thank you for what you're doing and for acknowledging that, and I hope that law enforcement is included a lot in those conversations.

Chairman Sanders: [Session 5 - 02:47:55] Commissioner Petit.

Commissioner Petit: [Session 5 - 02:48:00] I am in decade six of being a community organizer. President Obama and I have that in common, plus, I think I have a better jump shot than he does. The similarities end there. I am a big believer in community organizing. When I first learned about it, I was in social work school at a settlement house in North Chester in Boston. And to get into a settlement house, which was meant to be as friendly a vehicle as there is for the citizenry, you had to press an electronic button. Someone would come to the door and open to see who you were, and then they might or might not let you in.

It was an area where an 86-year-old secretary to the settlement house was hit in back of the head with a brick as she was walking up her sidewalk coming home from church. It was an area where the executive director of the settlement house went to Cape Cod for the weekend, and when he came back his entire house was empty, including the plumbing and the radiators were all gone. Stolen.

It was a place where the first two weeks I was on the job, at the metro stop that I went to, a young man was shot and killed because he stepped on somebody's shoe as he was walking through a crowd and he didn't apologize in an appropriate enough kind of way.

So I had to carve out a project for myself. The project that I carved out was going door to door asking people what they needed. What I learned was that this was a transitional neighborhood and most people were afraid to leave their homes.

One of the biggest reasons, beyond their public safety, was there were so many drug addicts and alcoholics in the area that they were fearful that their houses would be burned down, all of them in red-lined districts. Not one person had insurance. And I met one young gentlemen who he and his German Sheppard [*inaudible*] punch walls on either side of his three tenement flat in which his flat had 35 people living it. The three floors, including about 25 children. The other two were empty, and the guy quit his job and spent all of his time in a rocking chair looking to see if the two places were going to catch fire.

So when I convened a meeting in the middle of March in which the settlement house said, "No one is ever going to show up in the evening in the middle of March, it is cold and it's wet" and over 100 people showed up. And the purpose of the meeting was to discuss how to get these houses torn down. The ones that were vacant, and the ones that were danger fire traps to them all. We said, "Okay, let's go to city hall and find out if we can do something," and I went to the Department of Housing and said, "Listen we have a problem here. We would like these things torn down" and I said, "Can I see somebody?" And the person that I saw was the assistant secretary. Not like "Commissioner Secretary" but the scribe secretary. And she said, oh, no, we don't have anything for you. And I thought that's a terrible thing, I guess we just can't do very much. And I was walking out of the place ready to leave. I went past the City Council Chambers in Boston, and I saw this guy give a really strong speech about something, and at the end of it I asked him who he was and it turned out he was the Representative for the City Council serving North Chester.

When I told him what I had, he was immediately interested in all these houses being torn down. And he said, "Well, what do you want to do about it?" I said, "Well I was hoping that the Department of Housing would tear it down, but the secretary said that they are too busy and they don't have any money and they can't do anything." And he said, "Well, let's go back upstairs again." And at that point we breezed past the secretary, went to the door where the secretary, the Commissioner of the Department was, and he said, "Jim, I want to talk to you about something."

At that point what I learned was always go to the front door. Always go to the top of the pile and don't stop at all. And I saw that this politician and this housing director convened a meeting with us and Mayor Kevin White, who was the mayor of Boston at the time, and we went in with about 30 citizens and said, we want 35 houses torn down, and the mayor took me aside when it was all over and he said, "Listen you've learned a good lesson early on." He said, "The squeaky wheel gets the grease." He said, "That's the only reason why I'm responding. There's 5,000 houses in this city that need to be torn down, and we're going to tear down those 30 because you guys are here making an issue of it. You've got the boss involved with you; you've got radio, television stations with you. We're going to give you the money. By the way," he says, "if you can find a black and white deconstruction crew that will take down houses jointly I'll give you money for a hundred more." And he was betting that we wouldn't find them, and he was absolutely right. There was such a deep division there on this...I learned an important lesson.

Now fast forward to the current situation. That community organization model is exactly to me, what we applied when this coalition, this Commission itself, with the legislature. I mean we're the Congress and I have this five-part thing, I'm not going to get into it, but I'll just say the whole issue of data driving issues is what we started with in terms of child abuse and deaths in America. We actually put the numbers on the table, said it was grossly understated, and then it led to the next step, which was to create a forum where you can actually move information around, and we had a national forum on child abuse deaths in 2009 or something like that, and Teri was part of this the whole time.

We created a coalition that included us, the district attorneys, Teri's operation, NASW, and somebody else. We worked the media, which we generated a lot of it in terms of what was this issue surrounding it. Then we reduced the whole thing to yes or no political proposition. And that in my mind is a formula for moving issues from Point A to Point B, which I am especially interested in is creating system changes, because that's where the resources are in terms of winning budgets. In terms of winning the law. It's these governmental bodies called democracy, called what we have at the local, state, and federal level, that it's all about changing their mind or changing them. So for me, I've outlined these five little steps, is where I'm expecting this Commission to go myself, as you see what I just kind of laid out there. Data, forums, coalition, media, yes or no political proposition. When this Commission makes its report, it's going to be talking about yes or no propositions, much of it, which will be political. Just in terms of a political piece on this thing, I now run an organization called Every Child Matters. It is a political organization. It is a 501(c)3 that goes as far as the law allows in saying to the members, to people running for Congress, that you need to be strong on kids' issues.

To the extent that they disagree with that politely or not, we have a 501(c)4 and a PAC. And that PAC is what allows us to jump directly into races and say yes or no. This person is good. This person is bad based on their position on children's issues. So we are not doing that here,

that's a different matter. But the point is that kind of process is what creates vehicles like this, which in this particular case is a stepping stone because we could have gone to the Congress with a bill years ago with a lot of people saying, this is what needs to happen. No traction for it. This time we had...you all know. We had a 330 to 77 vote in the House and a 100 to nothing vote in the U.S. Senate. Thanks to people like Deidra and others, but we worked that process and now we have this kind of view.

So the piece to me is the whole issue of systems. It's the whole question of safety nets. It's the whole question of how resources and democracy get distributed. We know that kids and families are desperately in need of human investments. They are lagging behind the other rich western countries. It's not just a function of straightening out their personal behavior; it really is a function of what our culture values most importantly. And I know that they actually value children, we just haven't had the platforms and voices and the resources to project that as strong as possible. So for me, the whole game is political, and how do we make choices about what's valuable to us and what's not, and I'm going to keep doing it as long as I can go trout fishing whenever I need to rejuvenate myself. That's it. Thanks.

Chairman Sanders: [Session 5 - 02:56:22] Commissioner Rodriguez.

Commissioner Rodriguez: [Session 5 - 02:56:26] So I feel like I'm still very much learning about both the history of how this Commission was created and how we got to this point and the past recommendations that have been made and issues like the child fatality teams and their structure and how they function and the data collection and measurement. So all of those things I'm in learning mode on. Where I think I feel the charge of this Commission really deeply and this early is that my own experience was of probably being one of the red-button cases.

Part of the reason I think that I reject sort of, "it's not just the child welfare system" issue, it's that I feel a real deep obligation to that one third of the cases where they *are* known to the child welfare system because in my own life, I grew up, I was born to a mom who was very mentally disabled, paranoid schizophrenic with her paranoia directed at me. CPS was involved in our case since birth, and over my childhood I experienced my mother threatening to kill me and attacking me in front of psychiatric hospital staff. At my school she broke my collarbone, at my school when I was in second grade, in front of teachers and the principal. And I experienced a complete lack of action from anybody else in the community who just didn't feel like our family situation was their business. The only person at all that I felt had any power whatsoever was that social worker. Various social workers who periodically would come into my home, remove me, take me away to foster care and then break my heart when they returned me back.

So that happened across my entire childhood, and when I was 10 years old it suddenly occurred to me that the door to my house was not locked and that I could leave. And I did. So at 10 I ran away. And ended up being sexually exploited for the next two years on the streets,

and when I tell people that story they always focus in on how horrific that must have been, being a 10-year-old on the street, and I often tell people that actually I remember that time in my life being the most peaceful, because I had the complete relief that knowing my mom wasn't going to actually kill me.

So that is sort of the orientation that I come into this work with. And many of the policies and practices that are discussed, I find myself in my mind sort of comparing against the reality of what happened in my own case and what happened in many of the other cases of young people that I've worked with over the years, and hearing where the disconnect is. Like it would be nice if in a perfect world, but the reality being, this is not the way that people function and relate to many children. They don't actually...I don't think they saw me as their child, and I don't think they see many of our kids as their kids, and they don't take that sort of personal responsibility.

So I'll say first and foremost sort of on this Commission I feel a real deep responsibility to that group of children who I imagine, like me, feels like that worker and the police officer who comes in and removes them may save them from the situation, and then when we fail them and return them back time in and time out, and now I know being older and wiser that there was a judge involved in that equation too, and so I didn't know that at the time.

The second group of children that I think I feel a real deep obligation to, well two groups, sort of based on my own experience is … I actually disagree with you. I think that sexually exploited young people, they are a topic of this Commission, particularly when we have young people who are in governmental care. I think that system abuse and neglect is real, even though it's not apparent, and I think there's probably an opportunity on this Commission to elevate that issue. I know we work day in and day out in my day job as a lawyer and executive director of the Youth Law Center, we deal a lot with institutional care issues, and my own experience is that the exploitation did not stop.

When I entered foster care, and in fact I lived in several group homes where I was exploited out of the home and still see that issue coming up on a day-to-day basis. We've worked in several states on issues around youth who have died in group care. Either some of these sort of boot camp-run facilities for young people who are in the juvenile justice system, who are put under really strenuous conditions or they don't get the medical care that they need. Then we also deal with suicide issues. And in some ways, I feel that those are more egregious deaths that are due to abuse and neglect because our system is actually made a charge to protect those children and to parent them and to keep them safe from harm, and so while I realize that they are a very small population, and they are sort of dropped among those numbers of the already small population that we're talking about. I really do feel like we have an elevated responsibility and obligation to that group of young people.

