**COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES**

**MEMPHIS, TENNESSEE PUBLIC MEETING TRANSCRIPT**

**APRIL 28-29, 2015**

**DAY ONE—APRIL 28, 2015**

**Presenters:**

- James Henry, Commissioner, Tennessee Department of Children's Services
- Teresa Huizar, Executive Director, National Children's Alliance
- Chris Newlin, M.S., L.P.C., Executive Director, National Children's Advocacy Center
- Nancy Young, Ph.D., M.S.W., Director, Children and Family Futures
- Scott Modell, Ph.D., Deputy Commissioner, Office of Child Safety, Tennessee Department of Children's Services
- Carla Aaron, M.S., Executive Director, Office of Child Safety, Tennessee Department of Children's Services
- Amy Coble, M.S., State Director of Investigations, Office of Child Safety, Tennessee Department of Children's Services
- Michael Warren, M.D., Assistant Commissioner, Division of Family Health and Wellness, Tennessee Department of Health
- Amy Weirich, J.D., District Attorney, 30th Judicial District of Tennessee
- Michael Dunavent, J.D., District Attorney, 25th Judicial District of Tennessee
- Michael Cull, Ph.D., Deputy Commissioner, Office of Child Health, Tennessee Department of Children's Services
- Noel Hengelbrok, M.S., Director of Safety Analysis, Office of Child Health, Tennessee Department of Children's Services

**CHAIRMAN SANDERS:** Good morning, and welcome to the Commission to Eliminate Child Abuse and Neglect Fatalities hearing in Memphis, Tennessee. And we are excited to be here. We have a packed agenda this morning, looking forward to hearing about child advocacy centers, about some of the safety culture work that's being done in Tennessee, and also work on -- specifically on substance abuse and preventing fatalities. So we're looking forward to today.

We will get started in just a minute, but I wanted to provide some context for our hearing today, and then have each of the Commissioners introduce themselves.

So first, we will have a series of presenters, and we'll offer time for conversation with the Commission. There, unfortunately, will not be time for questions from the audience,

although, we do welcome written comments and written remarks that can be submitted through our website.

Each of the -- each of the presenters has a specified period of time, and we will stick to that time. But also, we'll be flexible with the questions that are asked by the Commissioners and extend time as needed.

Let me ask each of the Commissioners to introduce themselves, and then we'll get started with our first presenter.

Dr. Rubin, you want to introduce yourself?

**COMMISSIONER RUBIN:** Good morning. I'm Dr. David Rubin. I'm a general pediatrician and the co-director of PolicyLab at the Children's Hospital of Philadelphia.

**COMMISSIONER AYOUB:** I'm Amy Ayoub from Las Vegas. I own the Zen Speaker, a communications company. I've been a long-time advocate for abused and neglected children, and I'm a survivor of commercial sexual exploitation.

**COMMISSIONER COVINGTON:** Good morning. My name is Teri Covington. I'm the Director of the National Center for the Review and Prevention of Child Deaths, so I support the states in their efforts to conduct high quality child death interviews.

**COMMISSIONER MARTIN:** Good morning, ladies and gentlemen. My name is Patricia Martin. I am the presiding judge of the child protection division in Cook County, Illinois, so that is the foster care cases in Chicago. And I am delighted to be here. Thank you so very much for coming and sharing with us this morning.

**COMMISSIONER HORN:** Good morning. My name is Wade Horn. I'm the health and human services practice leader for Deloitte Consulting. I'm also a clinical child psychologist.

And before coming to Deloitte, I was the Assistant Secretary for the Administration on Children and Families at the U.S. Department of Health and Human Services.

**COMMISSIONER CRAMER:** Good morning. I'm Bud Cramer. I was a district attorney back many years ago, and I started the Huntsville, Alabama Children's Advocacy Center, which is now the National Children's Advocacy Center. We'll hear from Chris Newlin today.

I also happen to have served nine terms in the U.S. Congress where I was on committees that funded Justice, HHS, as well. So I'm very appreciative of this opportunity to serve.

**CHAIRMAN SANDERS:** And I'm David Sanders, the chair of the Commission, and Executive Vice President with Casey Family Programs, which is a foundation headquartered in Seattle that focuses on child welfare, and also was formerly director of Los Angeles County Department of Children and Family Services, the child welfare agency for Los Angeles County.

So we're going to get started with the Commissioner for the Tennessee Department of Children Services, James Henry. And really fortunate to have Commissioner Henry with us. And he's going to open up with remarks about the work in Tennessee.

Commissioner Henry.

**JAMES HENRY:** Where do you want --

**COMMISSIONER HORN:** Take your choice.

**JAMES HENRY:** Is this all right? Sure I get tuned up here. I'm kind of used to this forum, but I'm delighted that you picked Memphis to visit because I think that there's things going on here that we're trying to replicate across the state.

I've had an interesting journey with -- as being Commissioner. From day one, if you've taken much interest in Tennessee, you'll see that the system perceivably was pretty well broke here a couple of years ago.

And it was interesting that we -- how we rebuilt it into the culmination of that was last week when we received the National Voice of the Child Award, the Tennessee Department of Children Services, in Washington, DC, and had about 12 senators and eight or 10 U.S. congressmen there, and had very kind things to say about us.

But we've been very interested in partnerships. And, you know, Casey has been a huge part of our partnership.

And I was Commissioner of the Department of Intellectual and Developmental Disabilities in Tennessee, the first one, and I was in private business before that because my son was a -- had disabilities. He had autism. He was nonverbal. He was -- had multiple physical problems. He had a feeding tube, a colostomy. He was -- had spina bifida.

He had all those different problems. And, quite frankly, we could find no services for him. So, we started an agency that provided services across the South for those kind of children, and also got into troubled children.

So the time that I spent in the General Assembly, which was from 1978 to 1980 -- I mean, 1990, I was not only the chief advocate for people with disabilities and troubled children, but I was also John's father, and I was also a dad that understood that and ran an agency. And we quickly grew to one of the largest in the four states surrounding Tennessee.

You know, it's -- if I look back now, and when I came to the department, I had advocated for Department of Children -- of Intellectual and Developmental Disabilities for probably 20 years because we had always had it divided into something else.

And the governor came in and he offered me the opportunity to come and be the first department. And I thought it was a good time to retire, so I did it, and came over. And when you're retiring and not going anywhere else in a career, there's a lot of things that you've had the shackles removed from that you don't have to worry about much anymore, your next job, where your next appointment's going to be, and a lot of those things.

So I came over strictly with the intention of trying to change that department. We did. It'll be the first department -- it has been the first department accredited in the United States this year. And my Deputy Commissioner at the time has taken the bows for that she deserves the bows.

But anyway, children services quickly became a highlight in Tennessee with funding cuts and the normal things. What you don't understand about children services -- I'm sure you do, but most people don't, is that it's part of, you know, economic development. It's part of almost everything.

But the one thing that every governor and every administration and every new one forgets is the fact that -- that, you know, if you cut those services, you're cutting two-thirds of the money.

And so all of it goes through, you cut services, caseloads build up, you have deaths. And all the sudden, the press gets on it. And, you know, you have this -- usually this citizen's committee that's appointed. They come in and take the department's time.

So all of that happened in Tennessee at one time here, a little bit less than two years ago. And we went through a terrible time here with the newspapers, daily editorials.

And so when I -- the governor asked me to come -- and I was doing some consulting with the department. And he asked me to come over to Department of Children Services. Someone asked me, said Jim, have you lost your mind? You've got Intellectual and Developmental Disabilities on the way to accreditation, the first in the nation, so why would you go over and jump into a mess?

And, you know, I guess that the challenge -- and I had always been very critical of the department for a lot of different reasons, but the challenge of being able to go over and change something really appealed to me at that time.

Of course, behind every successful program, you'll find a successful team. And I was able to bring some really top-notch staff with me from the Department of Intellectual and Developmental Disabilities. Dr. Modell, who is here, came over as my Commissioner of Safety.

And also Dr. Cheetham came over, and Dr. Cheetham served in both positions. And we both served in both positions for -- as Commissioner of Intellectual and Developmental Disabilities, and Department of Children Services for about four or five months before I became permanent head.

And it came obvious to me very early in the game that there was three things that we needed to do. Number one is, we needed to get children safe, first of all. That would be our number one priority.

And then, we would need to get them healthy, which a lot of people don't understand the issue with health and how much that plays into a child's well-being as far as everything that he does. You know, number one, if you don't have the kid safe, you're going to be in trouble. Number two is, if you don't have him healthy, how can he progress?

So we spent probably more time than, I guess, 99 percent of the people talking about the child's health and being sure that it was -- that we understood exactly what it was going to take to make those children happy and healthy, once we got there, where they could do good in school.

So we created a deputy commissioner's position, which had never been before in the Department of Children Services. We created three deputy commissioners. One, to get kids safe, Scott Modell, Dr. Modell, heads up.

The other was to get kids healthy, which Dr. Tom Cheetham headed up, and Dr. Cull has taken over for him now. And Tom is staying with his first love, which is Intellectual and Developmental Disabilities.

And then, the other thing is trying to get kids back on track, and how you do that successfully except with an excellent program? And we were really fortunate to have someone that was doing a good job and had done a good job for a number of years, and Bonnie Hommrich is deputy Commissioner. We created three deputy commissioners.

People asked me, said, we've looked at your organization schedule and how in the world do you -- do you run an operation with so many people reporting directly to you? And it is an interesting chart. If you look at our pie, you will see that half of it reports to me, the other half reports to -- to the three deputy commissioners.

But one thing, if you're going to change something quickly -- and I think we've changed this department about as quick as you possibly could -- if you're going to change something quickly, you've got to have people reporting to you. You've got to have an open office. You've got to have people understanding, liking what they do.

You know, when I started e-mailing people 3:00 or 4 o'clock in the morning, of course, I'm on east Tennessee time and, you know, Nashville's on a different time, I think they thought I was crazy. And I probably was.

But you know, Wilson Kemmons, that I'm not sure that any of you know, but he was the head of Holiday Inn started right here in Memphis, Tennessee. Wilson Kemmons had a saying. He said, all he wants from you is a good half day's work, and 12 hours isn't too much.

So we started early and we worked late. And we decided to splice some fun into it. And we have, occasionally, now -- in those days, we had them every Tuesday night, we had one drink after work and talked about, you know, what we were doing. So I think it's a very important part of it.

The other thing we did is begin to look into the -- into the death review process. And what is health? What is child's health? We created what we call Philosophy Wars. And in the Philosophy Wars, we brought all the advocates in. And we brought them in, and what we do is take issues and we just talk about them. Sometimes we reach conclusions; sometimes we just get to know how other people feel about what is child's health, what does that encompass, what does it mean for the State of Tennessee to be involved in a child's health?

So, you know, we -- we do those. We also copied what New York does as far as CompStat. We completed another CompStat yesterday on one of our cases. And we always learn something from those. And we -- everybody puts their own particular quiz to it. But we created those and they've been very helpful in our learning experiences for us.

The press was on us big time about -- about, you know, disclosure of information. And so my first meeting, I was moving so fast from one department to the other and trying to run the both departments, my first meeting, I kind of got in a little trouble with the governor because the commissioner that I had replaced had figured that it cost $55,000 for them to bring some information that -- that they needed to give to the press. That was what the press was going to have to pay for it.

Well, it was obvious to everyone, maybe, that the price was so high that they didn't want to disclose the information. And of course, they got accused of that.

And my first press conference they had when I went over and was introduced, they asked me exactly, did I think that was a reasonable price? And I kind of grinned and said, well, it sounds a little high, which it does sound a little high unless we're still using Pony Express in Tennessee, but we're not.

And at the same time, the governor was making a case for charging $55,000 to bring the information. So he and I had a small conference right after that to be sure that weren't on different pages as we moved forward.

But he's been very supportive of us in our work. And, you know, the thing that we wanted to do, number one, was create a safety culture in Tennessee where we were completely open.

Florida has used our -- our safety systems and being able to put death and death reviews on the website. I don't know exactly how many we've done now, but we've had to go back and catch up, I think over two or 300. And we've caught up now and we're trying to use that. And you'll learn more about that in order to perfect what we do moving forward with children.

The other thing we did was get into, like I said, the health of children and being sure that they got what they needed at an extent that no one had ever done. And then, in our programming, we've taken it to new heights with being number one in trying to find permanency for kids.

I think you do that by a variety of ways. It's not -- you know, people wonder what this all encompasses, you know. There's an old saying, you know, communications is the problem, now -- you know, communications is the answer, show me problem.

And so we probably have communicated more with judges across this state. We created Three Branches Institute in coordination with the -- Casey. And so we have that. We've extended it now to regional Three Branches. And so we have a good dialogue with judges across the state.

One of the best meetings we've ever had was just right up here in Jackson about a month ago. And we brought the drug task force, the TBI, the FBI, the judges, the legislators, brought them all together, and we discussed the drug issues and the gang activities in these communities.

And it really helped us, and helped the judges understand something they can't work and can't find out from -- from the bench. So it's been a very good experience for us as far as being able to disclose information that -- that the public demands and that they have a right to know.

And we just absolutely are open to everything we can as far as -- and, you know, there are really no secrets anymore with the Internet. They can find out about anything they want to. So, you know, they can either find out through court in a lot of embarrassment or they can find out from your firsthand.

So all of our deaths go on the website, and our investigations into deaths. And, you know, I think the COA called it the best system they had reviewed.

And so we've -- previous, my predecessor had went back and dropped accreditation for the Baldridge Award. And we picked back up on accreditation. We hope to be accredited this year. Our regions are accredited and our youth developmental centers are -- are the first in the country to be accredited. And we're working on those.

It has created some different situations for us than we thought that we'd have as far as YDCs are concerned. But it has been a very, very difficult road changing a lot of things that we do with the YDCs, changing to -- you know, from a punitive system that was run by the Department of Corrections for a number of years, trying to change that culture into one that -- you know, where you're rewarded for good behavior instead of punished for bad. So we've been able to change that around.

You know, the -- the other thing that -- that I think has been very important for us is just how we treat employees. And we spend a lot of time with employees. And, you know, we put 2500 -- 2600 tablets in the field for our workers. And, you know, we've created opportunities for them.

And when we did the pilot program -- I never will forget, we didn't do a pilot because we looked at tablets and we looked at iPads, and we came back with the decision we would deploy the tablets.

But we did that. And when you listen to the workers talk about regaining part of their life and not wasting time in court and being able to hook to resources in the homes, it was an amazing event. It actually teared up some of our front-line workers.

And to give them iPhones instead of the old flip tops that we had. And all this cost money, and we were lucky to get the legislature and the governor in order to produce those kind of things.

How do you do that? You do it because your work never stops. People wonder where we're headed off to when the legislature is in town. We go to every reception that we can. We want to not only meet their constituents, but we want to be there to support them.

And the first time we go to a committee in Tennessee, it's not the first time we've ever met the legislators, because we've met them just like the judges on a million different occasions. And today, as I visit the department down here, the legislators will be invited and a lot of them will participate.

But the main thing is that they're invited. The main thing is they're engaged. The main thing is they know what we're doing. And when we come to ask for something, they know that we're not going to, say, just waste the money. It's going to make a difference in a child's life.

So it's been a very positive experience for us in the last two years. I think that the culmination last week was the Child Health Award being recognized nationally.

But more than that, I had breakfast with one of the largest newspaper's editor on last Wednesday or last Thursday. And she told me she knew how much things have changed because the complaints have quit. So we felt like that was a major, major, major win for us in both areas. Being open with the press has been important for us.

Now, the last part of what we do, before I leave here -- not only here, but leave this job, is we're going to try to make a difference for the next generation.

If you had been here in Memphis two months ago, they had a huge ACES conference. They did 17,000 interviews with people. And they found out what these kids are experiencing as children that no one can be successful in experience.

So here in Memphis, where the difficulties sometimes are the toughest, and in Appalachia in eastern Tennessee where, you know, for whatever reason, the hardest working people in America have stood still for 50 years, even after Jack Kennedy, you know, was able to put the Appalachian Regional Commission together and we spent millions and millions and billions of dollars on that region, and it is still depressed. And on top of that, now you have drug and substance abuse.

But anyway, I heard the mayor of Memphis and the mayor -- the county and city mayor get up and say, we've lost the last generation that we're going to lose in Memphis. So we'll be going after we get through here today to a new parenting center that they have where they're going to get involved in trying to make a difference in a kid's life where they don't end up in Department of Children Services or the juvenile detention centers or the youth developmental centers or, after that, prison. And so that's how we really want to change.

You know, our next stage will be going out and creating the same kind of environment that Memphis is creating here across Tennessee. We've been able to get a IV-E waiver, and we're going to be able to do a lot of things if we can show how it reduces kids coming into custody. So we're excited about this new year.