The third group of sort of children that I think I feel a particular responsibility to, you probably already guessed, and that's that I am now a mother myself, and I have had to

relearn and learn for the first time so many things about parenting based on sort of undoing what the system trained me to do as a parent. And so I feel a real deep obligation to those children and to those parents who grew up under the care of our system, where we failed them by giving them inadequate parenting. You all heard the young woman who came and testified in Tampa, who shared her sort of … she was the voice for those young people that she felt like were living in group care where they were not getting parented at all. They were getting supervised and they're getting cared for, but in terms of having...they do not have an Aunt Kitty. They do not have a mother who is mothering them in the way that they are going to be expected to mother their child. So they are really growing up with no model and although sort of... I know we are only dabbling or we're considering what our role is around preventive services, that is a group of young people that I feel like we really owe a responsibility to think carefully and deeply about what kind of preventive services we can offer them, because I don't think the research base is fully established but I know that what's been done shows that a majority of those, what happens to us when we grow up, we almost all become parents. Most of us become parents very young. The research at this point is showing that the majority of us end up involved in the CPS system with a report against us. So I feel like we have control over that group of parents. We have much of that in our hands. So that's sort of the third group of folks that I feel a particular responsibility to keep in mind as we're doing the work of this Commission.

Professionally as I said, I'm a lawyer. I'm the executive director of the Youth Law Center. Most of my career has been dedicated to working on system change in the child welfare system, and I think specifically around trying to make the child welfare system really be responsive to and rearrange itself rather than being an adult-oriented system that works around the conveniences of all of the adult players to being a system that really focuses first and foremost on the needs of the child, and whether that means blowing it up and sort of restructuring it, then that's what we recommend.

The first legislative bill I've ever had the opportunity to work on was actually back in 1999, when I was a youth organizer for the California Youth Connection, our state's foster youth advocacy group. We got to do the... I think it actually ended up being the nation's first foster care bill of rights, and then similarly got the opportunity to do the legislation that created our state's Child Welfare Ombudsman Office that handles complaints and concerns about our child welfare system. Because of that, I actually had the chance to set up that office and was the first staff person for that office. So the office then spent seven or eight years as one of... I had like the Jamaican temp job thing going on all through college, but I spent a lot of time both receiving and helping to investigate complaints about our child welfare system. So hearing from relatives. Hearing from social workers. Hearing from youth. Hearing from birth families—sort of all the different perspectives on where the system breaks down and how things go wrong, which is really invaluable because it meant that I walked into my career with a number of different perspectives on sort of where people... Growing up in the system, you tend to only see things one way, and so that was a wonderful experience.

My work at the Youth Law Center, I've been there now for the past seven years. I measure it by the birth of my daughter, who creepily looks exactly like the baby that you had on the slide. It's been bothering me ever since it was up there. Since there the projects that I've really been focused on are improving child welfare services and systems as they deal with babies and toddlers who are in foster care. So that's everything from early response and the way systems respond—we partnered with Cassie and did a lot of training, including in Washington, to really be thinking about what does the research say? What does the neuroscience research say? What does the child development research say, and how can we translate that down into practice—and so I think that is certainly relevant on this Commission.

Another big piece of the work that I do at the Youth Law Center is around improving quality of care. We operate an initiative called the Quality Parenting Initiative. We are in almost all of the CBCs in Florida. A good majority of the counties in California and Texas and Nevada and Philadelphia, and that initiative is focused in on making sure that once we do remove a child that they come into a system that actually has the capacity to provide them that excellent parenting. So we are working with a variety of both public child welfare agencies and private partners on figuring out how we get our system there. And as a result of working on that, I have thought a lot about the role of our resource parents or our foster parents, in both working with birth parents on monitoring and doing some of the surveillance to make sure kids in their care are okay, and on becoming sort of the informal support net for the families when children are reunified. To make sure that once our system steps out of those children's lives that they still have a support system, a presence, and there is still sort of somebody who can give a red flag if and when often times things don't go smoothly in the lives of those children.

Then obviously another area that we've done some work on is around teen parenting for both young people who are in the child welfare and the juvenile justice system. I already talked about that; I don't want to talk about that much more. But I would say the last area is sort of not substantively but procedurally that I might be able to be helpful with on this Commission is that I did spend 10 years of my career working directly with young people, and I've extended that to working with families as well, to help them think through their own experiences and translate those into stories that policymakers can understand, that the public can understand, and to help them to prepare to support them through that process, and I agree that when we get to that stage where we have recommendations that we need to move forward, I think a big part of what we need to do is to help people create the narrative for this Commission and help them understand that we're actually talking about children's lives and families, and then that's why there has to be the political will and the resources allocated to the recommendations we make.

So it's actually not really a lawyerly thing to do, and it's one of my favorite things to do still is to sit down with a young person who has a story or a birth parent who has a story and help them translate that story into something that they will walk away with feeling like, this happened to me, I can't do anything about that; however, I may have just potentially

changed the trajectory of many other children who are in my situation. I think that's a really empowering experience, so I'm happy to help with that.

Commissioner Ayoub: [Session 5 - 03:09:46] Jennifer, I was talking about making sure that the message sent is a message received, and I think for you to say you disagree, I wasn't clear because we agree. I believe it belongs here. I just believe that some people didn't think that it belonged here. I totally feel it belongs here. One of the things that the group I'm working with in Nevada is trying to make sure when they say...Chairman Sanders mentioned that there was just a law passed that said it does belong. It does belong in the child welfare system.

Commissioner Rodriguez: [Session 5 - 03:10:29] Not yet. We're almost there.

Chairman Sanders: [Session 5 - 03:10:31] It passed.

Commissioner Ayoub: [Session 5 - 03:10:43] But to make sure that it doesn't... that the victims aren't treated the same way as the system is already treating people, that we're finding these solutions. Do you know what I mean? That it doesn't get into the same system that we're trying to fix now too. I do agree. Did you work on that a lot?

Commissioner Rodriguez: [Session 5 - 03:11:07] Absolutely. Yes, and a big piece of that I think is making sure those are actually right back to the parenting piece. Those are young people who are going to be parents and this current system approach is actually to institutionalize them and to put the "trafficked" label on them. Those young people desperately need, they need us. They need somebody who loves them unconditionally and is going to teach them how to respond to their child. So totally great.

Commissioner Ayoub: [Session 5 - 03:11:30] Thank you. And thanks for sharing your story.

Commissioner Rubin: [Session 5 - 03:11:37] So my background, I guess you guys figured out I'm a pediatrician. I went to medical school at UCSF in San Francisco, where it's hard to leave that place without a vision for a future in health care that's related to population health and thinking about communities. I'm currently an associate director at the Penn site for the RWJ Clinical Scholars Program. There's a lot of physicians after their training who believe deeply in that population health model and their section with community. It's a terrific program, but we have a joke in that program that says, most of the folks in that program have one or two degrees of separation from UCSF.

So I went to do my residency training at the Children's Hospital in Philadelphia. To this day I believe it is the best children's hospital in the world. There I saw people from all walks of life. We have 400,000 kids who cross our threshold every year. 400,000 children cross the threshold to the Children's Hospital in Philadelphia every year. Half of those kids are in our primary care network. Where they have more 35 practices, from our primary care practices which are 90 percent Medicaid to our suburban practices, where my wife worked and I met

my wife in residency, that are more heavily skewed toward folks with commercial insurance, employed.

I myself work in a practice that has about a 30 to 35 percent Medicaid penetration rate, so on any given day I can see a grandmother raising her grandchild in poverty to a university professor's kid, and I enjoy that diversity and it's not so easy to predict, which families have the better coping skills in that situation.

So after residency, I actually decided because of that interest and the challenges that some of the families were going through that child abuse pediatrics was a good way to start to think about the population health model because you can think about those kids and how high risk those kids are in the child welfare system. You really begin to elaborate a population health model for kids with complex medical conditions as well too or other children in communities with behavioral health issues, etc. I have personal case experience in terms of diagnosing child abuse to what I still do today, and I think it's really important. You find me on Wednesdays in practice with families and getting that anecdotal experience, which I agree Commissioner Ayoub is so important to not be too far, so I really resonated with the Secretary earlier who was able to still retain that level of direct experience with those stories.

As I began my faculty tenure at Penn and CHOP, I decided that in the same way, although I was kind of a lone wolf a little bit, doing the stuff around the child welfare system the same way my infectious disease colleagues were thinking about how to treat an infection, I was thinking well what's the treatment arm for the kids I care about? Well it's what we do to them after we diagnose them and identify them. So it was hard not to get more involved and crawl in the window into the child welfare system, then the behavioral health system and the judicial system and the school system, etc., and it became larger and larger, and what I discovered which was real important and I talk about this is, is that the challenge we face is enormous. In particular for the kids we talk about on this Commission, but there's also a failure...there's a potential danger of overreaching. And a lot of the work that I've done has been to tell the stories about kinship care through data and to really think about how research could inform direct clinical practice or programs and policies for children. Some of our data illustrating some of the benefits in kinship care was very useful at the time of Fostering Connections was passed.

More recent work: Looking at the misuse of psychiatric medications in the Medicaid program, particularly for children in foster care, I think has been illuminating, and behind that sits, I think, some of the fundamental issues about lack of relationship and social isolation. And the potential risk of those youth growing up without proper trauma-informed treatment and then becoming parents themselves. So as I went along doing a lot of this work and interception work in particular in the city of Philadelphia in the state of Pennsylvania, eventually up to the Children's Bureau, the hospital asked me to take on with my co-director Kathleen Noonan, who's a lawyer, to develop a center for the hospital that really focused on how research could be more engaged to help practitioners, whether it be people in the hospital or clinic to

policymakers or nonprofit program directors, make smart informed choices based on the best research. We take that mission deeply. We have a very interdisciplinary team at the PolicyLab that includes folks like lawyers, to public policy folks, to social workers and psychologists. Folks with deeply embedded experience, and we value that our direct care of children actually informs this approach to really highly engage. Never get too far away from just practical commonsense of the stories themselves.

In terms of some of the work that I've just talked about, the center has allowed me to take a much more visible role in population health as it relates to health care reform. That's why you hear me talking a lot about Medicaid. There are opportunities happening in the implementation of the Affordable Care Act for which our Commission directly overlaps, and we should take advantage of those things. Those are not appropriations. Those are the implementation of the law. I wouldn't expect folks on the Commission to be very well versed on whether that's the Health Information Exchanges or the Calling Measure Program. My hope is that I can provide some value to thinking beyond just the child protective services system about other programs, like Medicaid in particular, but also other programs.

I think we all share that sort of vision of what is the community response? What is the larger child welfare system? So we were asked, as we became more well known for evaluative research, to start evaluating home visiting programs after replication, and the experiences have been mixed to be honest. I believe fundamentally that trial evidence demonstrates there's a value for home visiting services in this country to help folks at a community level. I believe they are struggling on the ground as they replicate. And that story, people are afraid to tell that story because they are afraid of endangering funding for these programs, but in that story, like the one I told this morning about a child dying of abusive head trauma in a home visiting program. Therein lies, I think, our responsibility to help support communities that want to connect the dots, and how do we do that through a matter of policy at the state and federal level? To help support these programs as we make investments and create what I call the "quilt" with very tight threads, that there are enough touch points for kids that they are not going to slip through the cracks. I'm not saying here that we have to solve poverty, but I think there are simple things that we can do, whether from a regulatory or a restructuring of the way we fund. We currently use appropriations to help incentivize and support the efforts of local communities to do the right thing for kids, and so I come here representing them.

Finally, we were asked to, and received a grant from the Department of Defense to actually begin looking at child abuse and violence in the military. It was germane in yesterday's conversation; that was the last thing I want to talk about. As I've gotten deeper into the reporting of child abuse events to family advocacy authorities in the military, I started questioning how deep do we want to go on the military, and I was struck by El Paso's presentation yesterday that when their child abuse deaths are the highest, disproportionately almost all of them were among military families. So there will be a point where we have emerging data that will be coming out since the peer review demonstrating the elevation of

risk during periods of postdeployment as soldiers return home from war that should help guide a conversation about deployment in a more standardized way of the resources to help prepare largely the men who are returning from war to reintegrate in the family sometimes with young infants.

As well I think we are also discovering that there's potential loss of information. The Military Family Advocacy Program is supposed to know about every case of child abuse within the military. There is huge reason to believe that that's not happening officially on many of our bases. Some of these kids may be reported to civilian authorities, but civilian authorities are supposed to let family advocacy authorities on the base know about it so that they can deploy, which often are much better resources than are available in the general community. That is one thing that Jill Nugin said to me after I pulled her aside after. I think after hearing El Paso's testimony, I think we should land the military question because the elevated risk in the military and the concerns about PTSD and understanding child abuse fatality in the military should be something we start to dwell into. Thanks.

Commissioner Dreyfus: [Session 5 - 03:21:57] Commissioner can I ask you a question? Because this is something I just don't have the expertise on this. I've heard a couple of things on the Commission. I've heard us say, "We should only be following the evidence." That we should only be recommending things that have clear research sitting behind them. Then I've heard people say, as we heard yesterday, "There's not anything close to the amount of research needed in child welfare to really have all the evidence that we need." I thought it was amazing what they say, $3,000 per case on fibromyalgia, $200 per case in child welfare being committed to research. Then I heard Director Bicha today talk about the need for states to be able to innovate. So I've heard us say things like, "No, we're not going to talk about promising practices; only if they've been validated and researched." And this is something as a Commission, where are we going to be on that? So I don't want you to answer the question today, I just want to put it on the table and I think you're just an expert for us in helping us think about that.

Commissioner Rubin: [Session 5 - 03:23:01] And also understand the limitations of research. Some people think I'm going to be here and telling, go research, research, research. I also understand the limitations of that research, and I also understand the limitations of evaluating home visitation programs without a trial, just like Dr. Olds said yesterday. It's not the same, and you have to be careful not to overreach with data, and I think that I'm looking forward to discussion about what the data does and it does not tell because there's very limited data on actual programs that prevent child abuse fatality, because it's such a rare outcome. There are programs that people can inform us that have pretty good evidence that, once the kid is in the child welfare system, reduce recidivism to the system. There's been some promising evidence, but I wouldn't call strong evidence, about child abuse and prevention from home visiting programs, although they do a lot of great things. The U.S. Preventive Task Force acknowledges that there's insufficient evidence to make a recommendation on child abuse and prevention from those programs. But we should

acknowledge that a lot of these programs whether or not real time on strategies in terms of funding or appropriations for programs. I think we can all acknowledge these programs are growing and largely exist in our communities and are part of that community fabric and the degree that we start to stitch things together there are all a part of the solution to creating practical, common-sense solutions to help kids and their families.

Chairman Sanders: [Session 5 - 03:24:30] So thanks to everybody. A lot of information here. We're going to take a break for 30 minutes. We'll reconvene at 12:55 in open session. We will reconvene into executive session during our break now.

Commissioner Petit: [Session 5 - 03:24:49] I'm going to be leaving at 1:00 to the airport in time to get back to Washington tonight. The question of work plan and task and all that kind of stuff. Even if we were here today until 3:00, 4:00, 5:00, I don't think we'd finish what needs to be done there. I think this exercise that we did was very useful. But I'm hoping that when we do … Vermont is when the next time we are actually going to be together. That we can devote an entire day just to what we need to gather. Unless that's what you're going to try to do this afternoon, and then we'll have an opportunity to look at that. I think there's a whole series of things that I have questions about in terms of additional information. How this stuff is going to be put together and what we're looking at and where do we introduce reports, studies, and all that kind of stuff. When does the review of the work plan and the modification will take place?

Chairman Sanders: [Session 5 - 03:25:41] We will start it this afternoon. We can continue in Vermont.

Commissioner Petit: [Session 5 - 03:25:43] The meeting doesn't start until 2:30, right? It's just going to be a start but it's going to be....?

Chairman Sanders: [Session 5 - 03:25:47] Just given what we heard, this isn't going to be a two-meeting discussion. Just on an ongoing basis, we'll have to continue in Vermont.

Commissioner Petit: [Session 5 - 03:25:51] One of the things I'm concerned about is that there is information that I'd like to see us get from the states. We need to begin that collection process fairly soon, and I think what we need to do is agree what is it that we're asking them to produce, then create an instrument and fielding that.

Chairman Sanders: [Session 5 - 03:26:19] Yep. All right. So we will reconvene at about 12:55 in open session. Thanks.

Commissioner Covington: [Session 6 - 00:00:01] …and seek staff help and direct the staff with what we would want from them, additional information or whatever it is we need from them, and have them help us crystallize the work. They are going to have to do a lot of the groundwork on this. I think they have already started doing a lot of the groundwork in a lot of these areas. We then bring it back to the Commission when we feel it is ready or near ready for some real action from the Commission. That is my recommendation.

Commissioner Rubin: [Session 6 - 00:00:30] If you follow that, then I think in that work that needs to be subdivided, were those thematic areas? I think that would help us. So for example, you already raised the one that was obvious, which was counting.

Commissioner Dreyfus: [Session 6 - 00:00:45] Yes, measurement. That is a big one. Just listening this week and for the last couple of days there were major things, I think, that came out; practice innovations and the whole funding strategies. I am just throwing these things out, but they may not exactly be where we want to go.

Chairman Sanders: [Session 6 - 00:01:04] I actually had some thought about that, which I think would help capture what we talked about today as well as some of the major themes, and aligning with the legislation. I do think your offer to look at measurement would be helpful. There has been a lot of thinking about this, and we have now heard a lot, so organizing that and getting to a point where we are clear on what the scope is and what we are counting, I think, is vital. I think that would be helpful as a major step.

Commissioner Dreyfus: [Session 6 - 00:01:34] David, could you add to measurement before you go on to the other? Just measurement. I think the other thing that we've heard is the clarification we need to have of who ultimately is responsible for making that determination, right? So I appreciate the measurement, but I just hope that piece comes into the conversation about medical examiners and training.

Chairman Sanders: [Session 6 - 00:01:58] I think that is one way. There is some imminence. I think the issue of current policy, expenditures, costs, and what, if anything, we know about it that is important. Anything we know about the results. We've heard a lot about the need for more resources. We heard it a lot yesterday, but do we have anything that points to where you invest that actually results in improvement in any of the measures that we have. I know that is something staff has looked at, I know that is an issue that Cassie has raised. I think we need to stay really focused on that, and I think that would be something to have us take a look at. I think Medicaid is clear, and beyond that, since Medicaid is such a large funding source and because of everything under the Affordable Care Act, I think we need to get some more specifics about that. I think on the work around Indian child welfare, we need to be caught up on that. We heard about the "red button" child protection system, of that 1/3 of fatality cases in the child protection system that are known. I think we need to look at what we want to do there. Then the last piece, and this is a lot but I think these are critical areas, is the engagement, and what Amy raised about how do we talk about what we are

doing in a way that will resonate with people? How do we do more of that? I think that is a critical thing. So those were just things that I thought would be…it depends on how much time you guys want to spend.