You know, making people aware, being a voice for children, being a real voice for children and, you know, sometimes not a popular voice, but you've got to make governors and legislators understand that economic development isn't just education and bringing jobs in. It's a big part of it.

But taking care of this group of children that are growing up in experiences that no one in the setting in this room right now would be successful in if they had those experiences, or very few people do it.

One of my pet peeves now is I do a survey of ACES on everywhere -- all the groups that we go to. And it's really revealing to see how many people don't end up at the table. And then, it's interesting to see every once in a while a kid that elevates to that place, that he is successful.

And you say, what's the reason? What was it that was different? But I think it's time that we try to not only just get back and try to clean up the dirty dishes, but we also move forward and try to set the table, which very few children services departments ever get into. So that's why I'm excited about the rest of my work at children services.

One other thing. It's very important that whatever your report is that it includes the problems that we have in longevity. I mean, you know, governors are important, Commissioners are important, but we have such a short length of time to make a difference.

You know, one of the -- one of the things that we've had, all of our governors here served eight years since the '70s. But do you recognize what a short length of time that is to really have a continuous model that you're working from?

That's why we want to create some kind of legacy that lasts after this administration, after this governor. There's no use to come in and start over again.

So my plea to you is, whatever you do, be sure you get to the right kind of people and you -- we start creating a culture in this country that takes care of this kind of problem, that we don't stop at the next administration or the next group of leaders and legislators.

And that takes a lot of work. And it takes partnerships with the newspapers. And the judges will be there for years. Legislators that you see will be there for years.

So it's very important that as we do our work that we are mindful of the fact that there's a saying on my wall, "Time is our Enemy". And it is. Because, you know, you're only going to be effective and be here for such a short length of time. No business could make it if they were serving the same length of time, if you change CEOs every two to four years.

There's been 18 months has been the average stay of the Commissioner of Department of Children Services since the 1996. No one -- no business could be successful. So that's why that it's important as you travel through that you have legislators that understand not only administrations, because they will come and go, but, you know, legislators are there for a long time usually. And leadership is usually always there for a long time.

So my challenge to is you is if you -- you know, when you do this report, don't just aim it. I mean, aim it to the congress and the people that can make a difference, the advocacy groups, the Caseys, the people like that that can make a difference over the years.

So welcome to Memphis. We're delighted to have you. And I'll be glad to answer any questions.

**CHAIRMAN SANDERS:** Thank you very much, Commissioner.

Are there questions from the Commission? Commissioner Horn.

**COMMISSIONER HORN:** I notice that Tennessee has a Title IV-E waiver. Can you describe a little bit about what the waiver is and is it -- do you have results yet from the waiver? How are you actually implementing the waiver?

**JAMES HENRY:** We picked eight Appalachian counties to start that waiver in, and we call it In-Home Tennessee. And it's a waiver that we can do anything we want with the money as far as it's reducing the number of kids in custody.

So we can try a lot of new ideas. We're really excited about it. We're meticulously keeping records to be sure that we do it. We think this ACES program is one of the long-term advantages to that.

You know, we can sponsor studies if we want to. We can do things with the YDCs that you probably couldn't do without that situation with the waivers. You know, we're looking at a youth challenge program that the National Guard puts on that Tennessee has not participated in, which 37 other states are, for the kids that don't get into custody.

You know, for the ones that are taking the steps towards getting into trouble, but you go and grab that kid now and he either ends up with a trade that he's good at or he ends up with a military career, maybe, whatever is best for him.

But it's just another tool in our kit. Rather than all the money being -- you know, being given to us to incentivize bringing kids into custody, we can -- now we're unshackled with being able to do many things that we didn't dream of three or four years ago.

So our waiver's till 2019. And hopefully, you know, it'll go past that. We have reduced numbers. When I came in, we had 8,500 kids in custody and we had -- we were down to 7,800. We've gone up a little bit because you don't want to move too many kids around school time. But we've got plenty of kids on visits and we expect those numbers to continue to reduce. So we feel very good about the waiver.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** There it is. Commissioner, thank you for your comments and testimony. I have a couple of questions.

Obviously, you're doing a lot of good work. And this Commission, while deeply interested in child well-being and ending all abuse and neglect, is first and foremost, meant to look at the question of how to reduce fatalities, many of which children are already known to us in one fashion or another.

So two things. One is the manual that we have here says there were 106 children died due to child abuse and neglect in 2013. But when

I look at the confirmed child fatality, abuse and neglect in Tennessee in 2013, on table two that I have here, it's 40. So one question I have, which is it: Is it 40? Is it 113? Do you know?

**JAMES HENRY:** In 2013?

**COMMISSIONER PETIT:** Well, I'm looking here, it says, the child fatality review found 106 children died due to child abuse and neglect in 2013. And then, when I look at a table that we have on confirmed child fatalities in Tennessee in fiscal year '13, there were 40. This says 40.

**JAMES HENRY:** I don't have any idea why there's a discrepancy.

**COMMISSIONER PETIT:** Yeah. I know. We can -- I'm sure we can find that out. But I guess the question I have is this. This is a state that has a lot of child advocacy centers. There's a lot of collaboration going on between law enforcement and courts and child -- children's groups.

What are you seeing, in the time you've been in office and beforehand, in terms of what is it trending? What is this all adding up to in terms of actually reducing child fatalities?

I'm certain that the CACs as set up are providing very strong services to children who've been victimized, working together with families. But are you seeing it show up in any way in actual reductions of deaths of children?

**JAMES HENRY:** You know, the tragic part of all of this is things you do that don't seem to ever change the numbers.

**COMMISSIONER PETIT:** Right.

**JAMES HENRY:** You know, I'm always amazed at how many people sleep on their children. And, you know, we have -- I think we had 138 deaths last year -- 136, something like that, from people just sleeping on their children.

We have one of the most extensive -- and we're starting another, you know, sleep campaign. And the Department of Health has one. But we haven't been able to affect those numbers. I don't know what else we can do.

The one thing about our kids in custody -- and I think that's where the whole program plays into it. I mean, not just having one part of it, but having the whole ball game, I think, you know, if you look at how we're investigating, and Dr. Modell and his group, but the training that we've given our CPS investigators, I don't know of anything like it. Being able to recognize quickly those kind of issues that come up where there's a danger here.

The other thing that I think that will make a difference -- and, you know, statistics are difficult because they're not -- you know, they're very few that are current. And, you know, we've probably got different statistics than -- and we have a very difficult time with the department before I got there reporting incidents. We couldn't define what was a child death, you know.

But most of the -- you know, the drug problems that we've seen ramped up, most of the problems we've seen with identifying these kids and putting investigators in the field and assessment people. We've got a new assessment academy now that we've created with Vanderbilt University that -- where we can assess kids better. We track them better. We investigate it better. We try to take care of them better.

I think that is going to make a difference. Whether it -- you know, with the ramping up of the drug abuse, it makes it very difficult to know exactly. And then, how people categorize those things from state to state makes a difference.

**COMMISSIONER PETIT:** One last question, please. You said the average stay for DHS or DCS, whatever it is, Commissioner, is 18 months for child welfare director. What is it for your average CPS worker?

**JAMES HENRY:** The average --

**COMMISSIONER PETIT:** Yeah. What's the turnover rate among your child protective workers?

**JAMES HENRY:** I think it's about 18 or 20 percent. We've concentrated a lot on how you make that -- we did pay them more for doing better training. We've been able to add workers the last two years when very few departments have been able to do it. We've reduced population, so it makes it better.

But we're still answering a ton of, you know, calls to the abuse hot line and priority one calls. And we've been able to ramp that up, which our staff is going to tell you about. But I think all those things help you.

And, you know, it just seems like there's a continuing layer here. Tennessee has a huge meth problem, has a huge heroin problem and substance abuses. And prescription drugs now are beginning to show.

And, you know, we're -- if we're -- if we're -- if we're not -- if we don't watch it, it'll be something else. But I think the way we can be prepared for that is have trained staff. And we've really spent a lot of money on training, how you identify these problems, getting a kid out when there's no other possibility.

**COMMISSIONER PETIT:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Covington. I think this will be the last question.

Go ahead.

**COMMISSIONER COVINGTON:** Thank you for being here this morning. I appreciated your remarks. I had a question. You mentioned that Florida was using the Tennessee example of posting cases of child fatalities that had been reviewed and they were posting on-line. Tennessee is doing that.

Can you talk a little bit about transparency and confidentiality and whether you see that as your -- where you see that being your friend or your enemy in terms of the challenges it creates for the department?

**JAMES HENRY:** Well, you know, I've got a saying, I'm not really worried about people know about what we do. The thing that bothers me is what they don't know that we do. Most people would be shocked to know the intensity and the magnitude of investigations that we do, the magnitude of the paperwork we do on children, how we follow them, how we look at everything surrounding that.

You know, I think if you can be transparent -- we invited the press to visit us on a Priority One call to go with us. And they created a huge story, and I think it made a difference in our state about showing what we really do to try to get in and identify kids that have trouble.

And that's why I think that -- you know, I think the media is going to find out everything they want to. And if you stonewall them, they will -- you know, they will create the story, and it won't be, maybe, in my opinion, factual sometime.

So if they want -- as painful as it is, we want to come with the truth first. We make a lot of mistakes. We've got 4500 employees out there, and someone right now is probably making a mistake. And every agency in this country is one newspaper release away or one death away from having a tragedy and a scandal.

So we just try to -- we try to -- if the press asks us, we try to answer it. And I try to be open and I try to be available. And we take the -- when it's our fault, we take the hit early.

**CHAIRMAN SANDERS:** Thank you very much, Commissioner. It was very informative.

**JAMES HENRY:** Thank you. Welcome to Tennessee.

**CHAIRMAN SANDERS:** Thank you.

**COMMISSIONER PETIT:** Can we get sometime between now and this morning what the actual number is on child deaths in Tennessee, if somebody knows?

**JAMES HENRY:** Scott's got it. I can ask him.

**CHAIRMAN SANDERS:** Actually, Scott will be testifying a little later today, sir.

So we have had a lot of discussion about the importance of multidisciplinary teams and, particularly, prior to a child fatality. And today we have two presenters who will focus on the children's advocacy center multidisciplinary team process as a potential model.

And I will go ahead and call up Teresa Huizar and Chris Newlin. Each presenter will have about 20 minutes for presentation, and then, the remainder of time will be devoted to questions from the Commission. I'm not sure who's starting.

Teresa?

**TERESA HUIZAR:** It looks like it's me because my PowerPoint's up.

Thank you so much, Chairman Sanders, and members of the Commission, for taking this opportunity to explore children's advocacy centers and how they have potentials for success, not only were they've operated traditionally, but in these cases as well.

And as you all know, National Children's Alliance is the national association and accrediting body for more than 777 children's advocacy centers around the country.

And in addition to that work, we also do grant making for the Department of Justice distributing about $10 million in grant funding each year to expand the reach of children's advocacy centers and improve them.

And as you know from your own background material as well, that about 315,000 children were served in those centers last year, and another 1.6 million kids and families received prevention services. So they have a large reach, and I think there is significant potential.

All of you on the Commission are very familiar with children's advocacy centers. And you had a wonderful tour of the Memphis CAC, which is a fantastic one, last evening.

However, for the benefit of folks who may be listening to this by webinar, I would just briefly mention that CACs provide a coordinated multidisciplinary team response to child abuse, and that really does cover the investigation, prosecution and treatment.

So with that -- and I'm guessing this is what I use to advance my slide. Yes, okay.

Core components of CAC. So the core of any children's advocacy center is a multidisciplinary team. And depending on the type of case, who comprises that multidisciplinary team certainly is going to vary to some degree, and also, depending on where the case is in the system.

But in general, I think all of you know that this response includes child protective services, law enforcement, prosecution, victim advocacy, medical, mental health, children's advocacy center staff and others.

And the goal of that is simply to make sure that all of the pieces of information are needed and shared in these investigations, treatment and prosecution, and the cases where that's appropriate as well.

We want to make sure that those services are provided in a way that's culturally competent, meaning that the services are really tailored to the individual child. And, of course, that's challenging because every kid and every family are different, and what they need is really different. But it's certainly the goal and the core standard for us.

Forensic interviews are the gateway to services within a children's advocacy center. You have a flow chart in your packet, and we'll talk a little bit more about it in a minute, about how cases come into the system.

But at the end of the day, helping determine what has happened or not happened, for that matter, and whether there's a need for further service is really going to come out of that forensic interview.

The piece that has been growing in the work of children's advocacy centers for some time is this piece around victim support and advocacy, the ongoing engagement with the family that doesn't end when the child and family leaves the day of the interview, but carries on through the life of that case.

And then, of course, all of you are aware that they also are required to provide specialized medical evaluation and treatment without regard to the child or family's ability to pay. Evidence based and trauma focused mental health services, again, without regard to the family's ability to pay for that service.

And the rest of these, case review, case tracking, so forth and so on, might sound initially a little bit dull because they're really about the organizational capacity of a CAC to deliver those other services.

However, they're absolutely critical in ensuring that children do not fall through the cracks, that we're watching what's happening to them continuously and we're conducting continuous case planning, not just at the beginning of the case, but throughout.

The thread that runs through all of these core components is a focus on, first of all, having a written protocol that outlines how services are going to be provided so that team members and partner agencies are agreed on that service provision.

And if something doesn't happen in a case that way that it's supposed to, there's something to call people back to. There's some guaranteed right on the part of a child to having services provided in a certain way because that's outlined in that written agreement.

These also have a common thread around accountability. There really are few places in the system where a team, a multidisciplinary team, is keeping itself continuously accountable for the outcomes around children -- around cases and around the outcomes for kids. And this is a place where that happens.

And I would say as well that we know that all of these elements are very important because we've looked at the evidence surrounding all of those individual elements. And I think Chris provided to you for your background materials, the annotated bibliography of research evidence that underpins these core components and our standards.

In terms of the case flow, those of you who were at the tour last night saw an example of this in a way that a flowchart will never adequately demonstrate, but you also have a one- pager of this in your background materials.

But a couple of things just to note. And that is that unless you were in a hospital-based CAC, for the most part, you're not receiving clients that are just coming off the street. These cases are referred by child protective services and law enforcement.

And in 39 states, what qualifies to be appropriate to be seen as -- at a children's advocacy center is outlined in statute. And that number's growing. Every single year, it seems like another state is adding defining legislation around that. And then, you have actually expanded what was in their original defining legislation.

So I think there's a lot of interest on the part of states and state government in viewing this as not only an incredibly beneficial service, but further expanding the scope of this work.

As an example, in these 39 states, some focus primarily on sexual abuse. But other states, like Nebraska, even include things like drug endangered children. So there's a wide continuum in defining legislation about what's viewed as appropriate.

When you look at the services provided by a children's advocacy center, I think the thing to keep in mind is that the joint investigation really begins from the time the referral is made, not simply from the time that children arrive on our doorstep, and that the multidisciplinary team convenes at the CAC.

From the moment a referral is made, people are already talking about, what do we need to do in this case? Who do we need to talk? How do we do this better? How do we start the coordination of services? So that front-end loading is very important before children arrive, and I think helps for a smooth transition to services once they do arrive.

When children are interviewed at the CAC, there's been a lot of attention paid to that, but I think the other thing to keep in mind is, it's really simply the opening of a door to what's going to happen after that.

In many cases, when they discover -- about 30 to 40 percent of the cases -- that either there's not enough evidence to proceed, from that point, you really can't tell what happened, or actually that there's been some mistake or misidentification and there is truly no case that's going to move forward, that's an important piece in terms of the criminal justice system.

It's an important neutrality to say, we're not trying to sweep everybody up into this. That if there truly is no case there, then we're going to move right along.

But once that forensic interview happens, we're also noting and assessing what services are likely to be needed by that family on an ongoing basis. And we're noting cases for case review so that we can do that kind of case planning and problem solving on an active basis throughout the life of that case.

You all received in your packet information about the primary presenting reason for referral to CACs, so you know that between 60 to 70 percent nationally of all cases that come to children's advocacy centers do so for child sexual abuse. That is, that's the primary referral reason.

Now, we all know about poly- victimization, so we know that the fact that a child is sexually abused does not mean that they haven't also been physically abused or neglected or something else. But when asked to identify the primary presenting reason, this is true nationally.

However, there's a tremendous amount of variation by state in that percentage. And I'll show a slide here in just a minute that points that variation out to you.

But one thing I'd like to note about this is, if you had looked at this chart 10 years ago, it would have looked quite different. Because 10 years ago, about 90 percent of cases would have been child sexual abuse.