Commissioner Covington: [Session 6 - 00:03:44] Well there is a big, huge one that I think resonated hugely yesterday, which is that broader "way up stream" approach, and where do we want to go in terms of community?

Chairman Sanders: [Session 6 - 00:03:51] Let me back up, I should have been clear. I was seeing the Medicaid as a step towards that.

Commissioner Rubin: [Session 6 - 00:04:00] I think Medicaid is an area of its own. I think community-based strengthening of community connections, because I think we have to be careful. Like I said, there are a lot of programs that are going to want to sort of appropriate: "Let's expand these programs." I feel like that is not our fight, as much as it is connecting these programs and strengthening them to be able to do their job locally. So that will raise on that one the question of how do you do that? What are the levers by which you do that? But also the other program, Medicaid, deserves its own special time. We have to talk about child care. We know how a lot of these kids are dying, because of the lack of appropriate child care, right? And so we have to think about where does that fit, if at all. Then the home visiting infrastructure, and I think it is going to fall into that group.

Commissioner Dreyfus: [Session 6 - 00:04:54] The one that I think should be there, and again, Commissioner Covington, this is your expertise, but I think very clearly it is these multidisciplinary reviews and the closing of the loop from recommendations to action, the strength of those, the consistency of those, and the requirements of those. But to what end? That is to the continuous improvement and accountability, and those multidisciplinary reviews don't just impact CPS, but have a multidisciplinary influence. I just hope that doesn't get lost.

Then the one other piece to me is, and again you guys might be surprised to hear me say this because I've been long saying it, we have got to understand about the welfare of America's kids and this larger, shared responsibility. I know I keep framing it in a public health frame, and I appreciate that means different things to different people, but from my public sector work that is how I think about it. Then I think about this little sliver of CPS and that it is not the whole child welfare system in its entirety. It is but a piece. It has accountability. It has a role and a function, but it is not the entire child welfare system. I do think that piece needs focus.

Commissioner Covington: [Session 6 - 00:06:13] That's why I like the idea of the focus on the "red button" cases too.

Commissioner Dreyfus: [Session 6 - 00:06:17] But just to Reggie's earlier conversation about just the quality of the CPS system as part of this larger child welfare. That is a piece of CPS, but I wouldn't want that to be the only focus.

Commissioner Ayoub: [Session 6 - 00:06:26] Does "red button" mean the most dangerous?

Commissioner Covington: [Session 6 - 00:06:31] Kids in imminent danger. The alarm sounds.

Commissioner Martin: [Session 6 - 00:06:35] I look at the distinction as the "red button" issues are the issues that Dave and Mike talked about—cases where kids are known to the CPS system or known to other systems, but we don't really take the next step and follow through. What do we do with those cases, and how should we attempt to follow through and work through those cases? And I think what Susan is talking about is the fact that there are issues within CPS that we need to recommend that they be strengthened. In other words, one of the things we talked about, for example, was whether or not hotline responders or recipients are actually trained and have ongoing training, whether or not we put CPS new workers in the field to get training, as opposed to just six weeks of in-class training. So some of the things that Reggie talked about today. Is that the distinction that people are seeing?

No one is saying anything. Yes? No?

Commissioner Dreyfus: [Session 6 - 00:07:29] Yes.

Commissioner Covington: [Session 6 - 00:07:30] Yes.

Commissioner Dreyfus: [Session 6 - 00:07:37] The only one left on my list was just courts, and clearly this whole civil and criminal, and not just the child welfare court but the courts in general on this issue of fatalities. We just haven't really done a lot there.

Commissioner Rubin: [Session 6 - 00:07:55] The other one I think we have to decide is I raised the issue of the military. I think with all the interest in the military, I think it would be hard not to look at the military with respect to this issue.

Commissioner Martin: [Session 6 - 00:08:05] Particularly since we started another war last night. Do you see the military as being its own piece?

Commissioner Covington: [Session 6- 00:08:08] Do you see the military as being its own piece?

Commissioner Rubin: [Session 6 - 00:08:26] I do. I think it deserves its own attention, much in the same way the Indian Health Service does. It is a very unique system, and I think we have to think about it differently in that context.

Commissioner Covington: [Session 6 - 00:08:41] Well, I think they could benefit from some recommendations related to information-sharing. I know that for a fact, from their end.

Commissioner Rubin: [Session 6 - 00:08:48] We might think about whether there is value there, and folks who deeply understand the military and who are trying to help someone identify those who could help us think about who would be best able to help us within that structure.

Commissioner Martin: [Session 6 - 00:09:03] I think every one of the ideas that just came out are fabulous, but I also look at the number of Commissioners and not only are there some that I would anticipate the Commission would ask me to kind of take a lead on, but there are some that I'm interested in working with, and I can't have everything that I want, and I clearly understand that. But I think we have a lot more issues than we have Commissioners or the ability to break up into groups. So I think that we need to look at maybe whether the biggest issue with military is about collaboration, and figuring out communication, and exchanging or sharing information and, if we can, finding another element that relates to that and then include a subsection on military or something. But we need to kind of start streaming this down a tad, I think.

Commissioner Rodriguez: [Session 6 - 00:09:57] I agree. We might want to think about waves of groups. If there are some groups that we can lay the groundwork on big, overarching issues, because I would obviously like to see that for highly vulnerable populations. I'm thinking about some of the parent issues there as well, but I'm not sure if that is one that needs to come at this stage. It seems like we've got some groundwork to do first.

Chairman Sanders: [Session 6 - 00:10:25] I guess I think a couple of things to your comment, Commissioner Martin. One, there are some things I think have to occur before other things can occur. I don't know that we have to do everything at the same time. I think the other is that, to me, some of these kind of flow together, and if we sequence them out, we can think about what we want to address first and what needs to follow that. Others are going to be short-term, and we won't have to keep working on them. I think we have to structure it in a way that says there are a handful of things that we have to get started right away. I think that the counting is one of them. I think we have to get in front of us what we are talking about. I think that we are making an assumption by prioritizing these things, and that we are beginning to kind of categorize into kind of the "known to the child protection system," or very broadly as well as more upstream prevention. I think that helps us in thinking about counting, but then we need to be clear about what that distinction is and what is contained in each of those categories. So I think there is some sequencing we can do.

Commissioner Rubin: [Session 6 - 00:11:38] I think some of it depends on the sort of level of knowledge and sophistication that these different constituencies already have with the issues. So for example, the Army has a Family Advocacy Program. We met someone from that. They

are going to need a lot less prep. It is more about identifying the right individuals and putting together a few good panels for us, right?

In other areas, like Medicaid, we are going to have to do a lot of work to get these people thinking about it, right? They haven't thought about it in that context. That is going to help prioritize the work of us as Commissioners versus staff.

Chairman Sanders: [Session 6 - 00:12:13] So how would we propose to proceed from kind of what is laid out so far?

Commissioner Martin: [Session 6 - 00:12:22] One of my recommendations, Mr. Chair, would be that we find those five or so core issues that we know that we kind of have to resolve. Like you just talked about, for example, the counting, which may guide our direction on some of the other issues. So find those four or five cores, if you will, and then put those on kind of a schedule, or figure out a schedule for those and then see how some of the other—not smaller, not less important—but some of the other issues that may take less time can fit into that schedule.

Commissioner Rubin: [Session 6 - 00:13:00] For example, because I have thought about the Medicaid group, I think we are going to need three or four months to just kind of work through educating people and giving them the time to do the work. So I see the goal and deliverable there is a late winter or early spring meeting at one of our public meetings where we put together a panel or two to really address what came out of that process and let people testify, and you guys have full opportunity to ask questions. Maybe in the interim, between now and then, we could give an update to the Commission at the meeting as to how that is going: "Here are the people we met with, here is what they are doing, and here is where we are on the timeline."

Commissioner Covington: [Session 6 - 00:13:45] I think too, as we proceed with this, that we make our site visits, that we really try to devote, whether it is the entire morning or the afternoon and beyond, to hearing testimony from the public and from the states in the areas we are visiting. For example, if we took Medicaid we would give it more than an hour, because we just can't do justice in an hour for really trying to hear different perspectives and that we try to really make those meetings rich around a specific topic.

Commissioner Rubin: [Session 6 - 00:14:19] Yes, or have a plan for how that is going to roll out over time so it's not just a 15-minute discussion.

Commissioner Covington: [Session 6 - 00:14:23] Correct. Because that, I think, was the measurement piece at every meeting we have been hearing snippets about. I personally like it to come at me all at once.

Commissioner Martin: [Session 6 - 00:14:39] One of the comments that I would like to add to the discussion, or something to think about, is when the committee that puts together the Medicaid format give me not just their positive turn on it, or their positive recommendation about how Medicaid could work, but the negatives about it too. I want to be able to have a full and complete discussion about it. And it's not that I don't trust you, Dave, or anything like that.

Commissioner Rubin: [Session 6 - 00:15:10] No, no, it is a fair thing. There is always an unintended consequence, right?

Commissioner Martin: [Session 6 - 00:15:16] I just want to hear both sides, and I want to make certain that both sides are rich with ideas so that we can have a full discussion.

Commissioner Rubin: [Session 6 - 00:15:24] Absolutely. I totally, 100 percent agree.