And so the trend over the last decade, the continuing trend, is the expansion of CAC services into serving other forms of child maltreatment, not because of something that NCA was promoting necessarily, but because they were viewed as child abuse experts in their community and people saw the success of the multidisciplinary team model.

I don't think this trend is likely to discontinue any time soon. And, in fact, if I showed you a slide of all the trend data, you would see it's only going in one direction.

In your background materials, you also have a detailed chart that shows by state the percentage of cases that have as their primary presenting reason child sexual abuse. But I wanted to show you the full range and the cluster around this.

So in two states, in Florida and in Wisconsin, only 40 to 49 percent are child sexual abuse. So the majority of cases are something other than that. On the high end, there are still two states in which 90 percent of cases are child sexual abuse, and you can see the cluster in between.

So one of the things to keep in mind in terms of how much this expansion has taken root is really back to that defining legislation and the funding component within those states. Because if the state is funding them to do a broader array of services, then you see that service provision, typically. And in states where the funding stream and also the defining legislation focuses that more narrowly, that may exist to a lesser extent.

So where are these wonderful centers we've been talking about? Well, they're all over the place, as you can see. Not surprising to you, I think. And just to point out, that the dots are individual centers.

The circles have multiple centers because the geography to get things on one slide is such that we had to kind of lump some nearby ones a little bit together there. But you'll see that this really is reflective of the population centers in the country.

And I'm going to show you two slides in a minute that shows you, again, the variability and service coverage of CACs. Because it's not simply a matter of where they are physically, but where they're serving kids generally.

In 30 years, tremendous strides have been made in growing the service coverage of children's advocacy centers and expanding their work. To go from 1 to 777 or more is incredibly impressive.

But at the same time, in areas that are incredibly rural or resource poor, there's a deficit. And we know that and are working toward that, but much, much work still needs to be done because there are about a thousand counties in the country that still do not have that access today. This just shows you, as well, the locations in Hawaii and in Alaska.

So the next two slides are just showing you service coverage and the wide range of that. We conduct a gap analysis every year or every other year to really look at the issue of not where CACs are located, but where they are actually provide -- providing services by agreement through their written protocols.

So not just that they're saying, oh, yeah, I serve those kids over there, but they have a written protocol that's agreed on by all of the multidisciplinary team partners giving them that role and responsibility.

Kentucky, as you will see, has very broad service coverage. It has, essentially, a hundred percent service coverage in varying stages of development, some with multidisciplinary teams, but not completely accredited CACs. But there aren't these enormous gaps where no one is receiving any service at all.

However, in the next slide, you'll see an example of a state -- this is the State of Montana where a much smaller percentage of that state is covered by a children's advocacy center, and where there are tremendous gaps in service coverage in that state.

Now, if you were to overlay the population map over that -- and we have those layers -- you would see that this really does cover the majority of the population in the state of Montana, but that doesn't do you much good if you're a child in one of those counties that's unserved.

Knowing that most of your compadres would have access or benefit to that service isn't much comfort if you've been abused and you need these services and you're 300 miles away from the nearest child advocacy center, and where there are no identified multidisciplinary teams as well.

So Chris will talk more about this in a minute, I think, as well. But one thing to know about the CAC model is that in every study that's been done about it, it's been demonstrated to be more effective than the standard response.

And so there are a number of studies -- these are just the top five or first five that I looked at. But having a shortened length of time to disposition in these cases, even regardless of outcome, just simply shortening that, reduces trauma for kids and families, an increased rate of prosecution, more satisfaction on the part of child victims and family members with the response.

And our outcome measurement system is also demonstrating that as well, where non-offending caregivers are responding in the 90 percentiles, 95 percent, 97 percent, that if they knew someone who had a child who had similar issues, they would refer them to the local children's advocacy center because of how strongly they feel about the benefits of the services they've received.

And then, of course, better access to medical and mental health care and cost savings for this service model. So there are lots of opportunities, I think, for CAC intervention in all forms of child maltreatment.

Now, I want to be clear that I'm not selling rainbows and unicorns and fairy dust here. We're not the panacea for everything. But there is a tremendous network and significant resources that could be brought to bear on things other than child sexual abuse. And in many parts of country, already that's occurring.

So when you really think about this, one thing that I keep in mind is this extensive national network of child abuse experts and facilities is unlikely to ever be rebuilt. You know, there's already been a lot of federal investment in this.

So we ought to take advantage of these effective centers and their experts because I don't think another one's going to crop up any time soon, or those kinds of federal resources are going to go to the development of a similar network.

It's a proven effective model already. Not specifically around neglect, and not even specifically necessarily around physical abuse, but in the studies that were done already, they've been done in the full population of whoever was being served by those children's advocacy centers. And in many cases, that did include some portion of physical abuse, especially severe physical abuse.

So do you have a hundred percent confidence that it will work in cases of neglect or other forms of physical abuse? Not yet. There's more research that needs to be done. But do we have a level of confidence? Do we have a good basis for believing that this multidisciplinary team model will be effective? We certainly do.

We also believe that these existing protocols can be expanded to cover that. Recently, we went through our own strategic planning process, and in the top seven issues identified by our CACs, here were two.

The top one nationally was expanding the use of CACs to physical abuse. Another one within the top seven was to all forms of child maltreatment.

So I'm here today to tell you that this push, this move, this thought about expanding the work of multidisciplinary teams is not something that CACs aren't already thinking about and deeply interested in if they had the resources to do those things.

Finally, I would just say that we have a lot of data, and that data could be mined and it could be analyzed in a way that might shed light on this work. NCAtrak is a case tracking software that 370 of our children's advocacy centers use. There are a million case records in that database right now, and it expands by about a quarter million each year.

One of the things that it does is follow the cases that have been referred to the CAC from beginning to end. There are barriers now to really looking at some aspects of that data, but we've already been mining that around the issue of revictimization and revictimization rates, you know, what might be driving that. And some of what we're finding is very counterintuitive.

What if we looked at these kinds of issues? What if we overlaid our data against child abuse deaths to see what's in it? Do we have kids who have been served by CACs that wound up as a child abuse fatality later, and what could we learn from the patterns in those families and the services that were provided?

So it's just something to consider that this large repository, we're just at the beginning of seeing what can be done with that data, what we can learn from it.

Finally, I would simply say this. That in addition to -- you know, if I may be so bold as to make a couple of brief recommendations, that is that data sharing systems have significant barriers now.

And there are things that could be done to improve that, not only in terms of clarifying definitions and classifications around child abuse fatalities, but also there is no federal information sharing statute that allows children's advocacy centers to share information across state lines.

So within states, a children's advocacy center can share data and pool data to look at and to analyze information and to say, I've seen this kid already, now you're seeing this kid, if their state information sharing statute allows for that.

But while law enforcement can share that information nationally, and while CPS can share it nationally, this great repository that we have can't allow the various children's advocacy center staff who are doing this victim advocacy, mental health, medical care and other things, to share that kind of data.

And I think that that is something that doesn't have a huge dollar sign attached to it, but could be a very concrete thing that would really improve the way in which we're deciding what we need to do with kids and families.

And I would say, finally, that the National Institute of Justice does a significant amount of research, but it doesn't have adequate dollars allocated to it, and it doesn't have substantial dollars allocated for this purpose to look around these issues.

And so they're flooded with applications for research, but very little around the issue of child abuse fatalities. And it would be a very powerful recommendation to really look at not just the National Institutes of Justice or the CDC or all of these isolated pots, but is there some way to pool that to really look at this more comprehensively than we do now?

And, finally, to make sure that if we're going to ask children's advocacy centers to expand the nature of their work and who they're serving, that we're providing adequate resources for them to do that effectively and well.

Thank you.

**CHAIRMAN SANDERS:** Thank you.

Mr. Newlin.

**CHRIS NEWLIN:** Thank you very much, Commissioner Sanders, and the rest of the Commissioners for the opportunity to testify in front of you. I'd like to also express my appreciation to Virginia Stallworth and the dedicated staff at the Memphis CAC for the wonderful tour and reception last night. So thank you very much, Virginia.

I'm going to build somewhat on Teresa's comments. I think we're both very dedicated to the work done in children's advocacy centers, and I think we'll both provide some differential comment in regards to this work.

I'm going to talk some about just where we come from as far as our origins within the CAC model, and how we've evolved over time. And some of it may echo some of Teresa's comments. Really, there's -- sorry, Bud.

But there's really three fundamental principles on which the CAC model is built. And, really -- and I would even think more broadly, the multidisciplinary team response to child abuse.

That is that, number one, it's a serious issue we have to address. That, number two, whatever system we actually have in place should actually help children.

I was sharing with a couple of the Commissioners last night my own personal experience with a young girl I was seeing in therapy in the 1990s who had been sexually abused by her father who communicated to me in a therapy session that if she had it to do all over again, she wished she hadn't told. And as we talked more about this, she said that, actually, what the system had put her through was worse than her dad sexually abusing her.

Now, there's no, you know, greater indictment for need for improvement than that type of comment from a child who's 13 years old. And so we -- that's what really has fueled the CAC movement and our development.

And the third is, is that whatever we do, it must involve the multidisciplinary team. There's no one agency, no one individual, no one profession who can address all the needs necessarily of children who've experienced abuse.

And I would suggest today that the ability to eliminate or reduce child fatalities is similarly going to require a multidisciplinary response. It's not going to be a Health and Human Services issue. It's not going to be a Department of Justice issue. It's an American issue and it involves all -- it's going to require a lot of multidisciplinary team partners.

So this is a picture of the actual first CAC, called the Little House, very creative term, based in downtown Huntsville. This is kind of where this whole CAC movement started, with an idea that we needed a child friendly environment.

A lot of the services that Teresa was talking to, referring to, were provided -- were then provided in this more child friendly setting, knowing that when children have experienced some type of abuse, they needed a more comfortable setting in order to come and participate in a forensic interview, medical care and therapy.

So we've grown a lot. Just over 30 years, next year -- next month -- excuse me -- will be our 30-year anniversary. And this is a wide shot of our campus today, which is -- has been phenomenal. And thanks to Commissioner Cramer for all of his support in helping develop this.

But we now have a co -- a multidisciplinary team located at the CAC with us. And that multidisciplinary team has evolved and grown over time. It doesn't just involve local law enforcement. It involves prosecutors, our child protective services.

We also have co-location for our crisis services of North Alabama, which is a sexual assault center. We have the entire domestic violence unit of the Huntsville Police Department co-located there, because we recognize that children who've been exposed to domestic violence are six times more likely to be sexually abused.

We also the entire Homeland Security investigations, the federal agency, co-located with us because of the need for federal and state engagement on -- in response to these issues, especially regarding the sexual exploitation of children.

So having this multidisciplinary team co-located together has had phenomenal impact. And I know during the tour last night, you heard discussion of the desire for DCS here in Tennessee to increase their co-location within the CAC here in Memphis.

Additionally, over time, we've -- it's good to recognize that we're responding to allegations of abuse and working with our multidisciplinary team partners, but it's also very good, you know, and more important or important, for us to try to prevent abuse from occurring.

Instead of only being responsive and reactive, it would be great to be proactive. And I appreciate the focus of this Commission on what can we do more proactively to prevent things from happening to children, you know, especially child fatalities.

So a lot of CACs, and I'll talk a little bit more about this, have included child abuse prevention programs within their communities. We're the same. I feel like, you know, without a doubt, that some of those prevention programs have had an impact in preventing child deaths from occurring. Unfortunately, they still occur.

We also serve as a training center. We've trained over 80,000 professionals. Just last year alone, we trained individuals from more than 40 countries around the world through our training programs.

And we also host the child abuse library on-line, which is a digital library, the first ever fully searchable digital library that's available to all CACs and multidisciplinary teams. That way, we can connect research to practice. We don't just have people engaging in the -- you know, the same way they've always done things.

So while we continue to serve -- we serve as a functioning CAC, we also are trying to help improve the work done by CACs and multidisciplinary teams throughout the country.

As we've evolved over the last number of years, and building on what Teresa said, we've really reached out to say, we don't just want to respond to child sexual abuse.

Quite honestly, if we're only responding to child sexual abuse with this multidisciplinary response, what we're effectively saying is we're discriminating against kids who may have experienced physical abuse. They're not maybe getting the same quality of response. And I don't think that anyone in the CAC feels like that's a tenable and appropriate situation.

So I agree completely with Teresa that we will continue to see the diversification of the client portfolio within CACs. That includes physical abuse. It includes kids who have been exposed to domestic violence.

We regularly interview children who are the only witnesses to homicides, who we have to interview to find out, you know -- and it's a difficult thing to interview a child who's the only witness to his mother's murder. And that's very difficult work that's done at CACs.

Also, drug exposed children, I know the folks here in Tennessee will be talking about that issue. But we do interview those children, which takes a very different slant.

We're very actively involved in child fatality review. And also, especially over the last several years, much more engagement within the area of commercial sexual exploitation of children.

These -- this expanding growth is because in the community -- in individual communities throughout the U.S., the multidisciplinary team partners recognize the value of this approach.

If it wasn't working, they wouldn't bring them. Nobody's telling people they have to do this. They're doing it because they recognize a multidisciplinary response to these issues can be effective, just like it's been with child sexual abuse.

Teresa mentioned briefly the issue of poly-victimization. I don't think we can underestimate it. Commissioner Henry made some comments about the adverse childhood experiences.

I can tell you just with kids we see alone last year, on average in therapy at the NCAC, had on average seven different victimizations. Seven different victimizations they've experienced. These kids are highly at risk.

If you look at the ACES data, that means, on average, the average child at the NCAC would live 20 years less. And that is absolutely not acceptable. That's why providing evidence based treatment is so critically important.

And as we continue to go down the road of looking at how to respond to child -- eliminate and prevent childhood abuse and neglect fatalities, the issue of poly-victimization needs to remain central.

I think there's a key there that, when we have families that have had different types of victimization, as I'll allude to in my later comments, that that provides a risk factor that we need to be looking at to actually help prevent potentially child fatalities.

Teresa also mentioned -- it's good to see that there's a lot of commonality in our presentations because we both have philosophical agreement on many things -- that the CAC is a model.

And within that model are multiple different evidence-based practices, whether it's evidence based medical examinations and evaluation, evidence-based forensic interviewing practices, evidence-based mental health practices, this model provides an umbrella under which multiple evidence-based practices in their individual specific discipline are included and incorporated together to create a continuum of services that are of the best quality. And I think that's what really is fantastic about the CAC model.

Now, many people think about CACs and all -- you know, Commissioner Cramer was a prosecutor, obviously. And when we first looked at the evaluation of CACs, a lot of people said, okay, well, what's the impact on prosecution?

And while we have had that focus, if you think back to the second slide that I showed that Commissioner Cramer wanted me to quickly get away from because it had his picture on it, it said it's about -- this really revolves around what's right for the child. It's about doing what's right for the child.

So you can see here that last year in our county, we had over 1300 reports of child abuse and neglect to our child protective services. Of those, our multidisciplinary team reviewed 972. So we're reviewing a vast percentage of those cases. And it includes a wide diversity of cases. It's not just child sexual abuse.

The focus of criminal prosecution involved only 143 cases. So this is not just an arm of law enforcement to only prosecute. Far more children receive medical exams, far more children receive therapy, far more children were protected by Health and Human -- the CPS system than we actually had criminal charges filed.

And I just want to make sure to communicate that CACs are not just about the criminal justice process. That is a key partner in what we do, but central to what a CAC is, is child, child advocacy center. Child is the first priority. It's the first word in our name. It's the first priority in every case that we undertake.

In fact, if you were to come to our multidisciplinary team this Friday, I can almost guarantee you, we'll be reviewing a case with a situation where a child was born addicted to drugs or exposed to drugs.

And in that situation, you'll see a multidisciplinary discussion about, what's the right thing to do in this case? Do we need to prosecute or do we need to provide some other alternative services? Is a felony prosecution necessarily going to be the best thing for this child, this family?

And -- because that's important for us. If we can provide rehabilitative services while still assuring the protection of the child, that will be a high -- a great priority for us.

Well, that's a colorful slide. That worked out well.

Let me talk briefly about some resources. I mentioned the child abuse library on-line. The child abuse library on-line is a phenomenal resource. As I said, the first ever digital library.

We actually have a grant from the Department of Justice for training in technical assistance of child abuse professionals. As part of that grant, we propose that we -- the child abuse library on-line be a resource for this Commission.

We are on top of the latest research that's out there. We put together a bibliography that we update on a regular basis of the latest research related to child fatalities.

Teresa also mentioned this annotated bibliography of the empirical and scholarly literature supporting the 10 accreditation standards. If you need 140 pages of reading for a long airplane flight, I'd encourage you to read it because it's the evidence, the underpins, everything, the original concepts of CACs and why we have these 10 accreditation standards.