Commissioner Dreyfus: [Session 6 - 00:15:29] One of the things I'm just reminded of is I think about our timeline and it is like the time for our report to be completed is like tomorrow, from my perspective of how quickly time marches by. One of the things we talked about for quite some time is that not everything we are going to have is going to be new. We're not the first Commission to tackle this issue, we are not the first state task force to tackle this issue, or the first multidisciplinary review team that has had some great suggestions, or other national associations, like potentially around the Indian Child Welfare Act, who haven't had a lot of thought into what needs to happen. So I hope that part of what is going to happen here, and I don't know if this is starting to become the matrix that I have been talking about, but I still think we need to do something where we go back, and I am going to put out a straw man of five years, to federal commissions and state task forces. You seem to know about where there has been some really good attention paid to multidisciplinary team reviews and how that has been rolled out in states and looked at in a systemic way. I just don't want us to think that all of our work has to be original work, and that sometimes it might be another national group that, yes, we kick the tires on what their analysis and proposals are. Maybe our job is to elevate them and give them place and presence in our report.

Commissioner Covington: [Session 6 - 00:17:00] We see that as a real key staff function, is to go and help find those things and sort of do some of that digging.

Commissioner Rubin: [Session 6 - 00:17:09] Yes, there are mentions about it. I remember Randy Alexander at one of the meetings talked about a report that was done 20 years ago. What did that report say? We reviewed that as a group to see what was in the original, so I think we have to go through these. I totally agree, that is going to help us.

Chairman Sanders: [Session 6 - 00:17:35] Let me throw just a thought, and I'm willing to be shot down. I would almost look at five areas, and then there are a couple of other things that

I'm not incorporating in this that I think are probably more ongoing pieces. One is this issue of counting, and I think we have a lot of information. I think that should be one of the things that we look at hearing about as soon as possible, and I'm looking to Teri, because I think that you volunteered to be part of that. But it seems like we should hear options that are based on what we know and what others know as soon as possible, and I would hope maybe at the next meeting.

I think we need to stay attentive. The second piece is kind of current policy, cost and so forth, because I think that for us to start talking about what some of the opportunities are I think we have to have a clear picture of what is out there right now, and I think that is an area staff has done a lot of work on. But I think having that really an area of focus is critical to have soon because I think that gives us some sense of what is possible, at least based on current funding streams. It could be that there is plenty of money out there, we just don't know because we haven't seen what all of it looks like.

I think the other three areas, which I'm not sure are quite as imminent, are pieces it seems like we need to hear about soon. So I will recharacterize the Medicaid to a public health frame, and that, to me, is the fatalities that are not known to the child protection system, just as a starting point for that. But then I think what is it exactly that we are talking about? What do we need to look at in that? So assuming that is Medicaid, but all of the other things that you said, Dr. Rubin, that probably fall under that, and we can get some sense of what the scope of that will be. I think the "red button" case is really defining what we want to look at, and to me that gets to something you said, Susan, about the role of the court. The court is going to have a role in all of those situations and so how broadly or narrowly are we looking at it? But somebody could define what that looks like.

Then for the Indian child welfare, getting a sense of the data, the structure, and what is missing so that we can began to build some knowledge base about what might be relevant to talk to Congress about.

So I would just throw those out there that, to me, encompass much of what we talked about. I think on the communication piece, we have got to figure it out as kind of an ongoing one, but I'm not sure if that is as much a subcommittee.

The counting, current policy costs, Indian child welfare, the red button cases, and the public health thing.

Commissioner Dreyfus: [Session 6 - 00:20:30] What about the multidisciplinary?

Commissioner Covington: [Session 6 - 00:20:35] I was looking at that and wondering if we could [*inaudible, too far away from microphone*].

Chairman Sanders: [Session 6 - 00:20:38] Right.

Commissioner Dreyfus: [Session 6 - 00:20:36] That's true.

Chairman Sanders: [Session 6 - 00:20:40] Well, there is post-fatality, interdisciplinary teams and I think prefatality, which to me fall into those two categories, potentially: red button cases as well as the public health frame.

Commissioner Dreyfus: [Session 6 - 00:20:54] Correct. Okay, I've got it.

Commissioner Covington: [Session 6 - 00:20:56] Public health?

Chairman Sanders: [Session 6 - 00:20:57] Yes, and to either or both of those categories we are going to look at the role of multidisciplinary teams. But I think the counting piece is really critical for us to look at the teams postfatality.

Commissioner Dreyfus: [Session 6 - 00:21:08] Correct.

Chairman Sanders: [Session 6 - 00:21:09] Does that answer your questions?

Commissioner Dreyfus: [Session 6 - 00:21:11] Yes. My only thing is, and I'm just putting on my former public sector hat here for a minute, I depended on the rolling up of all those reviews into specific recommendations that were actionable, not just by me, as a child welfare director, but would be actionable by others and the legislature feeling a sense of responsibility to them, not just my agency. So I just think there is something really important in those reviews, not just by the individual child but the collective accountability and improvement of the system.

Chairman Sanders: [Session 6 - 00:21:50] And I would just say I think that is an area that if we look at that, there has been some initial staff work on it that can be expanded and it makes sense to tie it to a committee that is looking at that independently.

Commissioner Covington: [Session 6 - 00:22:14] I think as we think about "special populations," as they call them, and we start thinking about Indian child welfare, we are going to find there are huge crossovers too because of the huge issue in Indian country of how do you count cases, find them, and investigate them? I think as we start out with this framework, we are going to start seeing a lot of intersections as we move along.

Commissioner Martin: [Session 6 - 00:22:35] I do too, but I thought counting went a little further when we talked about native tribes and native communities, because we were talking about infrastructure, and it was a little bit more expansive. So I think there is some intersection, but I'm not sure if it is enough to overlap and say just, "See page 12 of paragraph 4" type of thing.

Commissioner Covington: [Session 6 - 00:22:54] Yes, I wasn't implying that, I was using that as an example to show where I think we are going to start seeing a lot of crossovers.

Commissioner Martin: [Session 6 - 00:23:01] Okay.

Chairman Sanders: [Session 6 - 00:23:13] Cassie, Marilyn just said there will be a crossover with Medicaid too in Indian child welfare.

Commissioner Martin: [Session 6 - 00:23:20] Cassie, are you still there?

Chairman Sanders: [Session 6 - 00:23:25] She has dropped off a few times.

Commissioner Bevan: [Session 6 - 00:23:27] I did not.

Chairman Sanders: [Session 6 - 00:23:27] I thought you did. I thought you said you got dropped off the line.

Commissioner Bevan: [Session 6 - 00:23:30] They keep dropping me.

Commissioner Martin: [Session 6 - 00:23:39] This is Pat Martin. One of the questions I wanted to ask you is you had quite a few questions about CAPTA in our past hearings. I wanted to make certain, and I'm not suggesting that CAPTA has to be separate, and I'm still not convinced I really got your whole point. But the issues that you were concerned about, have you found a place for them within the categories that we were referring to and talking about?

Commissioner Bevan: [Session 6 - 00:24:15] Well not from [*inaudible, distorted voice*]. The citizen review panel versus the child death review panel versus the language of CAPTA does not match what we are talking about.

Commissioner Martin: [Session 6 - 00:24:25] So would some of the concerns that you voiced earlier about CAPTA and the noncompliance with CAPTA from states fall into like current policies and cross, maybe? Or not?

Commissioner Bevan: [Session 6 - 00:24:38] Yes. I mean the same with CAPTA.

Commissioner Martin: [Session 6 - 00:24:41] Yes. Okay, cool.

Chairman Sanders: [Session 6 - 00:24:42] And it seems one of the early steps, so what are states doing? I mean what are the policies that could have an impact and what are states doing?

Commissioner Martin: [Session 6 - 00:24:52] I think that is the question. How can strict compliance with CAPTA reduce or eliminate abuse and neglect, and then what are we doing about it? Right? Because if we said that strict compliance with CAPTA eliminates our problem then great, but if it doesn't affect our problem that may be a recommendation for another commission, right?

Commissioner Bevan: [Session 6 - 00:25:18] Right, and it might not. I mean if we're not talking about child abuse and neglect, we're talking about fatalities, a lot of what we are talking about doesn't fit. It doesn't fit. CAPTA has its definitions, but CAPTA doesn't say what do you do with near fatalities or fatalities, it just talks about reporting them. But does it help if we have a uniform reporting? Since states aren't reporting them all? I don't know.

Commissioner Martin: [Session 6 - 00:26:00] Can I assume, on this whole question that has come to the Commission multiple times, data sharing is data analytics, and that would come in through both the public health frame and the "red button" cases?

Commissioner Rubin: [Session 6 - 00:26:17] I still think they may.

Chairman Sanders: [Session 6 - 00:26:18] I actually think that the first step is defining what should fall under it and what are some of the elements, because I think we've kind of talked about it but I think that actually should be the first thing that the subcommittee does, bring something back that says, "This is the scope of what we are…"

Commissioner Rubin: [Session 6 - 00:26:33] Yes, and the same way that Commissioner Zimmerman was so compelling around how important it is to look at Indian child welfare, and it is a very separate set. You know, my gut is telling me we have to have a special emphasis on the military and military children. I just think they are struggling with this issue all the time, and although we don't have expertise on the Commission, I think it is an important population here in the country.

Commissioner Bevan: [Session 6 - 00:27:03] I actually did a report for DoD on military [*inaudible*].

Chairman Sanders: [Session 6 - 00:27:08] I was actually trying to kind of identify something that was as manageable as possible, but also helps the sequence, and was thinking that could be informed by what we do around the public health approach and the "red button" cases. I could be wrong. So do you think that it makes sense?

Commissioner Rubin: [Session 6 - 00:27:24] It is just that they have separate structural elements, just like Indian child welfare does, that are very stand-alone systems and resources, and I think that is what makes it a unique subpopulation, like the Indian child welfare programs for kids in this country.

Chairman Sanders: [Session 6 - 00:27:40] So do you think that is something that we should do right away?

Commissioner Rubin: [Session 6 - 00:27:43] I'm not saying it is going to have as much work, but I think we should prioritize like what is the strategy in terms of bringing folks in. For each of these groups, I think there is the acknowledgment of trying to help prepare potentially future speakers before a Commission. I don't see my role as going out there and making the recommendations. It is to help educate the people who are the ones that should be making the recommendations to us, and to give them enough information to really think about how they want to present their testimony to us and then come back with very concrete recommendations.

Commissioner Martin: [Session 6 - 00:28:12] What I would offer is that I think there are a lot of subgroups that we might want to give some emphasis to. So the Native American community, I think, should be separate, primarily because we have ICWA. I hear what you are saying, that there is a whole separate system for the military, but quite honestly I would then argue why aren't we having a separate paragraph, a separate page for black kids who are overrepresented in care? Why aren't we having one for Hispanic kids who are coming in and basically being overrepresented in care? We were talking about parenting young teens in care. So I think there are some highly susceptible subgroups of kids and families that we see all the time. I'm just asking whether or not they too should have some kind of special attention.

Commissioner Rubin: [Session 6 - 00:29:20] I think we should definitely address culture and race, but I think the reason why I select the military is procedurally the systems are different and they are unique, so therefore the applications of policy, whether legislatively or from a regulatory, are completely different. Yes, it is important to understand the unique representation of different cultures or ethnicities to this issue, but that is why I think ICWA and military stand out, because the systems are very different.

Commissioner Zimmerman: [Session 6 - 00:29:47] I agree. I think that African-American, Latino, black and brown children are in the state systems. So when we look at the state systems we touch on that. But racial inequity would probably, I would imagine, come into that public health model. And I agree with Dr. Rubin, military is different and there is different jurisdictions. I mean Air Force does things differently than Army does, and all of them do it differently than states do.

Commissioner Martin: [Session 6 - 00:30:15) I just want to be clear that everyone understands my position, that doesn't mean we have to agree with my position.

Commissioner Covington: [Session 6 – 00:30:16] You are a judge; don't put us in that position. [*Laughs*]

Commissioner Martin: [Session 6 - 00:30:25] But I think Black culture, Hispanic culture, and Asian culture are just as important as Native American culture. Just because we don't have a special statute does not mean that our culture should not help our system understand that our cultural differences matter too. And I'm not saying you are saying that black culture isn't important, but what I am saying is that it is different. Part of our problem in the overall system, as far as I'm concerned, is that we fail to appreciate how that difference is not taken in consideration. So all I'm saying is I hope that our report is at least written and drafted in such a way that each and every person who reads it can understand that we are looking at these issues and appreciating each of the majority cultures that we see. Somehow it needs to be identified, and maybe that is a paragraph or a subparagraph somewhere else.

Commissioner Dreyfus: [Session 6 - 00:31:40] Right, but Judge I want to say something, because you are making a really important point. This isn't about a paragraph somewhere in a report, this has to be this issue of race and equity being a guiding principal to everything this Commission writes. To me it is not a special section, it is something that should be coming through everything. It should be coming through counting, it should be coming through current policy, public health, red button, and so on. I think the difference, for me, about ICWA and the military is they are very different systems, whereas all the other children you are talking about, the system is for them right?

Commissioner Martin: [Session 6 - 00:32:18] No.

Commissioner Dreyfus: [Session 6 - 00:32:19] The system that we have responsibility for, not ICWA where you have got different tribal courts, government to government, sovereign nations; or military, where they "take care of their own" kind of thing. That, to me, is where it is different. But I think this issue of race, equity, and culture should be a guiding principle that permeates everything, any subgroup that our Commission, our entire report is written on, and I think our whole preamble should state such. I mean: look at who the kids are who are being killed. They are disproportionately represented.

Commissioner Martin: [Session 6 - 00:32:55] We say that all the time, but we talked about, while coming over here this morning in the cab, how most of the work that is studied, most of the programs that are studied, most of the stuff we talk about that is evidence-based and is based on adults and we are trying to apply that to kids. Most of the studies in JJ are based on boys, and we try to apply it to girls. So I'm not convinced that the system is built for black kids, Hispanic kids, and Asian kids. I think, quite honestly, it is a system that is not built with them in mind, and we are squeezing them into the system, and that is why they don't fit very well. So whatever we do I'm in the majority, but I do think, and I would ask us to seriously think about, making certain that it is more than a line in the preamble that we took in consideration culture and different cultures and ethnicities. I think we have to make the federal government recognize that black culture, Hispanic culture or Asian culture are the kids and families who are seen as just as important as all the other cultures.

Commissioner Rubin: [Session 6 - 00:34:04] Here is what, as I am listening to this, because I'm listening to Commissioner Martin that if it is that important and you feel that, I have no problem saying, "Who would we want to hear from as a Commission, and should we have a subgroup that addresses issues of culture and ethnicity," right? I am certainly willing to endorse that. I think it is extra time, but there are people we haven't heard from who could probably speak and give us a lot more sort of detail about whether it is the underrepresentation of certain subgroups of children in research efforts around child welfare programming. But we would have to have an advanced strategy just like we had in Medicaid of who is going to inform this Commission as to how that weaves into the issue of addressing child abuse and neglect fatalities. I think if that is a subgroup that is great.

Chairman Sanders: [Session 6 - 00:34:54] Let me throw out a couple of things. One, I think we are really pressing ourselves to think we can do so many subcommittees. I actually think let's hear from the red button and the public health subcommittees as to what comes back as the scope. If we feel it doesn't address the issues that are important to us, then I think we have to look at other options. But I think let's hear what that is. I would just say, really strongly, Indian child welfare, because it is government to government, and I think that is distinct. I'm not disagreeing about the military, but U.S. territory. I mean there is a different kind of relationship. So it is kind of where do we draw the line? It is not the same structure in Guam or Puerto Rico, at least as it relates to the federal government in funding, as it is in states. So just where do we draw that line? I'm fine with the line being the military, but to me that is completely different than Indian child welfare. I don't put them in the same category.

Commissioner Covington: [Session 6 - 00:36:05] I also think of the military, and I really think it is important, and I attend their annual fatality summit every year. We work really closely with their Office of Family Advocates. But I have a suspicion there is some work being done already there that we might want to see. I think there is some charge related to domestic violence and child fatalities in terms of creating some national strategies around that. I may be wrong.

Commissioner Rubin: [Session 6 - 00:36:36] Having participated in some of this issue, it is happening. I mean there are people addressing this in a variety of different ways. I think we would be missing an important opportunity to elevate a conversation around the risk of violence within families, and supporting issues around PTSD, and some of the issues that our veterans are returning with. We are trying to promote safe and stable families, and the fact that I do think will become evident during the tenure of this Commission is that there are inefficiencies built into having two separate systems that create a loss of information and puts children at risk. That is really critical for our charge.

Chairman Sanders: [Session 6 - 00:37:23] We can choose to vote on this or if there is consensus we can just move with it and probably look to who should lead this.

Commissioner Ayoub: [Session 6 - 00:37:30] Chairman, am I hearing two different things, though? Isn't there a difference between having a subcommittee for something and just letting the staff know we really want to hear from like the military?

Chairman Sanders: [Session 6 - 00:37:44] Sure.

Commissioner Ayoub: [Session 6 - 00:37:45] Like from the military, that we want to hear from certain things. We don't need a subcommittee for that.

Chairman Sanders: [Session 6 - 00:37:49] That is a great point, because we are still going to want to hear from researchers on the risk around prevalence, and things like that, which may not be directly part of a specific subcommittee. So yes.

Commissioner Rubin: [Session 6 - 00:38:04] I totally agree. I still think for even something like that, what I haven't seen enough of is engagement of us in helping to think, "Who would be the right people?" Sometimes it would be helpful to think who needs an advance call? Have we approached all the right groups? So to me this gets down to a matter of how the staff works with the Commissioners, whether there is a full subgroup or whether that is literally a telephone call we are just going to invite a couple of Commissioners to sit in on and strategize.

Commissioner Ayoub: [Session 6 - 00:38:37] I agree with that. I think sometimes when an email goes out, and we get so many emails that say, "If you have any ideas let us know" … You don't normally get as much of a response on that as you do a direct call. So we have shared enough of what we are interested in or what our expertise is so that maybe the staff could call one or two of the Commissioners on each of the subjects. It doesn't mean that you can't also send out an email, but there needs to be follow-up on it.

Chairman Sanders: [Session 6 - 00:38:57] I would suggest, though, it is difficult to do it with 12 people who all have busy schedules. We had a planning subcommittee and there was a strong sense that is not something we should do because having a smaller group that is working with staff to say, "Have you talked to so-and-so? It would be really valuable." But we chose not to do that, at least for right now. So I think that we probably have to think about the best way that staff can engage 12 people who are really very busy.

Commissioner Rubin: [Session 6 - 00:39:39] You can assign people or people can volunteer if they want to for these interest areas. I'm just saying that I would approach the Medicaid strategy a lot different than the military strategy. For me, if my responsibility was to engage with the staff on military I don't think I would be flying, nor do we have the resources to send us all over the country, but at the same time that would help. There might be some meetings at the Pentagon, or one or two meetings, and there might be a little bit of discussion like "Go talk to so-and-so," and the staff goes out and does a lot of the advance work, whereas Medicaid may require a lot of hand-holding, going down to Baltimore, and sitting at CMS, and

meeting with different folks across a variety of their programs. So I think let's assign people to interest areas and then how deep you go there, I think, is a determination of the Commissioners who are interested in that area working with the staff.

Chairman Sanders: [Session 6 - 00:40:30] So what is the sense of including the military? It sounds like most people are okay. Would you want to volunteer? I mean I have thoughts about who could at least take the lead in organizing this.

Commissioner Ayoub: [Session 6 - 00:40:54] Military, you are talking about?

Chairman Sanders: [Session 6 - 00:40:55] No, for counting, the current policy, Indian child welfare, red button child protection, and public health framework.