And, finally, there's a bibliography on there regarding the efficacy of CACs. Just to echo what Teresa said, every single study published in a peer reviewed journal has found positive impact of this model. Every single one. Not one study has been published in a peer reviewed journal that finds any differently.

And that's great that we sit up here. And I'm a nerd, I like research. I like to read research. Someone was asking me the last book I read, and I was, like, well, I can tell you the last several studies I've read because that's just, you know, kind of how my DNA is.

But at the end of the day, it's about each individual case. It's about each individual child. It's about each individual family that comes to our centers, and are they getting the services that they need to help them heal from what may have happened to them if, in fact, abuse did occur.

So I'd like to briefly share with you just a quick -- very quick story about a young 12- year-old girl who was -- there was an allegation that she had been sexually abused by her mother's brother.

And as a result of this allegation, it was reported to child protective services and she was brought to the child advocacy center -- a child advocacy center for a forensic interview.

As Teresa mentioned, before the interview, the team gets together and discusses the information available, reviews the case, makes sure that everybody's oriented to what we, you know, want to try to do in that particular case. The forensic interview was conducted, and this young girl actually disclosed the abuse by her uncle.

Following the interview, as you would expect for any parent, the parent wants to know, okay, what's going to happen? What's going to happen now?

And the investigators, we're going to sit down and talk to the mother and share with her what the next steps would necessarily be. And the young girl, she was 12 years old, asked if it was okay if she went outside and wrote on the sidewalk with some chalk.

Now, you know, of course, you know, there's no problem with that at all. We want her to be safe. But, you know, say, hey, you know, just be -- make sure that you recognize that whatever you write, other kids who come to the center will see exactly what you write on the sidewalk. And she said, yeah, that's fine, no problem.

So when the investigators come out from this meeting with the mother, they come out to front steps, and these are the steps that they see. You can see the bottom step -- and I'll read it for you just to be clear. This young girl -- and this is what she wrote, knowing that other kids would be walking up these steps.

On the bottom step, it says, when you step here, you have faith. The next step is, when step here, you have hope. The next step is, when you step here, you are not afraid. The fourth step is, when you step here, you are loved. And the fifth step is, when you step here, you are ready.

So I don't know if necessarily in every case, in every research study, that we do everything we can for every single child that. But there is no doubt in my mind that, based on this child's testimony here, which is the most powerful testimony you're likely to hear during this entire time, we actually -- the CAC and the multidisciplinary response was truly effective and truly supportive. And that's what we should be doing.

So I appreciate the opportunity to share this with you. I think it's one of the most powerful testimonials I've ever seen about the impact of our work.

So where do we go from here? Future opportunities. As I mentioned, our child abuse library on-line stands ready to help with any kind of request that you have. If you do a search, you know, we can access every single research article there is going back to 1888. So if you want something, we can find it for you.

Interesting, we have a research librarian who is widely recognized for her ability to find important information. And we want to be a resource for this Commission in that regard.

I do want to make a couple of comments, much like Teresa did, about thoughts, big thoughts, about where we go in the future, and then, I'll be happy to entertain some questions, as I'm sure Teresa will also.

CACs in their, you know, concept are in broad terms a reactive approach. And I say that especially related to the investigation. Law enforcement or CPS gets an allegation, they get a report. Subsequently, an investigation is undertaken. And so we're reacting after a report has been made.

Reaction doesn't necessarily help prevent child abuse and neglect fatalities. If we're only reactive, we're not going to necessarily be able to help prevent things.

So I want to put this as a frame, that the CAC model and the multidisciplinary response to child abuse has been extraordinarily effective as we've tried to highlight today, that in our response to these allegations -- and I think we can continue to do more that in that regard.

However, I think in some ways, the big lesson from this is, the multidisciplinary response is critical, but how might that necessarily be tailored specifically to prevent child abuse and neglect fatalities?

And while it's not a complete thought, it's not a complete proposal, I would at least like for this Commission to entertain the idea of a modified multidisciplinary team concept that can be applied to child abuse and neglect fatalities that would involve different -- similar, yet maybe different, partners.

And within the law enforcement realm, the 9-1-1 centers who receive lots of calls, could be a resource. Domestic violence, because any time there's a domestic violence call, they have - - they are tracking those.

So if you have a child who's born -- every time a child is born and they give a home address, what about just running that as a cross reference against 9-1-1 database to see how many reports have we had out to that home? How many domestic violence calls have gone out to that home? How many animal control calls have gone out to that particular home from a law enforcement perspective?

It gives us an idea, is this child going into an environment at a very, very young age, one day, two days, that may have had real issues with impulse control and criminal activity.

Additionally, the other multidisciplinary partners from a CPS perspective might be their intake, exactly what are they saying. There's a lot of screen outs that occur. We all know this. They're getting deferred for an alternative response.

And in that situation, we need to know, how about those addresses where this child may be going? And their data management systems that -- to be able to access, have we ever had cases involving that address. Typically, CPS searches cases by last name of the parent, but I think the address can be an important -- another important way to pursue this.

Engagement with emergency departments as part of the multidisciplinary team for the cases they may be seeing in NICU when PICUs for the children who arrive to the hospital.

We have a great relationship with our local hospital and the medical director of our NICU and of our PICU because we recognize that, sometimes, there's children who arrive there with significant medical issues. And if we can address those, they need to be part of what we're doing. And plus, they have medical expertise to help, you know, support this team.

And as I mentioned from a non-NGO perspective, involvement of CACs, and as Teresa has mentioned, this vast database where we have children who have been victims of abuse and we know where abuse may have occurred, and domestic violence programs, could present an opportunity for a modified MDT approach that would not be responsive after allegations happen.

But if you had a algorithm that you ran through, that every time a child was born you ran through these things, and if there were any kind of markers for concern, maybe there would be this group that would review those cases to say, do we need to provide some proactive services in this home to try to prevent abuse from happening?

Will it work? I don't know. But we didn't know if the CAC model would work. It sure made a lot of sense at the time. And I think it's time for us to look for visionary ideas on how we can try to protect all of our children, especially those most vulnerable children who are subject to child abuse and neglect fatalities.

So with that, I'd like to thank you for the opportunity to speak with you today and reserve the rest of our time for Teresa and I to be able to answer questions.

**CHAIRMAN SANDERS:** Thank you. Very informative.

Commissioner Ayoub.

**COMMISSIONER AYOUB:** Mr. Newlin, you mentioned commercial sexual exploitation. Are the centers nationally reporting that they're seeing victims of exploitation often lumped under the term trafficking?

And if so, is that familial trafficking? And if so, do you -- is the treatment the same? Because there's a lot of thought that that should be separate from any other trauma.

**CHRIS NEWLIN:** Yes. I think several -- let me try to respond to the multiple parts of your question, which is very appropriate and timely.

I think we, as a society, are beginning to much more have the conversation about commercial sexual exploitation of children. I was just in Little Rock yesterday, talking to all of the state multidisciplinary teams about this specific issue.

Earlier this year, the National Children's Advocacy Center conducted a survey with CACs throughout the U.S. regarding the commercial sexual exploitation of children and the services they're providing.

What we found is CACs are involved in these cases. Unfortunately, we're not seeing a huge number of them. Many of those cases are being handled by federal investigatory partners, so they may or may not necessarily be utilizing the services of a CAC.

But we do have some model programs around the U.S. that are responding to this issue and very -- much more proactive, somewhat of a modified multidisciplinary team, specifically around the commercial sexual exploitation of children.

We are seeing, I think, within CACs -- and I can speak for our own -- a majority of the cases that we see involve some type of familial involvement, whether it's a mother or a family who may be allowing their child -- access to their child in exchange for, you know, some type of resources, financial or other; or individuals who are actually self-engaging their child in the production of indecent images of children and access for sexual activity, typically, again, in exchange for, you know, something of monetary value.

So I think we don't have a huge, great understanding of everything that's going on. I can tell you one big issue that it was in the survey that was overwhelming was, there's not specialized training that people have received necessarily, either multidisciplinary teams, forensic interviewers, medical providers or therapists, specifically on this.

There's a program in Georgia that is adapting trauma focused cognitive behavioral therapy specific to this population, but it's an adaptation that's still in the early exploratory phase.

Because we know with the vast majority of commercial sexual exploitation of children, it requires a very diverse approach that involves protection and shelter and safety, in addition to care. And there is a much longer time for building trust necessarily within that relationship, which is not the same as maybe interviewing a seven-year-old child who's been a victim of a single incident of sexual abuse.

So we -- we have a lot to learn still. And I think we, as a nation -- it's just not CACs. We, as a nation, are seeking to have a much better understanding.

I would just advocate that one thing we need is a much broader conceptualized -- agreed upon conceptualization of what we're really talking about, and an understanding -- one area where we don't have good data at all is exactly how much is this necessarily happening? How big of a problem is this?

The ability to define and measure that in a meaningful way is not really out there, and that's something that's really needed. So thank you very much for your question.

**COMMISSIONER AYOUB:** Thank you. Do you know when they aren't -- you said there's not a big number coming to the centers, and that usually comes through law enforcement.

Do you know if that's because there's other places that law enforcement is taking these victims or it's because they're locking them up and it's still looked at as a crime, and not a victim?

**CHRIS NEWLIN:** I don't know so much. I think we're -- one of the good things is, is that there's a shift in the thinking about this, that locking up is not -- not so much the approach.

I would say that a good number of these may be identified by federal partners. And, historically, CACs were built with engagement with local CPS, local law enforcement, local prosecutors.

And so when I mentioned earlier our now collaboration and co-location of Homeland Security investigations is an effort to try to bridge this gap into the federal system.

You know, Homeland Security and FBI both have forensic interviewers that conduct interviews with children who have been victims of commercial sexual exploitation. They are oftentimes done at CACs. But it really is kind of handled by those federal authorities.

The more we can do to bridge this federal/state gap, I think would be advantageous for us in responding to the issue.

**COMMISSIONER AYOUB:** Thank you. And just one more question.

It mentioned on one of the slides, I think, Teresa's, that a component of CACs is evidence-based trauma focused services. Could you just give me an example of two -- a couple of those?

**TERESA HUIZAR:** Oh, sure. Well, in terms of sexual abuse, I would say that the most common interventions are TFCBT, trauma focused cognitive behavioral therapy, and CFTSI, which is child and family traumatic stress --

**COMMISSIONER AYOUB:** Where I understand it.

**TERESA HUIZAR:** Sorry. Sorry. Sorry. All these acronyms.

So the first one is trauma focused cognitive behavioral therapy, TFCBT. And the second would be CFTSI, which stands for child and family traumatic stress intervention.

But for physical abuse, it's actually a different constellation of services. For that, it would be AFCBT, which stands for alternative for families cognitive behavioral therapy, and PCIT, which is parent child interaction therapy.

So I think that one of the things that we're seeing overall is that children's advocacy centers are getting more training and multi-modal therapy, which is critically important because the same intervention will not work for all things.

Which is one of the things that your question implied around commercial sex trafficking, that we have to be able to adapt what we're doing to the particular population that we're working with.

**COMMISSIONER AYOUB:** Thank you very much.

**CHAIRMAN SANDERS:** So we have a number of questions here. Commissioner Cramer, then Dreyfus, then Horn, then Covington.

**COMMISSIONER CRAMER:** Very quickly. Thank you both for your presentation here today. Virginia, thank you for your tour last night, those of that were able to go to the Memphis CAC. It's a marvelous site there, very mature center that's grown over the years with plenty of community partners.

I think it would be important for this Commission to know, how do you pay for all what goes on at the CAC? Virginia talked us through some of their budget connections. And you've got agencies that co-locate, agencies that participate by budget.

You've also got -- we would benefit, I think, knowing what federal funds you access, what recommendations you might have for us that would allow you, as in Virginia's case, to add interviewers, to add medical exams, forensic medical exams, pay for therapy that's carried on there.

Could you give us some generalized response to budget?

**TERESA HUIZAR:** Sure. Well, you know, Chris will be the expert on his own budget and how that breaks out. But I would say that it's been an interesting and beneficial public/private partnership.

The federal money, in terms of the Victims of Child Abuse Act, is very small seed money that was very important to the development of CACs and to improving them. But $20 million a year will only get one so far.

So that's a -- it's an integral part, but what it really allows children's advocacy centers to do is leverage private dollars. And so the vast majority of CACs are independent nonprofits. And they are raising many, many private dollars to fund this work.

We did an estimate a couple of years ago that between 225 million and 500 million private dollars are raised by children's advocacy centers on an annual basis to support their work. So you start getting to some large numbers very quickly.

So when you think about the federal investment, it's a small, but important component that allows them to say to donors, to state funders, to state legislators and others, the value of this work.

Now, 25 states fund children advocacy centers in various ways. Some through fines. Some through fees. Some through sort of their general appropriations process.

In no state is that 100 percent funding. Even in those that have a very heavy investment on the part of the state, it doesn't fund all of the work for all of the population.

But then, there's the piece of this where -- federally with the Victims of Crime Act, that's an important component of this and that probably has not gotten enough attention.

So for children's advocacy centers, these fines and fees that are collected federally, and then, distributed down from states to localities are intended to help reimburse costs or provide services to crime victims. And so that really revolves around -- in the child abuse arena, typically, it has revolved around medical services and mental health services and victim advocacy.

So many CACs receive some monies for victim advocacies through that pot. What it will not pay for at all are these gateway services around forensic interviews. And that's the critical component because a forensic is a victim service, first of all. And secondly, it's a gateway for all others.

And so encouraging OVCs, regulations, there in comment, period, for their final regulations to include that as a billable service would really greatly expand the ability of CACs to properly intervene in these cases.

**CHRIS NEWLIN:** Yes. And again -- so I really echo the issue about the Victims of Crime Act. It has been very supportive of CACs, in addition to the Victims of Child Abuse Act.

We do see, as Teresa was mentioning, a large number of states, and it's growing, who provide state level funding. So there's federal funding of a small amount, state funding, typically, from legislators who recognize that in the investment in this multidisciplinary response approach is actually an investment. We're helping their agencies do their job.

Similarly, at a local government perspective, we're helping the local law enforcement, the local CPS, the local prosecutors do their job. It facilitates it.

Teresa, you know, mentioned in her comments about a cost/benefit analysis. What we have found is, everybody talks about -- so let me go back to kind of my story at first about the girl who said, if I had it to do all over again, I wish I hadn't told.

The reason that she was traumatized is because of a duplication of government activities. That's what caused her trauma. Being interviewed by six different people in six different places. That was a horribly inefficient system.

So from one side, from a policy side, we say, this is duplication of services. From a child perspective, it's trauma -- it's system induced trauma.

And so what we have done with this is to -- in many ways, like a Sixth federal reg, a lean processing, is to create a much more efficient process that reduces trauma in the child, but also saves money.

We reduce the actual expense from these agencies, these individuals who would, otherwise, be individually conducting interviews and these other activities. Streamlining that process has achieved a cost savings that is fantastic, not just for children, but for the systems involved.

So federal funding, state funding, local funding, fund-raisers, grants, foundations, we have very what I would call braided funding streams at all CACs. No two CACs are exactly alike. But there -- this is clearly not a top down funded approach.

Could there be additional support from federal? Absolutely. Let me also mention, there is money that comes to CACs and supports CACs through the Children's Justice Act, CJA funds. If you look at the CJA legislation, it very much looks in that regard.

And I would like to echo what Commissioner Henry had mentioned earlier, twice in his comments, as I recall, he brought up the issue of economic development. And just last week, Commissioner Cramer and I were in Alabama and spoke at a conference actually talking about child maltreatment and economic development.

And so this is something -- we don't need to think about it as just a children's issue. This is -- we're very good about investing in job training programs so we can have people be able to work in new industries that are coming to our community. What about with those kids when

they're 4, 5, 7, 10, 11, about making sure they're protected so they actually can participate in those programs?

So the investment in our children is an investment in the future economic viability of any state or community or nation.

**COMMISSIONER CRAMER:** Just quickly. With regard to the 700-plus Children's Advocacy Centers, would you say that more than 50 percent of that money comes from the private sector and the other amount comes from a collection of state money, federal money?

**TERESA HUIZAR:** I would say it generally ranges between 40 to 60 percent, yes.

**COMMISSIONER CRAMER:** From the private sector?

**TERESA HUIZAR:** Uh-huh.

**CHAIRMAN SANDERS:** Commissioner Dreyfus.

**COMMISSIONER DREYFUS:** Thank you so much. It was wonderful.

So I'm sitting here -- and it was a good tour last night and I've been involved with child advocacy centers over many years. And I'm sitting here and I'm thinking as someone that's been involved with this work a long time, that we're sitting on a 20th century version of child protective services in a 21st century world.

We depend on people calling into a hot line. We depend on one person with, hopefully, a supervisor to make screening decisions. We rely on an investigator to go out and hopefully have the kind of experience and training and supervisory support around them to make the right decision. And I don't think that's the way of the 21st century.

So you were talking about the continuous trend to expand cases that CACs are involved in. And, to me, what that's starting to look like to me, is what might be that version of child protective services for the future of our country where we're putting more resources into that very important front end, right, in terms of mandatory reporters and their training and our -- and the people are calling.

Because these kids are typically -- that are killed by abuse and neglect were known to someone, even if they weren't known to the child protection system. Someone knew them. Someone saw them.

I could see then CP -- the child advocacy center or the concept of that starting to do the kind of triaging that says that there are certain calls that come in that are screened in and someone does go out, but we go out in a multidisciplinary way.

And then, I could see that following through to the ongoing measure of safety throughout the duration of that child's time in the, quote, unquote, child welfare -- experience with the child welfare agency.

But we're sitting now with federal funding that basically stays pretty far away from any investment in child protective services. It's a very deep in federal funding mix. I don't know

whether or not the federal regs allow CACs to enter data into SACWIS. I'm assuming maybe not.

And then, I'm also curious about Medicaid. I'm curious about why it is that, you know, CACs are providing critical behavior -- evidence-based mental health, and we have parity in our country and mental health is health, and yet, I don't hear that Medicaid is a significant partner in the funding of these critical services.

So I would say if our -- my question is both an observation and a question. One is, I think CACs, the history of them and the continued evolution of them, could very well be to my fellow Commissioners a model of what child protective services needs to look like in the future.

But it's got to get anchored regulatorily -- from a regulatory standpoint and fiscal standpoint into some federal things that I don't think today it's connected to. It's kind of just viewed as a nonprofit in the community doing great work. And I don't think that's going to be enough.

**TERESA HUIZAR:** Well, first of all, thanks for recognizing that. But a couple of things in regard to the comments you made and the information that passes through CACs. One of the things that happens in the State of Tennessee, which is very helpful, is that there's a data transfer that happens overnight from those cases that are screened in as severe -- because in the State of Tennessee, that's what's going to get them to a CAC, and that really dumps into the data system that centers here within this state have.

So that when you are at a children's advocacy center and you come in in the morning, you have those cases already in the cue. And if they don't show up at the CAC, it gives you the ability to say, well, why not? You know, why wasn't this scheduled for interview? Or what are you doing with that case? Or do we need to staff this? So that can be very powerful. And I'd like to see more states replicate that.

But I think what you're talking about is a step further from that. Beyond looking at something like what constitutes severe, what if there was some sort of predictive analysis that went -- that data went through before it ever arrived at the CAC, so that one had some kind of risk assessment and triage.

And that way, not just saying either, yes, you're in or no, you're out, but here are the red flags and the constellation of concern that we have around this case, which could be very helpful and very powerful for the multidisciplinary team.

In terms of Medicaid, I don't think this is going to shock you. I mean, these services are certainly billable, many of them to Medicaid. However, for the average small CAC that has two or three employees, the cost of actually going through the process to administer that bill for it and those sort of things is so onerous that CACs prefer to raise the dollars privately rather than to go through that process because from a cost effectiveness standpoint, it's simply not there.

So it's not a problem probably that you can entirely solve or we can entirely solve, but it is a problem that definitely needs solving because I also sit on the board for the National Center for Child Traumatic Stress Network. And one of the issues they're dealing with all the time is

how to appropriately bill for evidence- based treatment through Medicaid. We have the same issue.

You know, they have complicated and very robust billing departments, and they're struggling with that. So imagine a two or three or four- person children's advocacy center. So there's got to be something to cut through some of that red tape if we want to try to increase the sustainability and access, I think.

**CHRIS NEWLIN:** Let me share kind of my comments. I completely agree with Teresa on the last point regarding Medicaid. If you looked at our last two years for our audited statements, you'd see that our administrative and development costs, fund-raising costs, are 11 percent of our entire budget. 89 cents of every dollar goes to direct service.

Now, you compare that with any university, a lot -- any -- you know, most for- profit companies. What we've done is we've prioritized so much to be in direct service because of the overwhelming need and demand for service that we don't have the infrastructure to be able to do exactly what Teresa says.

I have a board member who's a physician who says, you know, that he continually has to update, update, have someone stay absolutely on top of just the billing and the codes and the requirements, that it's overwhelming. And if his office is struggling, ours would be completely overwhelmed.

So if there was a way to streamline Medicaid services, if they were being provided, let's say, at an accredited CAC providing an evidence-based practice, that would be a fantastic thing.

Teresa also mentioned something, and I'd like to build on it. We've had some initial conversations with the modeling and simulation department at the University of Alabama Huntsville about looking at child abuse cases.

You know, you may not know it, but for one of the computer rankings or systems for college football is done there. They have all this data they dump in there, like millions and millions of things to say, who's the number one team? Who's the number two team?

And they have the ability to do incredible modeling and simulation. I think the opportunity to do that within the child abuse arena would be fantastic, especially if we were able to identify some variables.

Finally, now here's going to be a radical statement, which I don't mean it to be too radical. But I think the child protective services system, going to your 20th century concept, really, we need to evaluate.

I think that including within one agency child protective services, adult protective services, food stamps, Medicaid, everything, has created such a spread and such a -- yes, it is all related to the well-being and protection of families, but kind of everything is.

I think if there was a department that did child protective services and it was a stand- alone, very focused, very engaged, you know, organization that didn't so much look at -- you know, have to also worry about food stamps and all these other areas, it could be very focused on

the issue of child protection, I think that would -- that would clarify their mission and enhance that ability to really be able to address this issue.

So as we go forward, I think that's something that ought to be looked at is, could we have better impact if we were to have a really defined -- anybody knows if you're trying to do lots of different things, it's really hard to do any of them really well.

So I know that's maybe a little bit of a radical thought, but I do -- I think our children are requiring a radical response.

**CHAIRMAN SANDERS:** So we have a couple of more questions, and then, we'll close this session. Commissioner Covington, and then, Commissioner Petit.

**COMMISSIONER COVINGTON:** Thank you, really, a lot, for your thoughts. I got the sense that you were -- and I'm being honest here -- a little defensiveness in terms of we really are trying to do the physical abuse piece through the advocacy centers. Because I think that that's been a criticism in the past is like, why aren't we doing the child abuse -- physical -- the physical child abuse cases?

And I'm a real believer in that. I have -- you know, looking at fatalities at the far end, I often wonder why weren't these kids -- why weren't they identified and addressed through a multidisciplinary setting a long time ago?

Because a lot of these families we see, these kids that come in, when you start looking at the patterns and we get Tom Morten's news stories every single day and we look at these cases, and when you look backwards, you just sort say, oh, my gosh, if there had been a multidisciplinary look at this child early on in an investigation, we could have done better to have protected them, I think.

So I'm all about looking at a 21st century model that looks way beyond just putting a poor, lowly CPS investigator to be the only person out there in the field, having to make this decision about safety and protection and prevention.

So I'm wondering -- I'm trying to wrap my head around what this would look like. And I think it's more than being at a house where a child would go to. I'm trying to figure out if you really radicalized -- I don't think it's really radical, I think it's just where we need to be -- a system that uses an MDT model early on when even -- even to the point of when reports come in.

I mean, I still am perplexed about why we have one person sitting at a telephone making a decision about why we investigate or not, when multiple voices or eyes would make a difference. But it's going to cost more. But -- it will definitely cost more because there's more people involved.

But I'm trying to wrap my head around what that would look like? And have you thought about what that could look like using a CAC model in terms of place, in terms of who's at the table and in terms of how you do this? Really, it's early involvement, way earlier involvement of multiple peoples, multiple disciplines.

We've been talking -- it's not even just law enforcement and CPS, it's a public health nurse. I mean, who knows who's at the table? I'm not really sure who it is.

But have you given more thought to how - - what this could look like and what that would require in order to expand?

And I guess the other piece that fits in there is, where does CPS sit into all of this in terms of statutes and state laws and everything else that goes into it?

**TERESA HUIZAR:** Well, there are some states that are experimenting a little bit with this because, as you know, many states have had their equivalent of this Commission looking at child abuse fatalities and child abuse stats within their state.

Illinois is one right now that's looking at the issue of -- and interestingly enough, they've really decided to open it up and ask the question you're asking, which is, what if we didn't start from the proposition that CPS is going to look exactly like it is, but it could look like something very differently than we've imagined it before? And you know, they engaged the state chapter of children's advocacy centers right away. They're in very early days, so I don't know.

But one of the things that they asked them to imagine was, what if you all were doing the screening? What would that look like if we provided you the resources and you were doing the screening through the multidisciplinary team?

Now, nothing's been implemented yet. So there's no -- you know, there's no test bunny. There's no something with data to go back and look and say, well, was that really different or not?

But I think the fact that states are asking this question and they're exploring it means that there's some will to at least pilot some circumstances that might look different. And maybe that's a place to start is, you know, we may not be able to revolutionize the whole system at once, but could we fund some pilots to really look at this within states.

**COMMISSIONER DREYFUS:** Just remind everybody, too, the waivers, right, would not allow -- like say the State of Tennessee wanted to experiment around this. The waivers would not allow them to do the experimentation in CPS because that's not a IV-E eligible activity, right? David, is that correct?

I believe it is. So I just want to make that point that we do have -- there's a federal financing glitch here in terms of how the federal government participates in a state's child welfare agency and puts very, very few dollars into the front end, which is that CPS function.

**CHRIS NEWLIN:** It's interesting, if you go to any conference -- child abuse conference building -- you know, to respond to the question, you know, there's training for professionals of all kinds.

You know one thing you will not see? You will not hardly ever see training specifically for CPS intake professionals. How to effectively screen. You'll see all kinds of -- you know, training on all kinds of stuff, but we don't have training specifically for intake.

And it is an incredibly challenging job because you have to be adept at being able to quickly assess a situation, be able to try to ask questions with people who may be calling with very

disparate kinds of dispositions, and try to assess, you know, hey, are we going to take this call or not.

I think the moral of -- the model that we're talking about here is that, you know what, we seem to do a heck of a lot better when we have a team approach. Now, team approach means it may be more expensive, but I don't know -- that means we're valuing the protection and well-being of our children, which, you know, is a very slippery slope.

So I think we could have a team screening approach, which is kind of what I was suggesting to you with that modified multidisciplinary team, that that would be a group of people who could help evaluate certain situations. Some may be so clear that we're going to respond. Others that may be more concerning, we may want to do something, you know, more reactive.

But if we're going to stop child abuse and neglect fatalities, we can't even wait for anyone to call. We are going to have to do something more proactive to identify at risk families. Much like participants in our healthy families program, who we go out there two days after they get home, and we're out there in the home before they're ever getting off as long as they will allow us in the home, with phenomenal success in more than 98 percent of families with no substantiated abuse or neglect cases.

So I think the moral is it's not so much what CACs can do. I would proffer -- you know, as much an advocate as I am for CACs, that, really, what we're talking about is a multidisciplinary team. That there's -- a multidisciplinary team response is going to be what's going to be effective for being able to review this.

The CAC, I think, could be a part of that. But again, CACs primarily serve 3 to 18. If we're talking about child abuse and neglect fatalities, we're talking under three. So we're going to have to be working in an arena in which CACs don't typically work. And there may be partners that need to be involved that have not previously necessarily been involved as part of a team.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** Thank you. And thank you for that presentation. A few things. One is, the good news, I think, from our subcommittee point of view on child protection, is that virtually everything that you've outlined and everything that's been raised is actually being recommended.

So the MDT approach to intake, to investigations, to pre-mortem, to look backs, to the post-mortems, I think we're sold on that idea. I have some questions, though, just mechanically and otherwise about this. So let me, if I may, just ask you those.

One is the MOU protocol instrument that you talked about. Is that standardized across the country? Does it vary from jurisdiction to jurisdiction? And I don't know if you've given it to us yet, but I haven't seen it.

Can you give us an actual physical copy, electronic copy, of the MOUs?

**TERESA HUIZAR:** Well, certainly we can pass on copies of examples of MOUs. There are certainly differences among them based on the types of cases that CACs are seeing, and also the service array that they have.

However, the national standards for accreditation have a long list of things that are required to be in those interagency agreements. So you'll see differences outside of that, but those common elements will be the same.

**COMMISSIONER PETIT:** Okay. So I think just for our purposes, it would be useful to actually see them and make reference to them.

**CHRIS NEWLIN:** I would agree. The other impact of that is different state laws. Different state laws across the country may require particular things or particular aspects. I'd be more than happy to provide you -- the Commission with a copy of our interagency agreement.

**COMMISSIONER PETIT:** But the important point, I think for me, is that there is a structure and a framework that surrounds this thing. And that if you depart from it, you do so purposefully. So you can depart from it and retain some flexibility, but you do it with a forethought.

**CHRIS NEWLIN:** Right.

**COMMISSIONER PETIT:** The second point that I want to raise is, in listening and working with Teresa over the last few years on this thing, every time I see CAC and I think federal, I think DOJ, Department of Justice.

And I'm wondering where Health and Human Services is on this. Is there a vehicle within HHS? Do you have a liaison? Is there a relationship formally between the CAC association -- I don't mean formally. There isn't going to be formal relationship.

But is there a relationship between CAC and some unit of DHHS? What are they doing in this area?

**TERESA HUIZAR:** Sure. Well, first of all, the CJA funds route through HHS. And so those Children Justice Act monies, which are accessed by CACs to some degree, and certainly, by state chapters in other states, so there's a connection there. And we do have a relationship there.

However, they haven't been our primary funder. And there has been an attitude, I would say, on the part of -- you know, and because, I guess, federal funds are limited, there's been an attitude of sort of, don't get outside your bounds in regard to if you're being funded by one pot within the federal government, you know, sort of hand slapping and don't think about touching any other.

So I think that the fact that there's an interagency work group on child abuse that exists among federal and government agencies means that there's a little of bit of that feeling. So there's partnership around issues, but there's not some other financial flow through.

**COMMISSIONER PETIT:** Okay. So the front end work, CPS, even though we keep saying it doesn't get much money, in fact, it does get billions of dollars when you add up all the

federal and state money. And when you look at the CAC spending, it's actually a very, very tiny percentage of that.

So in thinking about scaling this to 50 states and the millions of children referred, you've got 39 states that are participating, 11 states that are not?

**TERESA HUIZAR:** Oh, we have 50 states that have children's advocacy centers, but we have 39 where there's defining legislation within the state about the services they provide.

**COMMISSIONER PETIT:** Okay. But in terms of being able to do the full intake review, the prerogatives, the treatment, et cetera, have you guys costed out what it would take to do that across the country?

**TERESA HUIZAR:** Well, one of the things that we did class out was what it would take within the 800 existing ones simply to add an additional person to do some of the work that we're talking about here.

What would it take to have someone who's facilitating this additional screening? What would it take to have someone who coordinated the MDT around that activity? What would it take?

If you just do the multiplication at $50,000 for that position, you're talking about $80 million. So you start getting to a sizeable number quickly.

**COMMISSIONER PETIT:** Well, what I would suggest, though, is that what we do is we work backwards from the need, not project forward based on what we think we have. The issue is, exactly what's needed?

Whether it's the 800 or whether it's in other jurisdictions, what percentage of all kids that are being reported in and confirmed as abused, neglected, are you actually able to be part of a process that responds to it? Do we know?

**CHRIS NEWLIN:** I don't know. Teresa may. I don't know that we can necessarily nail that in. It also is a matter of scope. I mean, we have to define where we're starting from. Do we want CACs to respond to all forms of child abuse and neglect reported, recognizing that neglect is a large percentage of it, of the cases that are necessarily seen, Commissioner.

**COMMISSIONER PETIT:** And believe me, I don't think for one second that this responsibility rests solely with CACs. There are a lot of other people in here that should be accepting responsibility for defining this kind of stuff.

But, Teresa, let me ask you something. You mentioned the peer reviewed studies all showing an affirmative. Have you done any specifically on, this is what used to happen with fatality rates, whether it's in single state or a single jurisdiction or across the country, and ever since we introduced this, it's fallen to that? Has there been anything that's actually looked at that question of fatalities?

**TERESA HUIZAR:** Not specifically fatalities, no.

**COMMISSIONER PETIT:** Do you have any ideas on how one could measure that within the CAC model? What would it take for you to be able to say it made a difference in that particular area?