Commissioner Female: [Session 6 - 00:41:03] You are the Chair, so I want to hear your recommendation.

Chairman Sanders: [Session 6 - 00:41:07] I would suggest Teri for Counting. Just lead it, and then others might volunteer. Others would volunteer. I'm sure people are ready to jump on that. Current Policy, I would suggest Cassie. For Indian Child Welfare, Marilyn. Red Button, I was actually thinking Jennifer. For Public Health frame, that is a question of either Susan or David, and I think the question about the military…I don't know if you have a preference?

Commissioner Rubin: [Session 6 - 00:41:47] I was suggesting that I could stand to learn a lot from Commissioner Dreyfus, so I was hoping to double up on the Public Health stuff.

Commissioner Dreyfus: [Session 6 - 00:41:56] I'm your co-chair.

Commissioner Rubin: [Session 6 - 00:41:57] Then I am happy to do military as well. I would also add that with Commissioner Petit, I know he cares a lot about that Red Button issue, so I would probably have him involved in that group as well too.

Commissioner Martin: [Session 6 - 00:42:07] Who did you just say?

Commissioner Rubin: [Session 6 - 00:42:09] Commissioner Petit.

Commissioner Martin: [Session 6 - 00:42:10] Oh, okay.

Commissioner Dreyfus: [Session 6 - 00:42:14] On the military piece, I'm trying to propose something here. I think about this again and I go to … I have got to believe the military has a lot of study they have done on this already. And again, as I said before, not everything has to be new work, and I'm just wondering if there is not some opportunity with staff, and if Commissioners are wanting to participate they can, but I just keep thinking about if there is any way to maybe take NAPCWA, National Association of Public Child Welfare Administrators,

along with representation from the military, to have a unique convening in D.C. where they really sit down and hammer this out for us in order to prepare for us some joint testimony and recommendations. It doesn't have to be a subcommittee of the Commission with Commissioners. I don't think this issue is not pretty far along.

Marilyn, I think for Indian country this does need a committee, because I think it is not as far along as maybe the military is in some of their thinking around this issue, or maybe I'm giving the military too much credit.

Commissioner Rubin: [Session 6 - 00:43:30] Yes, I think that the military is interested in it. It is obviously becoming elevated. They are a little bit further out in front of sexual violence and domestic violence, and the child abuse stuff is sort of coming on behind at the end. I think you have all the different military branches. That could be one of our recommendations at some point, is to ensure that happens. Whether we can pull that together to help them do that, I'm not sure, but I think what I can do is at least help them start off, having been near this issue with respect to the work that we are doing, is help the staff get started. Rene Robichaux runs the Family Advocacy Program. There are people I can just direct them to quickly who can help them organize an approach to interfacing with the military.

Commissioner Covington: [Session 6 - 00:44:15] I think, though, we have to really be careful. I think the military is really concerned that we are overstepping our bounds, as a Commission being engaged in their work. They expressed that to me at a pretty high level, that they are concerned when staff attended their Child Fatality Summit. They had some real concerns they expressed about it.

Commissioner Rubin: [Session 6 - 00:44:39] That's fine. Yes, I want them to make the recommendations; I don't want us to. I have actually liked the recommendations, and this is the way I viewed it even in our Department of Defense work. I think they know their system the best. I think we should rely on their efforts to help us think about what makes sense for their system.

Chairman Sanders: [Session 6 - 00:44:58] So in part I was thinking that since we were in some agreement that should be something we focus on that we look for, and David would be leading, to come back to us next month and kind of give us some more detail about some of these issues. We wouldn't get started with a full set of activities, but more this becomes part of our conversation next week, and we'll have a better sense of where we were going to go with it.

Commissioner Rubin: [Session 6 - 00:48:25] They need to communicate to the military that we are interested in forming recommendations around this issue, but for their system. I think that would be my goal for the next month before the October meeting, is just to initiate that level of outreach to see how they would like that to play out, right?

Commissioner Martin: [Session 6 - 00:45:46] So this is Pat. I don't know how far the military is along on implementing some of the things that they are talking about and some of their programs and policies around domestic violence and spousal abuse. It certainly seems to me that if there is some tension with us looking at some of these issues, one of the things we might want to do is kind of see if they were willing to give us a preliminary preview of some of their recommendations, and see if they are recommendations that we can agree to or assign to, and then kind of incorporate them, based on "This is an area that needs attention, and the military has worked out some of these recommendations, and we also recommend these things" or something like that.

Commissioner Covington: [Session 6 - 00:46:30] Yes, I see what we could do would really be to support them as they are trying to make some solutions.

Commissioner Martin: [Session 6 - 00:46:34] Right. That's one way of looking at it.

Commissioner Rubin: [Session 6 - 00:46:37] But also think about the individual programs themselves because you have the different layers of the military. We had someone from the Family Advocacy Program sort of asking for standardization of expectations when commanders change base, in terms of the types of programs that need to be available. With that in mind, that really elevated it, to me that we could provide a lot of value for the Family Advocacy Programs who would probably like to see a little bit more standardization of programming offered across the military.

My experience with them so far is a lot more open and transparent. The military, to me, is very willing. I think where backs stiffen up is when other people who are not military start to make recommendations for the military. I think if you approach it with the engaged standpoint, and allow them to make the recommendations and us to elevate the recommendations that they believe are important, it is usually a productive process.

Chairman Sanders: [Session 6 - 00:47:41] Do people want to volunteer? Is there any opposition? A couple of things that I was thinking that would make sense are I can work on a memo at least suggesting what we would hope to have a conversation about next month, and also make revisions to the work plan, based on this conversation.

Commissioner Female: [Session 6 - 00:48:05] [*Inaudible, too far away from microphone*]

Chairman Sanders: [Session 6 - 00:48:09] I'll do that as part of the memo, and hopefully identify at least a process for doing that, or maybe some suggestions because some people have been working on some of these things already.

Commissioner Female: [Session 6 - 00:48:20] [*Inaudible, too far away from microphone*]

Chairman Sanders: [Session 6 - 00:48:24] Oh, I knew you were going to ask that. How soon? I guess it will have to be the end of this week.

Commissioner Female: [Session 6 - 00:48:25] [*Inaudible, too far away from microphone*]

Chairman Sanders: [Session 6 - 00:48:24] So do Commissioners just want to volunteer after we send something out? Because Teri, I will help you. I will volunteer.

Commissioner Rubin: [Session 6 - 00:49:05] Then I think it is the staff who is partnering. When we did the public health I was thinking about Hope, only because I know she has a lot of relationships to leverage in terms of that environment. Hope and her team; her and Marci. I'm going to defer to you. How do you think about sort of creating mini-teams if there is going to be some of this subgroup work?

Commissioner Martin: [Session 6 - 00:49:27] Before we get to that question, I think there are a couple of people that we may have elected to be Chairs of committees that aren't here. Although I don't think they have the right to decline…

Chairman Sanders: [Session 6 - 00:49:39] Who is that? Only one.

Commissioner Martin: [Session 6 - 00:49:40] Jennifer and Mike.

Chairman Sanders: [Session 6 - 00:49:43] No, Michael said he wanted to be on that.

Commissioner Martin: [Session 6 - 00:49:44] Oh, okay. Because I was going to say we might just want to ask them first.

Chairman Sanders: [Session 6 - 00:49:49] I think he probably wants to do multiple things.

Commissioner Martin: [Session 6 - 00:49:52] Okay, then we are fine.

Chairman Sanders: [Session 6 - 00:49:54] But Jennifer we probably need to say something first.

Commissioner Rubin: [Session 6 - 00:50:00] Then we haven't talked to Commissioner Horn yet.

Commissioner Martin: [Session 6 - 00:50:10] If you have no place for me…

Commissioner Covington: [Session 6 - 00:50:16] [*Inaudible, too far away from microphone*]

Commissioner Ayoub: [Session 6 – 00:50:28] In hearing those, I don't feel like I belong on one of those, but I would like to offer the communication with the staff.

Chairman Sanders: [Session 6 - 00:50:29] Yes. I was going to actually suggest that we talk further about what that might look like.

Commissioner Rubin: [Session 6 - 00:50:34] That's a great idea.

Commissioner Martin: [Session 6 - 00:50:38] I would like to work on the Native American issue, if that is okay. If you don't mind.

Commissioner Rubin: [Session 6 - 00:50:48] That's great. Yes, I think I'm going to start with my Army partner, who is a physician in the Army. He is doing child abuse work. Maybe he could have Estelle help us a little bit.

Commissioner Dreyfus: [Session 6 - 00:51:04] I just think it is important that the first thing we do, like, for instance on Public Health, which could get bigger than a bread box really soon. I just think each of these, whoever is the chair, there has got to be a scoping. There has got to be a set of, "These are the goals and this is the scoping."

Commissioner Rubin: [Session 6 - 00:51:24] Yes, so maybe our goal in the next month that we are working on is just to try to set up a draft scope for what that looks like.

Chairman Sanders: [Session 6 - 00:51:44] And this would create our agenda for our deliberations in Vermont, because this would hopefully be the start of our ongoing work plan to get to a final report.

Commissioner Covington: [Session 6 - 00:51:57] On that note, can I ask if anybody feels they need to hear more from the people related to measurement for Vermont, or are you pretty saturated?

Commissioner Rubin: [Session 6 - 00:52:05] Actually, I was going to say part of what I wanted to know was who haven't we heard from yet? I am struck by like the nonfatal injury stuff. There is nonfatal injury and there is the Indian child welfare stuff that we talked about.

Commissioner Female: [Session 6 - 00:52:19] [*Inaudible, too far away from microphone*]

Commissioner Rubin: [Session 6 - 00:62:20] Yes, but nonfatal injury and also the CDC. Where does the CDC fit with respect to counting serious injury? At all or not? Where are they?