**TERESA HUIZAR:** Well, I think, first of all, we would have to find -- select, I should say, children's advocacy centers that are providing an array of services that covers -- if you're really looking at that question, then all forms of child maltreatment. You're going to have to look at neglect as well since that drives such as tremendous amount of child abuse fatalities.

So -- and then, you're going to have to compare that against comparison communities where that's not the case, you don't have the CAC intervention.

Now, the difficulty, I will tell you just from meeting with researchers already about doing this kind of gold standard study, is that CACs are so ubiquitous in the principles behind them in terms of multidisciplinary team intervention, that trying to get a control group is almost impossible.

You cannot get a pure control group anymore because this -- we've spread like, you know, weeds in that way. We've spread like top seed.

So I think that it would be good to do research around that, but we're going to have to look at the limitations of that in terms of identifying it as the causal factor.

**COMMISSIONER PETIT:** Another question I have is, do you have a relationship with a National Association of Public Child Welfare Administrators? Is there a meeting, a conference planning, a training session, an exchange of materials? What exists between you as an association and the Public Child Welfare Association? Is there a relationship?

**TERESA HUIZAR:** We do have a relationship. But, quite candidly, it's not as strong as with our federal and national law enforcement, prosecutors and other aspects of it. So in terms of child protective work and child protection work, we have a very strong relationship with CWLA, for example, and for NASW.

But in terms of the actual administrators themselves, I mean, quite frankly, when we start talking, especially child abuse fatalities, people start getting a little touchy. And I would say it has been slightly more challenging than engaging some of the other partners in this work.

**COMMISSIONER PETIT:** Last question, if I may. In terms of prerogatives, CPS is the gateway -- the state CPS agency is the gateway to family court. No one else actually is able to access family court unless it's worked through CPS. And the criminal courts are accessible, basically, through law enforcement and specifically DAs.

So in the work that you're doing, is there any loss at this point of prerogatives? What happens when there's a difference of opinion between CPS and the people that is brought in to look at a case?

I mean, is there -- when we talk about modifying a system, we have a huge system in place now that employs hundreds of thousands, if not a million people, affects millions and millions of families. All legislatures deal with it. Bodies of law that go from the table to the ceiling on this thing, policies, protocols, prerogatives, et cetera.

I'm not one who believes that's going to be flipped on its head anytime soon, but I am concerned about this business of exercising these prerogatives, keeping in check how that interaction works.

**CHRIS NEWLIN:** We deal with this on a regular basis, Commissioner, because sometimes in the protection of children, we have -- we are at a crossroads with what we need to do to protect a child.

We may need to go into the family court process to assure their protection, but that may interfere with the integrity of a criminal investigation that's going on. So we go back to our core founding principles: What's most important for this child? Should we -- you know, is it appropriate to potentially put them in a risky situation so we can secure a criminal conviction or have a greater likelihood?

That's something that's debated on a regular basis, not only by our multidisciplinary team, but by MDTs around to say, what's the right thing to do? And I can tell you, we have foregone prosecutions to make sure we protect the child.

We have even ceased forensic interviews just because a child is so traumatized that the most ethical thing to do is to make sure we get that kid immediately into some crisis intervention. That's more important than pursuing a forensic interview to obtain evidence, because that's prioritizing the needs of the child.

So those are two brief examples of how we will -- you know, we won't necessarily be focused on criminal. We have to balance between protection that can come through the family court process and what we might be able to do from a criminal justice perspective.

**TERESA HUIZAR:** I think the critical thing that -- I'm sorry.

**CHAIRMAN SANDERS:** We're going to have to wrap up in just a minute. If you have something quick, go ahead.

**TERESA HUIZAR:** I was just going to say that in regard to that, an example from Tennessee is, I attended a case review where just this sort of thing was going on. I mean, it's routine that people from different perspectives may have different interests or different ideas about how to pursue a case.

But at end of the case presentation in determining what the next step was, there was an actual vote. You know, what should we do? And the team learned to live by the vote. And that can be very useful in terms of both holding people accountable for next steps and also having a sense that you have to have some way to close down these differences of opinions and arguments and move forward on a case.

**CHAIRMAN SANDERS:** Well, thank you once again. Very informative. And thanks for taking the time on this and providing all the information that you did.

**TERESA HUIZAR:** Thank you.

**CHRIS NEWLIN:** Thank you.

**CHAIRMAN SANDERS:** We're at a point of taking a break. And so we'll break for 15 minutes. Actually, let's give them a round of a applause for their great work here.

**(WHEREUPON, A RECESS WAS TAKEN FROM 10:06 A.M. UNTIL 10:21 A.M. AT WHICH TIME THE HEARING PROCEEDED AS FOLLOWS:)**

**CHAIRMAN SANDERS:** We're going to have a series of presentations with opportunity for question at the end on the National and Tennessee's Response to Children with Drug Exposure.

And this has been a particular area of interest to the Commission, so we will start with Nancy Young, who is the Director of Children and Family Futures. And she'll have 15 minutes.

**DR. YOUNG:** Great. Thank you very much, Dr. Sanders, and to the Commission for the opportunity to discuss the role that parents with substance abuse disorders play in child abuse and neglect fatalities.

Do we have the PowerPoint slides? And for those of you that are not facing the slides, I hope you'll have an opportunity to turn -- oh, great. Terrific. I didn't see that was there. I'm going to start my time when the PowerPoint slides go up. How about that?

**CHAIRMAN SANDERS:** They're working furiously on it. Feverishly.

**DR. YOUNG:** I once was a lunchtime speaker and everyone had finished their salad by the time the PowerPoint got up, so that was -- that was nerve-wracking.

All right. There we go.

According to the national survey on drug use and health, 8.3 million children in our country live with a parent who needs treatment for alcoholism or illicit drug abuse. That translates to 11 percent of the kids, or three in every school classroom.

Clearly, not every child that lives with a parent that's affected by substance abuse disorder is at -- is abused or neglected, or is at imminent risk of a child fatality. But it paints the picture of three in a classroom of how many kids in our country are affected by parental substance abuse.

With such large numbers, it's clear to us that it's not the sole responsibility of the child welfare system to respond to the crises of parental substance abuse disorders. Child welfare systems cannot achieve their intended outcomes with child welfare resources alone.

It requires resources, expertise and support from several other systems to make a difference. Substance abuse and mental health agencies, maternal and child health, health practitioners, hospitals, home visiting, early childhood agencies, domestic violence prevention agencies, housing, all of these are needed partners for child welfare.

But we find too often the connections between child welfare and substance abuse treatment, in particular, are not grounded in solid collaborative practice.

Today, I'm going to talk about several different topics that I was asked to speak to. And rather than read those, I'm going to get started with the numbers.

Astonishingly, there have been no studies published in the scientific literature in the last decade on the prevalence of substance use in child welfare. I was surprised to see that when I was asked to review an article just recently.

This is the summary of the literature that does exist from over a decade ago. But without current literature on this prevalence issue, we rely on administrative data sets. The National Child Abuse and Neglect Data System, NCANDS, does not contain any reports on the role of parental substance use in child abuse reports, investigations, substantiated charges or the number of victims.

In the most recent child maltreatment report, five states voluntarily reported on the ways they measure substance use in their NCANDS report, and we've provided those details in our written summary.

Among those children that are removed from their parents' custody, the very well known AFCARS, Adoption and Foster Care Analysis and Reporting System, it includes voluntary items, again, about parental abuse or alcohol or drugs is a factor in the child's removal.

There has been a steady increase over the past 15 years to a national average of 31 percent in 2013. Typically, when we cite this data, a ripple of comments quickly spreads throughout the audience because no one in the room believes that one-third of child removals are the result of parent's alcohol or drug use.

There's a similar increasing trend in the percentage of cases in which parental rights have been terminated. In 2013, some 44,000 children had birth parents whose rights were terminated associated with their parents' substance use. That's second only to neglect.

Generally, practitioners tell us that neglect is the code that's entered when the state SACWIS system doesn't have an easy way to record substance abuse as the reason for removal.

The reliability of these data are called into question, however, when you look at the variation from state to state. Sorry, Judge Martin. Note that Illinois does not report these data at all. Among other states, the percentage ranges from a low of five percent in New Hampshire to over 60 percent in Alaska and Texas.

We've also looked at these data within states with similar wide variations between counties. Orange County, California reports 29 percent, and neighboring Los Angeles reports six, with a statewide average of nine.

I have visited all but one state in the United States, and I have never had an audience say they believe these percentages are reliable. Even among the states of Alaska and Texas, where they reported high rates of parental substance use as a factor in child removals, audiences told me these numbers reflected undercounts.

So my first question is to you. How can we ensure safety of vulnerable children whom we cannot reliably count? Despite the question of reliability of the AFCARS data, it's quite disturbing to note the consistency across states in the prevalence of parental alcohol and drug use as a factor in child removal among infants.

Those orange bars in this graph represent the rate of alcohol and drugs is a factor in removal among children under the age of one. Given these higher rates or, perhaps, better data collection among babies, we must consider the likelihood that these are infants with prenatal substance exposure, even if it was not detected at birth.

So let's turn our attention to the most at risk of these children, infants born with various conditions at birth. The Health Resources and Services Administration, HRSA -- and you have this chart in a handout because I know no one can read that -- provides guidelines for uniform screening during pregnancy and at birth for 32 core conditions and 25 secondary conditions.

This slide recaps those tests. And one of the attachment, again, details those suggested tests and the estimated prevalence of those conditions. The most prevalent condition tested for at birth is sickle-cell anemia, which is occurs in an estimated 1 out of 350 births.

What you will note in that list is that screening for prenatal substance exposure is not on the list of recommendations. Yet, alcohol is a known teratogen, which is an agent that can disturb the development of an embryo or fetus.

The classes of teratogens include radiation, maternal infections, chemicals and drugs, inclusive only of alcohol and cocaine, as well as some prescription medications for mental illness such as Lithium. Opioids found in prescription pain medications and even heroin are not teratogens.

The good news is that screening programs for prenatal substance use has reduced women's use by more than half when using a validated tool and follow-up by a medical home, a trained physician or a physician staff. However, out of the estimated half-million babies born with prenatal substance exposure, only 22,000 pregnant women were admitted to publicly funded treatment in 2011.

According to the National Survey on Drug Use and Health, among pregnant women, about 15 out of a hundred use cigarettes in the month prior, which is associated with low birth weight babies. Nine out of 100 were current users of alcohol. Five out of 100, users of illicit substances. Two out of 100 reported binge drinking. One out of 250 were heavy drinkers, placing their infants at risk for developing fetal alcohol syndrome. You remember the prevalence rates on those other diseases that we test for.

With guidelines that babies are tested for 57 conditions, is it just stigma that prevents us from identifying babies who have been prenatally exposed to alcohol or drugs? Or is it our conflicted societal values that suggest that this population of mothers should be treated punitively rather than utilizing a public health response ensuring the family's safety and well-being?

Recall that about 80 percent of adolescents have experimented with substances of abuse by the time they're juniors in high school. This shows you that two-thirds first use marijuana during those critical brain development years of adolescence.

About one out 10 of these kids will develop a substance abuse disorder as a result of their genetics, individual brain chemistry or conditions they experience known now as adverse childhood conditions or experiences, ACES.

And changes in the neuro transmitters in the reward pathway of their brain will lead to dependence on these mind altering substances. That is why Dr. Nora Volkow, the director of the National Institute on Drug Abuse, refers to addiction as a developmental disorder of adolescence.

But for this particular brain disease that is almost always begun in adolescence, the stigma means that this set of families remain hidden and marginalized. We suggest that addiction represents the elephant in the room of child abuse and neglect.

We remain confident that we will soon be able to embrace the changes that are needed in our healthcare system and in child welfare services to confront that elephant and work towards healing families and protecting these young children.

Because every one of us recognizes that, regardless of the circumstances that called for removal, children want to go home and live with their own families. Even children who achieve permanency through adoption at very young age want to know their birth parents.

And the numbers don't lie. Eighty-five percent of children who touch child welfare in substantiated cases of abuse or neglect either stay home or go home. Eighty-five percent of children going home to their birth families mean we must refocus our efforts on the whole family through supports and services that promote recovery.

Why are we so confident that these changes are possible? Over the past 15 years, the federal government and some private foundations have provided funds to test programs that respond to these families. The largest of these federal investments came in the 2007 amendment to promoting safe and stable families to test various strategies, commonly referred to as the regional partnership grants or RPGs.

We note that Commissioner Bevan played a key role in the legislature for this program, and the roll-out was under the leadership of Commissioner Dr. Horn during his tenure at the Administration for Children and Families.

The RPGs were guided by three goals that you see in the logic model. Applicants were allowed great flexibility in proposing programs that would meet their communities' need. You see the primary groupings of the broad program strategies that were tested. In each of these programs, we collected detailed information based on operational definitions of these strategies. And the National Center on Substance Abuse and Child Welfare created technical assistance tools to assist other communities to implement similar strategies.

We also monitored performance that were closely aligned with operational definitions in the child and family services review and the SAMHSA national outcome measures. We assessed program performance over time. And as such, we began to notice these five Rs that jumped out at us.

The families participating in the RPG programs did better in terms of recovery, children remaining at home, reunification rates decreased recidivism and a dramatic difference in the rate of children who returned to out-of-home care.

For the sake of time, I'm not going to go through those in detail. And, in fact, four reports to congress have been issued on this program.

I'm going to switch back to this one because I think that's very, very important. Despite the faster reunifications and the other progress that we saw in the RPG families, after 12 months of reunification, only five percent of children had reentered care. The average performance in the states in which RPGs operated was two and a half times that rate, with 13 percent of children reentering care.

By providing parents timely access to substance abuse treatment, recovery management services, parenting programs adapted to parents in early recovery stages, as well as the other program components I mentioned, RPG families outperform services as usual in each of these areas.

The result of the RPGs and other federal grants and foundation supported programs means that we can no longer say we do not know what to do.

So what do we know about this smaller set, if you will, of families in which child fatalities happen? A few years ago, we began smaller meeting on those cases of child neglect.

A few years ago, we began to note several technical assistance requests coming into the national center about infant rollover and co- sleeping deaths. The requests seemed to focus on parents who were co-sleeping and didn't wake up while their infant suffocated. Tragic.

Since we were getting these anecdotal reports, we decided to look systematically at child fatality reports to determine if there are patterns of child fatalities associated with parental substance use disorder. We've provided an overview of the summary of that report as an attachment to my comments.

In brief, we focused our review on the American Academy of Pediatrics' 2011 report and recommendations that bed sharing should not occur when one or both parents are smokers, when parent has consumed alcohol or when a parent is using certain medications or illicit substances.

We found 17 reports from states and one large county that were issued since 2011 using data after 2009. The reports generally classified rollover deaths as accidental, and only classified them as child maltreatment if the parent had been previously warned about bed sharing.

I won't belabor the details here. You have them in writing. In general, even if the report noted the parent's substance use as a factor in the child death, rarely did the reports go on to make specific recommendations regarding substance use as a risk factor.

Of the 17 state reports, 16 mention poisoning and overdose deaths among 15 to 17 year olds. Of those 16, only seven went on to make recommendations. None of those recommendations mentioned the need for substance abuse treatment or interventions for this population of adolescents.

When we do not address the underlying risk factors that contribute to those fatalities, when we ignore the elephant, we've missed an opportunity to make life-long difference in the life of children and their families.

So how can we help to prevent those deaths? Effective implementation of the 2010 amendments to the Child Abuse Prevention and Treatment Act would go a very long way to prevent child fatalities associated with parental substance use disorders.

But CAPTA guidelines and the legislative references to the need for a plan of safe care for infants are, essentially, ignored in most states, and there is no annual federal summary of the effects of this legislation.

We have not found a state that has designated a single accountable agency or person responsible for the implementation of CAPTA requirements regarding newborns. In many states, state agency staff and even child welfare consultants were unfamiliar with these components of CAPTA that were envisioned to protect infants.

Only a few places have established protocols to implement these CAPTA requirements, but no state has designated an agency responsible for ensuring that this population of babies have a plan of safe care, and no state monitors the implementation.

There is little guidance and no monitoring by the federal government to determine if babies with prenatal substance exposure are going home to safe environments.

The follow-up after babies go home is also wanting. For example, the MIECHV program recently reported only 12 percent of enrolled home visiting families had substance use issues. Only seven percent of home visiting grantees selected alcohol use or abuse as risk factors to monitor. This clearly represents a missed opportunity, and one that this Commission could rectify.

There are several key actions that the Commission could recommend that would ensure the effective implementation of plans of safe care and better ensure the safety of these.

I've detailed those in the written statement, but in brief, require NCANDS and AFCARS to include parental substance use as required data items; universal prenatal screening using validated screening tools and leveraging Medicaid, which pays for half of all births in our country, as well as private insurers; ensure the full implementation of the parity laws to ensure appropriate levels of treatment and lengths of stay for all pregnant and post-partum women; ensure multidisciplinary team's approach to implementing plans of safe care prior to the birth event. This is happening in at least one jurisdiction I know. But often, those multidisciplinary teams do not include the treatment agencies. They need to be partners.

Designate a state office responsible for implementing and monitoring plans of safe care; ensure priority access to home visiting services; ensure eligibility for those early intervention services; rule in instead of rule out children with prenatal substance exposure and require state child death reports to specifically assess the role of substance use.

I appreciate the time today. While the role of substance use in child fatalities has been underemphasized, there are both federal policy levers and state action that point to the potential for a more deliberate attempt to address this critical linkage.

Thank you again for your time today, and I look forward to your questions.

**CHAIRMAN SANDERS:** Thank you very much. That was some new information for us. We have a team presenting from the Office of Child Safety, led by Scott Modell.

**DR. MODELL:** Yes. Thank you Dr. Sanders. And thank you, Dr. Young.

Presenting on our panel will be myself, Scott Modell, Carla Aaron, Amy Coble from the Department of Children Services, Dr. Michael Warren from the Tennessee Department of Health, General Amy Weirich from the 30th district and General Mike Dunavent from the 25th judicial district. Did I get that right?

**MIKE DUNAVENT:** That's right.

**DR. MODELL:** Okay. We normally don't go by district numbers, we go by counties. We live in different worlds.

But I'm going to start briefly and give you a perspective on Tennessee just to give you the scope of --

**COMMISSIONER COVINGTON:** Can you tell us who you are again? I'm sorry.

**DR. MODELL:** No. That's okay. My name is Scott Modell and I'm the deputy Commissioner for the Department of Children Services. I oversee the Office of Child Safety. To give you a perspective on Tennessee, so in Calendar Year 2014, last year, we received 140,648 calls to our child abuse hot line. We had an additional about 10,000 referrals come through e-mail, fax and U.S. postal mail. So it's about 150,000 referrals.

And Chris Newlin spoke earlier about intake, the child abuse hot line folks not having training. In general, our folks are trained. They're case managers. And our screen out process, when calls are screened out, I like to say, we don't have a QA on it, we have a hundred percent redundancy.

So if one of our case managers screens out a call, a supervisor reviews that screen out. And if a supervisor screens out a call, their supervisor reviews that screen out. So we review with 100 percent redundancy every screen out. And then, we QA that screen out review and we look at the number of calls that were reentered as screen outs each month and use that to inform our training.

Our staff used these structured decision making tool by the Children's Research Center. We just revalidated that instrument. So I just wanted to mention that.

But the over 150,000 referrals translated into just over 68,000 investigations, with 198,000 allegations of abuse and neglect to be classified.

With drug exposed children, from 2010 to 2014 represents just about 280,000 allegations. Forty-five percent of those came from children five and under. And since 2010, we've seen roughly a 20 percent increase in drug exposed children allegations.

Moving on to child deaths. In Calendar Year 2013, in the State of Tennessee, there were 871 children who died. Of that group, of the 871, there were 13 children in our custody, in the department's custody, that died. Of those 13, zero died of abuse or neglect.

Outside of children in our custody, what we would consider our noncustody population, there were 232 children of that 871 children who died in our state, where there was an allegation of abuse or neglect.

So we investigated those 232 investigations -- those child deaths. Out of those, 46 were substantiated for abuse or neglect. Of those 46, 42 of them were born in the State of Tennessee, so we had the birth records. And we looked and nine percent were born with a diagnosis of neonatal abstinence syndrome.

From 2012 to 2013, we actually have seen a statistically significant reduction in sleep related infant deaths. We had a 10 percent decline. We've partnered with the Department of Health, and we're going to be talking about safety science and safety culture after this presentation.

But using those systems and partnering with the Department of Health, we have seen this statistical reduction in child deaths related to - - sleep related child deaths. And we're very proud of that and hope to continue to see that trend as we move forward.

And that is just the brief overview of sort of our data with respect to the scope of our CPS process. And I'm going to turn it over to Carla Aaron, who is our executive director of the Office of Child Safety, to give you a brief historical perspective on our practice and policies as it relates to drug exposed children.

And then, we'll kick it to Amy Coble, who will share with you some of the promising practices we have in CPS. And then, Dr. Warren, and then Generals Weirich and Dunavent. And we'll conclude on time, and with time for questions. Thank you.

**CARLA AARON:** Good morning. I'm going to give you a brief historical perspective of the policy and the practice changes that we've had in Tennessee.

For about the past 10-plus years, we've continually seen a rise in parents and children who have been affected by drug exposure. Probably in the last 10 years, methamphetamine has come into Tennessee and has just exploded.

On the heels of that, we've had prescription drug usage that is just continuing to explode, continuing to bring challenges to the work that we're doing with our children and our families.

As that has come about, we've really partnered very closely with our law enforcement partners, with our district attorneys. In the State of Tennessee we have what we call child protective investigation teams, lovingly called our CPIT teams. And we do a lot of our investigations -- almost all of our severe abuse investigations are done using that multidisciplinary team.

They've been very helpful in providing support, education, training opportunities for our front-line child welfare investigators over the years. As law enforcement becomes more familiar with the drugs that are coming through Tennessee, they're sharing that information with us and really working closely with us as we deal with that.

So as meth and the prescription drugs exploded, we had to adjust some of our policy and our practice around the response to the child abuse allegations that we were receiving.

In doing that, we had some policy issues that really needed to be strengthened for our front-line staff. So recognizing that drug- exposed children, drug-exposed infants had some different challenges, we developed policies that were specific to drug-exposed children, and we developed policies for drug-exposed infants. We thought we were creating what we needed to give our staff in terms of guidelines and responding to that.

In doing that, I do think we created a sense of urgency. We even changed some of our response times to ensure that we were meeting -- making face-to-face responses with children under the age of two within 24 hours.

Here in Tennessee, we're a multiple response -- we have a multiple response system. So we also created guidelines that gave children under the age of two the assignment of an investigation when there was drug exposure involved in that.

In doing that, again, it created a sense of urgency. With the investigative tract, it almost always provided the opportunity to work with law enforcement, to work with the district attorneys across the state, in doing that multiple response for the very young children. And we think that worked well in many situations.

There were times, though, that we think, because given that priority or that kind of radar focus on those very young kids, we might have minimized some of the opportunities to respond urgently or as an investigation to some of our older kids.

So that would definitely be lessons learned that we are now looking to really look at what's the right approach for that? Again, we thought it was a good approach. We had a lot of opportunities to get in, work with families within that first 24 hours. We were able to intervene in the hospital setting before the babies were released.

Really began working with the mothers. Particularly, with the babies that were kept in the hospital for lengthy periods of time, we had an opportunity to get in there and work with the mother doing a -- connect them with -- connect her with the resources in the community, begin the treatment process and really connect them with a network of providers that could help support that mother or that child when that child came home.

If the child didn't come home from the hospital, we certainly had time to make plans -- appropriate plans for where that child would be released to.

So I think that was one policy change that we made and that was helpful. Now, we're going back to really look and see, do we always need to have an investigation assigned for those very young kids? Sometimes we do; sometimes we don't.

We're relying on our structure decision making tool to really help guide that. We're also relying on some other safety tools that we're using to help us guide with the best way to respond to the very young children.

We don't want to leave out the three -- two -- well, two and up -- and over age group, either. We want to be able to be responsive to their needs, working with them within their communities and coordinating those efforts, assigning them as investigations when it's appropriate.

We also have an assessment track that's been very helpful in engaging the families and working with families with the older children, we think, to have a response that meets the needs of the children and families.

The other -- I guess the last thing that we've learned, kind of the lessons learned, would be to ensure that our training meets the needs of what our staff are seeing out there.

We're constantly reviewing policies and looking at training opportunities with the information that we get from our front-line staff with what do they need to really build and support the work that they're doing with the front-line staff.

**AMY COBLE:** Thank you. The next thing that we have in Tennessee, we developed a team specifically around those children that were affected by NAS, and it was specifically in the east part of our state.

So this occurred just a few years ago, approximately three years ago. What we found was there was several investigators in this area, too many to be quite honest, that were not trained specifically in this particular diagnosis.

And so we minimized the number of investigators for the hospitals to interact with. And through that interaction, that really significantly helped our relationship building and communication with the hospitals regarding the children that were affected by NAS.

We developed a team. It's called our drug-exposed infant team. And it is currently still in a pilot stage, so we're learning from that. We're trying to assess data from that, looking at how effective the team has been and how we want to continue to create -- if we want to continue to create other teams of this nature to - - to specifically address the concerns that we have with those children.

Another thing that we did and that we're continuing to look at is we instituted something called a hospital liaison. We have them stationed, actually, in the hospital setting. One is in east Tennessee.

And that was very effective because it helped us to enhance communication between the hospitals, the child abuse physicians, as well as the social workers who are working with the children that were affected by this, and the families that were in the hospital settings with them.

The hospital liaisons are -- we have currently expanded that. We also have one now in middle Tennessee, and we're looking to expand that all the way in Memphis here locally soon.

The reason that these hospital liaisons were so effective is because they were able to communicate the departmental policies, as well as the hospital settings to also communicate what they needed from us as a department to better tend to these children and the needs of the children based on their diagnosis.

The hospital liaisons are also a part of their care teams. We also have been a part of theirs task force. And also, any type of family meetings that we have with the families regarding the NAS children, the hospital liaisons are the communicators between the department and the hospitals to make sure that we are a part of those meetings and that we are effectively

utilizing the resources that we have to make sure that the children and the families get what they need to be successful past their discharge.

We also looked at policy and the enhancement as Carla was talking about earlier, what we needed to do to focus on the parents' ability to care for these children and how that was going to look and what we needed to do to address that issue with them.

During this process, we -- we were getting a lot of investigations, specifically, with these children. And we found that some of these cases really could be assessed through our multiple response system. And so we're looking through that policy now and just trying to determine how we can more effectively provide services through all of our tracks through our child protective services. So I'll turn this over to Mike.

**DR. WARREN:** Thank you. Than you Chairman Sanders and Commissioners. My name is Dr. Michael Warren. I work with the Tennessee Department of Health, and I'm pleased to talk to you today about the public health response to neonatal abstinence syndrome in Tennessee.

Just to put this in context, if we think about a pyramid type model, we think about all the births of the population, in our state, that's about 80,000 a year, as the base of that pyramid. We know that a subset of those births are going to be drug exposed, and that may be to a variety of legal or illegal substances.

We know, for example, in Tennessee, 14 percent of all women of child bearing age on Medicaid have more than one paid claim for more than 30 days of narcotic during their pregnancy -- I'm sorry -- during child bearing age.

We also know from a recent study of Medicaid data that 28 percent of pregnant women on Medicaid filled at least one prescription for an opioid medication during that pregnancy.

There are other significant exposures. In Tennessee, about 16 percent of all pregnant women smoke. That's a state-wide average. We have counties where that number approaches 45 percent. We also know that about six and a half percent of Tennessee women reported drinking alcohol in the last three months of pregnancy.

So that takes you sort of the middle part of that pyramid where there are drug-exposed babies.

Then we go to the top of the pyramid where a smaller subset of those babies will actually develop recognizable signs or symptoms from that drug exposure. Drug-exposed infants, in general, are at an increased risk for delivery by C-section, low birth weight, pre-term birth, feeding problems and respiratory distress.

And a lot of our efforts have focused on neonatal abstinence syndrome, which is a small piece of that pie. That really talks about a withdrawal syndrome typically associated with prenatal opioid use.

It's a clinical diagnosis that's made based on a history of exposure, some sort of evidence of exposure, either through screening test of mom or baby, and then, the presence of clinical signs of withdrawal.

This is an entirely preventable diagnosis. And with very few exceptions, these cases occur because of -- excuse me -- prenatal opioid use. There are, just for academic purposes, a very few cases that occur iatrogenically, meaning when kids are in the hospital, we actually put them through withdrawal.

These are typically critical -- critically ill infants who are on prolonged courses of pain medications or sedatives, and as we work to get them better, they undergo withdrawal. But, in general, we're talking about prenatal opioid exposure.

And so there are two very straightforward ways to prevent this. The first is to prevent opioid misuse or abuse among women of child bearing age. And the second is to prevent an unintended pregnancy among a woman who is at risk of opioid misuse or abuse. If you don't have either of those elements, you don't have neonatal abstinence syndrome.

It's estimated that about 50 to 90 percent -- and I recognize that's a very broad range -- of those infants who are exposed to opioids will actually develop neonatal abstinence syndrome.

And so that gets back to that larger issue of drug-exposed versus the babies who actually develop symptoms. And I'll tell you the babies that I worry about the most are the drug-exposed babies who don't go on to develop symptoms, and in the absence of universal screening, may fly under the radar, and then, go back to a home environment that is concerning.

We know that babies born exposed to opioids are at an increased risk of a number of birth defects, things like spina bifida, gastroschisis, certain congenital heart defects.

And it's important to know that NAS, in and of itself, is not fatal. Now, the circumstances leading to a diagnosis of NAS certainly put a baby at risk for other adverse outcomes. But babies typically do not die of neonatal abstinence syndrome.

We've seen a rise in this country of NAS associated with concomitant rise in opioid sales, opioid treatment admissions and accidental drug overdoses. So the point that NAS accounts for about one and a half percent of all births in Tennessee, this is a very costly diagnosis.

Most of these births in our state and other states are covered by Medicaid. The average first year of life cost for these babies are about $44,000, compared to an otherwise healthy infant covered by Medicaid in our state, which is about $4,000. So about an 11-fold increase in cost.

In our state, NAS infants account for about two and a half percent of the infants on the Medicaid program, yet they account for 13 -- I'm sorry -- 14 percent of all infant expenditures for the Medicaid program. So a disproportionate share of costs.

And that's not limited to our Medicaid program alone. This epidemic is presenting huge challenges to public healthcare and our child welfare partners in Tennessee.

So with that background, our state recognized the need for multi-agency collaborative approach to address this epidemic of neonatal abstinence syndrome in Tennessee.

And so in 2012, a special subcabinet working group was convened. That group consists of representatives of child serving agencies, children services, Medicaid, human services, our children's cabinet.

And, really, want to take the opportunity to publicly thank Commissioner Henry and the DCS staff for their work on this issue, and other public health issues around child safety, including our child fatality review. They are very valuable partners who are at the table for those processes.

There was also an earlier question about Medicaid involvement. We've had strong support from our state Medicaid program on NAS and other efforts to improve infant and child health outcomes.

So that subcabinet meeting is attended by cabinet level representatives or their designees. And it's really focused on understanding the NAS epidemic in Tennessee and identifying solutions.

On of the first things that we identified is that we needed a good way to count these cases. And you've heard that theme in several of the presentations earlier. We need a better count.

Prior to 2013, our data on NAS prevalence came from hospital discharge data. The challenge with that is there are data lags and limitations. Typically, it's about 12 to 18 months before we can get that data and make that data publicly available.

Really hard to make good policy and programmatic decisions on data that's a year and a half old, especially when you're in the early stages of an epidemic like this.

The other thing is that the claims data that we get from that gives you information about the number of cases and where they're occurring, but not really about the exposure source. And if we're going to tackle this, it's really important to know, is this occurring because Mom was using heroin or because Mom was using Oxycodone? And the approaches to that may be different.

So in our state, the Commissioner has the authority -- the Commissioner of health has the authority to add items to the list of reportable diseases and events. And so in 2012, the decision was made to add neonatal abstinence syndrome as a public health reportable event as of January 1st, 2013.

That was a collaborative effort involving public health, the birthing hospitals, our perinatal quality collaborative, and we worked together with those folks to develop a brief reporting tool for hospitals to be able to report essential information on NAS cases.

Now, this reporting is for public health surveillance only. We don't collect identifying information. The information is not reported to DCS or law enforcement. And importantly, it does not replace the requirement to report suspected abuse or neglect to the Department of Children Services.

So hospitals enter this data on-line through a reporting portal. We use a commercially available product called Survey Gizmo. When we started this effort September of 2012, our Commissioner challenged us with standing this up by January 2013.

So four months, which is not a lot of time to get an IT project through state government. And the response was, if you'll let us use this on-line tool, we can have a survey built by dinner. And it really was that quick. And so we were able to stand that up and work with our hospitals.

The data is input from the hospitals, and then, analyzed by our Department of Health epidemiologists. And then, we have weekly surveillance reports, which are posted on-line. And you'll see on example here.