Commissioner Covington: [Session 6 - 00:52:33] We can think about it.

Commissioner Rubin: [Session 6 - 00:52:34] Think about it. Okay.

Commissioner Covington: [Session 6 - 00:52:38] I can think of a couple people where they have done some model work we might want to bring in. The CDC maybe, but they really haven't been involved with it since they finished their definitions.

Chairman Sanders: [Session 6 - 00:52:51] Pat, do you want to say something?

Commissioner Martin: [Session 6 - 00:52:57] Dave asked who have we not heard from? I was going to say that Marilyn gave us a good outline earlier of some of the positions or people that we might want to hear from Native American country.

Chairman Sanders: [Session 6 - 00:53:09] I think he was speaking specifically on counting.

Commissioner Rubin: [Session 6 - 00:53:14] She was asking about her counting group.

Commissioner Dreyfus: [Session 6 - 00:53:18] The only thing I can think of that fits into this that I still think goes into the counting is who is responsible for making the final determination. I don't know if we have heard all we need to hear about that, but we have heard from a couple of folks in both Michigan and then again yesterday on that issue.

Commissioner Ayoub: [Session 6 - 00:53:44] For me, on the counting, I would like to be clear on like yesterday somebody mentioned counting the preventative deaths, which sounded great when they said that, but then I heard another side of that.

Commissioner Covington: [Session 6 - 00:54:00] No, I've got that covered.

Chairman Sanders: [Session 6 - 00:54:03] Also we heard yesterday two different numbers through two different systems, and I'm not sure how much of that is driven federally or how much of that is purely at a state level. So are there other counting vehicles that may overlap with this that are in federal statute? It would be helpful to delineate what those are.

Commissioner Martin: [Session 6 - 00:54:28] David, I guess I do have one comment. That is if I understand your comment about our agenda for the Vermont discussion, with having the chairs or sub-chairs bring in their draft of the scope of their responsibility, I don't want us to cut it off and say that these are the golden five. I would like to leave some room and some flexibility so if we hear something that we hadn't thought of, this great thing, we can find a space to put it in and kind of include it and figure out how to work that issue as well.

Chairman Sanders: [Session 6 - 00:55:06] So if it seems worthwhile, it would seem to make sense for me to take a look at what was proposed as part of the work plan, because there are a set of questions and I think these six subcommittees will address a lot of those questions, but there is still going to be questions that aren't … and I will try and capture those also as things we can at least look at. So if they aren't captured in subcommittees, what else do we

need to consider? Does that work for people? The confidentiality was the last thing on our agenda.

Commissioner Covington: [Session 6 - 00:55:49] Well it certainly comes through in counting because you really have to be able to share information to get the right count. So that is a big one for us.

Commissioner Rubin: [Session 6 - 00:55:55] It also comes through in public health too, as to how well people communicate or what information people have to make decisions on the ground, right?

Commissioner Martin: [Session 6 - 00:56:09] It also comes in the multidisciplinary things, pre and post.

Commissioner Covington: [Session 6 - 00:56:12] And the red button issues in terms of multisystems issues.

Commissioner Martin: [Session 6 - 00:56:14] So maybe there is a confidentiality component to each one of the five or six.

Chairman Sanders: [Session 6 - 00:56:18] Versus separating them.

Commissioner Martin: [Session 6 - 00:56:20] Right.

Commissioner Covington: [Session 6 - 00:56:21] Yes, because I had data analytics kind of crossing over all of them, and confidentiality.

Commissioner Rubin: [Session 6 - 00:56:25] Here is one thing which you said before: There are large groups, I think, who are working on this issue of confidentiality. Have we tapped into what their explicit recommendations are, who are trying to work on this now? Have there been a number of convenings on this? So I think I would probably task the staff to identify where is that work happening, right? Rather than reinvent the wheel here on that one, right?

Commissioner Zimmerman: [Session 6 - 00:56:49] Strangely, I was just in the Rosebud Reservation about two weeks ago, and they have figured out a way, with all of their agencies working together, where they have got one intake form for the entire reservation. So the families and the kids don't have to tell their stories over, and over, and over again. They have one for whether it is domestic violence, or mental health, or child welfare. It is one intake form, and they have created MOUs. But they are a sovereign nation and they can do that. And I'm not sure where Indian Health Service sits in that relationship because of the HIPAA, which is different for them.

Commissioner Covington: [Session 6 - 00:57:29] Well it goes back also to the wonderful example they gave in New Zealand yesterday. What they didn't tell you is that every person born in New Zealand gets a single identifier that carries them through to every system, so if they go into CPS they have the same identifier as on their birth certificate. The government agencies can access all of those records off of the one number.

Commissioner Dreyfus: [Session 6 - 00:57:54] In Washington state, just so you know, we had a common client identifier across 26 data sets. If you want to learn more about that I can tell you who to talk to. It's a pretty amazing system.

Commissioner Martin: [Session 6 - 00:58:05] So David, I have a couple of questions about these subcommittees. I would like to preface my question with I have no idea right now whether or not this would come into play. If, in fact, I am working on a subcommittee and we want to talk with someone and make an effort to have a meeting with someone, and we feel that it would be necessary for us to go meet that person. I say that particularly since what little information I know about Native American cultures and tribal courts, there is always this issue about whether or not you need to meet someone face-to-face as opposed to doing telephones when you don't know the person really well, and providing gifts if you are the person holding the meeting. And these are cultural things that I know very little about, but I know a little bit about, which I want to know, what is our ability to do that? Who do we need to call for approval to do that? How do we do that, if it is necessary? And I don't know if it is necessary yet.

Chairman Sanders: [Session 6 - 00:59:15] Yes, so what I was anticipating was that we would began to identify scope and things like that, and bring back for the full Commission to have a conversation about each of the subcommittees. That seemed like the right direction. Once that direction is set, I think it is Commissioner work and to the extent that it requires travel, that is travel that would be reimbursed. I don't know what the process is.

Commissioner Martin: [Session 6 - 00:59:40] Okay, I just wanted to make sure that was something we could take in consideration in trying to develop our scope.

Commissioner Rubin: [Session 6 - 00:59:47] The other thing is, as I'm thinking about the different issues, and what is in, and what is out, I imagine almost like a table. This also gets back to your question about race and equity. Where we have these issues—public health, legislative, policy, and all the other stuff—and then across the top you want to make sure that you hit race and equity in each of those areas, right? You want to make sure that you hit confidentiality issues. You know, the data systems and what appears across the top that every one of these areas that is going to be addressing some of those things. So that is a check and balance as you start to think about the recommendations, that you have filled in all those boxes and have a good understanding of whether you want to say anything in those boxes or not. That helps me organize in my mind.

Chairman Sanders: [Session 6 - 01:00:40] I think that is why it is so important to bring back to the Commission as part of our conversation, because we should be looking for those areas because that is going to be part of what is in our final report. We have to make sure these things are covered.

Commissioner Rubin: [Session 6 - 01:00:54] I think the staff, particularly along the top there with all those specific issues, because they have been working really hard on that, could be looking to call out sort of what are the existing recommendations and who has done what. So we are going to be overlaying some specific focuses on some other systems and then we are going to bring it all together. But I'm not sure if we need to govern that top row. Let the staff really be out in front of us on that because they have already been thinking a lot about those issues.

Commissioner Dreyfus: [Session 6 - 01:01:19] A question. Bud is not with us, I don't think, anymore. The children's advocacy centers, their role and the best practices of them, will that fit in multiple places, or how does that come into this?

Commissioner Martin: [Session 6 - 00:01:55] I thought of that in terms of we have heard a lot of suggestions about having interviews similar to the advocacy centers for kids who are in very severe abuse and neglect situations. So I was looking at that as part of that theory and that model kind of being involved in the "hot button" issues. I don't know if that is the only place, but that is where I kind of put it in my mind.

Dave, my other question is one of the Commissioners earlier today or last night mentioned something about the person or the senator who recommended her or him. They have been having conversations with them and trying to get a sense of whether or not there are some issues that they are particularly interested in having addressed by this report. I want to know are we thinking about that on any level?

Chairman Sanders: [Session 6 - 01:02:30] I think that is a great point. That should fall into those things that are part of the question, because it is part of the questions for the work plan, as well as kind of anticipated in the work plan that would have an engagement plan that we have endorsed as a Commission. So next month it seems like that is going to be one of the things that probably falls outside of the subcommittees, although it is something probably Amy and I should talk about as it relates to communication. But I think that will be one of those categories, yes.

Commissioner Rubin: [Session 6 - 01:03:10] Yes, one of the top categories, when you made the CAC comment, I think interdisciplinary connections, right? And so CACs fit under there, but there are also the ways we strengthen the ability of community, whether it is community advisory boards for home visiting programs. We have heard about a variety of recommendations already, but that feels like it is on that top axis across all these things. It

affects whether it is Indian child welfare, military, public health, or legislative and policy issues, right?

Chairman Sanders: [Session 6 - 01:03:40] So some of us have a lot of work to do in the next few days. Is there anything else that we have not covered that we need to absolutely cover for today?

Commissioner Dreyfus: [Session 6 - 01:03:54] David, I just want to thank you. I think this has just been a really wonderful discussion. I think the Commission has shown that we really can all sit down together and figure out where our intersections are, but I just wanted to thank you for creating the process that got us to the point where we are able to have this discussion. I don't think we could have done this when we first started. I think we had to get out on the road, I think we had to have a few meals together. Do you know what I mean? And learn what we learned in order to get to where we are today. So I just want to thank you for that leadership.

Chairman Sanders: [Session 6 - 01:04:29] Thank you very much. So I think that unless there is anything else we will stand adjourned.