This is about the most real-time data that you can get in state government. So the reports are posted on Monday for the cases that ended the prior Saturday. This is a week old just because we had to get the slides in in advance. But if you go to our website, you'll actually find data for the week that ended three days ago.

We also publish monthly surveillance summaries with additional analysis and prevention highlights and opportunities. So just a few highlights of our data to date.

In the first two years of reporting, we had 1,954 cases reported; 936 of those in 2013 and 1,018 in 2014. There was no statistically significant change in the rates between 2013 and '14, even though there was a slight rise in the count.

We know from these reports that in 2014, 69 percent of our mothers were taking at least one drug prescribed to them by a healthcare provider.

I want to repeat that because I think it really emphasizes where we need to go. Sixty- nine percent of these mothers were taking at least one drug prescribed to them by a healthcare provider. And of those who were only taking prescribed drugs, 80 percent were on replacement therapies.

If you compare the data year to year for the first two years of the surveillance system, we had a statistically significant decrease in infant exposure to illicit and diverted drugs from 2013 to '14, but a statistically significant increase in prescription drug exposure during that same time period.

So what are we doing with that data? We really have focused on two primary prevention strategies, and those are the ones I mentioned earlier: Prevent substance abuse or misuse among women in child-bearing age, or prevent unintended pregnancies among women who are using opioids.

That last bullet is particularly important because we know among the general population, about 50 percent of all pregnancies are unintended. But if you look at national surveys of opioid using women, about 86 percent of pregnancies are unintended.

Our own Tennessee Medicaid data shows us that 14 percent of all women of child bearing age had a prescription for an opioid for more than 30 days, but only 15 percent of those had an identifiable claim for a contraception. So a lot of opportunity to think about preventing unintended pregnancies.

So a response to this has been broad and multifaceted, a true public health approach based on data and focused on identifying and reducing risk factors. I'm going to share with you several of those responses now.

The first was the Prescription Safety Act of 2012. This was proposed by our governor and passed by our legislature, which requires registration and use of our prescription drug monitoring program, our controlled substance monitoring database. So before a prescriber is going to write a prescription for an opioid or benzodiazepine, they're actually required to go in and check this database.

The results from that effort are quite remarkable. We've seen a five percent reduction in milligram morphine equivalents dispensed over the last few years. That's a standardized way of looking at opioids.

And we've seen a 42 percent reduction in doctor shoppers from a peak in 2011. Those are classified as folks who have four or more prescribers and four or more pharmacies. So really exciting to see the work of that prescription drug monitoring program.

We petitioned the FDA for a box warning back in 2012, and that was subsequently rolled out in 2013, for extended release opioids analgesics.

We've made changes to our controlled substance monitoring database that I was just telling you about. For women of child bearing age, there's actually an alert that pops up in a pink box that says this is a woman of child bearing age, you need to be particularly thoughtful about counseling about unintended pregnancy and the risk of neonatal abstinence syndrome.

Our Medicaid agency has put into place requirements for prior authorization for certain long acting opioids. There is an additional process that providers go through prior to being able to prescribe those.

We've also partnered with our state department of mental health and substance abuse services on SBIRT, screening, brief intervention and referral to treatment. So we're actually training local health department staff who provide family planning and primary care services and local health departments to be able to perform that screening, and then referral to community health centers for treatment.

In that same vein of partnerships, we partnered with our state department of environment and conservation to place drug drop off boxes and to host drug take back events across the state.

I mentioned earlier that there's a real focus on preventing unintended pregnancies. And so we've made a huge effort to promote voluntary reversible long acting contraceptives.

We've had a couple of pilots over in east Tennessee, which is really the epicenter of this prescription drug epidemic for us, and we have done things like partnering with methadone clinics to bring in family planning services, so that women of child bearing age can come in can have the opportunity for counseling, and then, placement of a contraceptive.

We also have had our health educators from county health departments go into county jails in a number of counties in east Tennessee to do general health information and educational programs.

And one of the things they've seen out of that is women who indicate a willingness to sign up for a voluntary reversible, long acting contraceptive. So they then are able to bring those into the health department and provide those free of charge.

As we've looked at this epidemic, we realized there are a number of questions to which we don't know the answer. And so we funded last year a series of research projects. We funded these for one year and required that the grantees collaborate with academic and community partners. And the task was really to answer questions that were answerable with Tennessee data within one year.

And so, as of June of this year, they'll be approaching that one-year mark. And so we are excited to see the results of those. But those topics include: Developing a risk model for neonatal abstinence syndrome, identifying the best practices for care of women at risk for delivering an NAS infant, as well as the care of an infant with NAS, identifying the barriers to contraception among opioid abusing women, and then, understanding provider knowledge and behavior.

One of those projects has actually already been completed and was published in Pediatrics last month.

There are a number of other things that I would tell you, but we don't have time, so I just want to highlight a few more. There is a working group that has been convened to look at a coordinated approach to care of infants with NAS, and that's involving public health, our evidence based home visiting programs, clinicians and our Department of Children Services, so we can best think about a model for how we care for these babies consistently.

And a couple of final points, things that we're doing that are more broad than NAS alone, but really relate back to this problem. You've heard ACES mentioned a couple of times. And I will tell you, as a pediatricians, it's really exciting to start to hear ACES really come into the common vocabulary as we have these conversations.

We are measuring ACES through our behavioral risk factor surveillance system, or BRFSS, in Tennessee. And we know that 52.1 percent of Tennesseans have at least one ACE. And if you think about three or more ACES, one in five Tennesseans have more than three ACES.

So we're exploring opportunities for how we address this through our evidence based home visiting programs and other strategies for supporting parents to reduce the exposure of toxic stress.

We actually have used some of our federal MIECHV funds to do a universal outreach program for all babies born in our state. Every baby born gets a welcome packet with a letter from our first lady, information on safe sleep, information on breast feeding, tobacco exposure.

But then we analyzed birth certificates for a number of risk factors that are known predictors of infant mortality in Tennessee. And babies who are at medium or high risk for an infant death in the first year of life actually get an outreach phone call or an outreach visit.

So really trying to equip parents from those very first days to be able to take care of their kids.

And I would be remiss with Commissioner Covington here if I didn't mention our public health child fatality review. We've had that in place since 1995, and that's mandated by Tennessee law. It occurs in all 95 counties, with a multidisciplinary team of children -- of reviewers who review deaths of children 17 and under.

In 2013, we reviewed a hundred percent of all our eligible cases, and those reviews can be great sources of data about parenting, caregiver substance use.

So to close, just a few take away points. The first is to remember NAS is not inherently fatal. Certainly, the circumstances leading to the diagnosis put a child at risk for other adverse outcomes, and so those are important to consider.

The other is that NAS is a symptom of a larger epidemic of prescription drug misuse and abuse, and it is entirely preventable.

Two years of our surveillance data in Tennessee suggests that the majority of cases are ones in which Mother is taking at least one substance prescribed to her by a healthcare provider.

We have to move upstream and engage in primary prevention. And I'll close with just reminding of those key strategies. Those are preventing substance abuse and misuse among women of child bearing age, and then, preventing unintended pregnancies among women at risk of substance abuse or misuse. Thank you.

**AMY WEIRICH:** Good morning. Did I just turn it off or -- there we go.

I'm Amy Weirich. I'm the elected District Attorney here in Shelby County. Some of you I met last night at our child advocacy center. So again, to those that I didn't get to meet, welcome to Memphis. And we're very honored to have you here and talk about this very important issue.

My colleague to my right, General Dunavent, he and I have been tasked with giving you the urban and rural perspective from prosecutors to this crisis of babies being born addicted to illegal drugs. And to do that, I have to take you back a little bit.

Currently, in the State of Tennessee, we have a statute in effect that sunsets in 2016. Before that statute went into place, I was the district attorney here and was approached by some of my prosecutors who report every day to the child advocacy center, and they made me aware of a problem that was being brought to their attention of babies being born at our local hospitals who tested positive for illegal drugs.

Bear in mind, that if that baby is born testing positive to those illegal drugs, that means the mother ingested those illegal drugs a day or two before giving birth.

We are not talking about women who have taken illegal drugs in the third or fourth month of their pregnancy and prosecuting those women. We're talking about ingestion close in time to the birth.

And so what we began doing after much thought and research and deliberation, was we began prosecuting. And I put quotes around that word because it was really more of a velvet hammer approach that we used in our office. We would give the women the opportunity to have their court -- their case handled in our local drug court.

We're very blessed in Shelby County to have a long-standing drug court who has used the treatment options to address criminal behavior caused by drug addiction. So the women who gave birth to babies who tested positive were given that option.

We had just a handful of women in the program. And then, there was an attorney general opinion that was issued that, basically, for -- I'll spare you the legal details -- but, basically, told us to stop, that we could not prosecute women for what they did to a child before that child was born.

So I quite literally had to go down to drug court and dismiss the charges against some of these women -- all of the women.

And there was one in particular who broke into tears, begging us not to dismiss her case. And that doesn't happen in the criminal justice system. She knew that drug court was her only vehicle to get help for her drug addiction. But because of this attorney general opinion, I had no other choice.

So the DA's conference of the State of Tennessee working with the agencies that you see represented at this table, and many throughout the state, worked for a while to come up with a statute that is currently in effect in the State of Tennessee, which gives us this authority under the law to prosecute women for assault.

And, again, I'm very blessed in this urban jurisdiction to have a drug court. And so the women -- their cases are prosecuted there. And, again, I put quotation marks around that because the focus of it is to get them help for their drug addiction.

We had one woman who had given birth to eight drug-addicted babies. We -- a few weeks ago, we took in two women in the program. And between those two women, they had 22 children that they had given birth to.

But we give them the opportunity to work through the drug court program. And if you are familiar with drug court treatment programs, you know it's not as easy as just reporting to a probation officer. It's very difficult work, but impactful and meaningful work, if it's successful.

And if they succeed, their charges are dismissed and their charges are expunged from their record, which is a huge incentive and a huge motivator to many of these women who don't view the criminal justice system as a means to try to help them get a leg up.

We are cognizant of the issues and the negativity and the perception that we are just locking up mothers left and right, and nothing could be further from the truth.

I think when you look at the charts, Shelby County is the biggest county in the state, and to date, we have had eight reported cases. We currently have within our DA's office six women who are being prosecuted, again, putting quotations marks around that word, under this statute.

So we're certainly not arresting every mother who gives birth to a baby that tests positive for illegal drugs. We are choosing the worst of the worst, and hoping that through this drug court treatment program, we can give them the strength that they need to be as one of the mothers told me, the mother I've always wanted to be.

And with that, I will turn it over to my colleague, Mike Dunavent.

**MIKE DUNAVENT:** Well, good morning. And thank you again for having us. I'm the elected district attorney general in five counties -- five rural counties that surround Shelby County here to the north and to the east.

And we thought we would bring you this urban versus rural perspective because it is quite different in the nature of the challenges and resources that we have of -- at least available to us by way of criminal prosecution and law enforcement investigations in these areas.

Most of the women who deliver and give birth to babies from my district travel to Memphis to do so. We have community hospitals, but, typically, labor and delivery occur in larger metropolitan areas. And so many of my women travel.

And so when there is a diagnosis of neonatal abstinence syndrome, a real harm to a baby born here in Shelby County, if that mother is a resident of my district, we have the added challenge of investigating the proper venue and jurisdiction for charging that misdemeanor assault and determining when and how she ingested illegal narcotics.

And let's make it clear. The Tennessee law that was passed that is due to sunset unless it's reauthorized, only criminalizes ingestion or illegal use of a narcotic drug, which would be a prescription drug or cocaine or an opiate, something like that, not methamphetamine.

And that brings me to the rural perspective that I have in my district. Of course, Tennessee is among the national leaders in methamphetamine laboratory production. We also lead the nation in prescription drug abuse.

And in my district, unfortunately, two of my counties lead the state in unemployment rate and teen pregnancy as well. That drives that poverty, and that teen pregnancy drives a lot of the substance abuse, including methamphetamine manufacture.

So while we certainly focus on NAS from opiates and prescription drugs, in my district, the challenge of drug endangerment or drug exposure is methamphetamine.

And when I say exposure, I mean a two year old sitting in the floor of a house where an active meth lab is bubbling nearby, illegal felony methamphetamine manufacture. That is a volatile and toxic chemical that could explode at any moment, could harm or kill a child, and our response to that.

So in those circumstances, the state law does allow us to charge an additional offense in addition to the actual manufacture of methamphetamine for exposing or endangering that child in the proximity of that initiation process.

And we do that. We've done that quite regularly in my district. And, of course, criminal prosecution does and can change behavior. We know that we want to incapacitate the people who are endangering children through felony manufacture of drugs.

We want to, when there is an addiction that's driving that behavior by mothers or caregivers, we want to use the criminal justice system for treatment, to direct them into treatment and rehabilitation. Typically, with methamphetamine, that's a long-term treatment. And we can do that with the longer sentences and supervision and some of the restrictions that are placed on those women by our sentencing scheme.

And we, in our district, developed -- and I think some other counties in the state, we developed with cooperation with the TBI an actual drug endangered child protocol, which is a written protocol that we all drafted -- I say we all -- those of us with law enforcement, prosecutors, child advocacy centers, first responders, fire department, schools, nurses, hospitals, that when a child is removed from an active meth lab home that is to be quarantined and there's a criminal investigation, exactly who is going to do what, when? How do we preserve evidence? How do we treat the child? How do we examine the child? How do we process through that?

And so that's been very helpful. Just a written protocol that is agreed upon, that is used for training purposes and is followed. And does, in fact, supplement the multidisciplinary team approach that we see in our CACs.

So I would tell you that in the rural areas where we don't always have drug courts, where we don't always have the best and most technologically advanced hospitals, where many women who are giving birth to NAS babies are coming to Shelby County anyway, our challenges are different. And incapacitation, deterrence and treatment and rehabilitation by the criminal justice system can and does work.

I agree with my colleague, General Weirich, that no one wants to lock someone up and throw away the key when there is an absolute possibility and probability that with the right treatment and rehabilitation, we can save these mothers particularly, caregivers, and we can reunite families.

But make no mistake about it, in my district, methamphetamine manufacture is a significant felony that has the potential for serious bodily injury or death to a child. And so we take that very seriously.

I will say that Public Chapter 820, the law that we have now passed in Tennessee that allows for the charging of a misdemeanor assault, was passed into law by Governor -- and signed by Governor Haslam on April 24th of last year.

And according to a survey by the Department of Safety, Commissioner Gibbons, from April 24th, 2013 through December 31 of 2014, there were -- according to a survey of district

attorneys, there were 28 cases that had been initiated here statewide that were either initiated or in the process of being moved through the system.

And a majority of those district attorneys who responded to the survey believe that that law will, in fact, prevent child abuse through neonatal abstinence syndrome or through drug exposure by ingestion by pregnant mothers. And I'm one of those who agrees that that is, in fact, an effective tool that we can use.

So I will say that this last session in the general assembly, there was a proposal to add methamphetamine to that law. That measure failed. So perhaps we can continue to talk about those solutions or proposals in the future as it relates to methamphetamine.

Thank you.

**CHAIRMAN SANDERS:** Thank you. And thanks to all of the panelists. I know that we have questions, so I'm going to start with Dr. Rubin, and then, Judge Martin.

**COMMISSIONER RUBIN:** Well, thank you very much. I mean, just as we've traveled around the country, every time I think I've seen a public health panel, it's like, wow, I get another one just like this one here today that just, like, wow, right? And really sort of illustrates the vision, right, and what it will take to fully getting this to the kinds of plans of safe care that you talked about, Dr. Young.

All right. And I'll start by saying that, you know, it's unconscionable to me that under CAPTA we have got requirements for plans of safe care that -- for which there's no accountability, right?

And as I think about this, this is -- I sort of wrote down four words. One was responsibility. So who -- who in state government -- and you mentioned this, and I'm going to open this up to the whole panel -- should have responsibility for this?

Well, I think Dr. Warren makes a wrong strong case just through his presentation where this belongs, right? In the public health sector, right?

Then there's accountability. And I'm going to ask, so how do you create -- I think part of the problems with CAPTA is that it's not big enough piece of pie for the states to really pay attention.

How would you create accountability in terms of tying this to money, whether through public health or through Medicaid program, because I think Medicaid will get the attention of some folks, right, in terms of federal participation around accountability.

And then, there's sort of funding for -- and sustainable funding for services. Because you mentioned grants that help support this. And so, how do you provide treatment services to a mom after pregnancy when she's uninsured, right?

And then, finally, there's the evaluation and quality improvement, right, which is how we work in our public health. And we saw a nice demonstration of that. But that would almost flow from the first three.

So I want the panel to speak to those areas and how you create teeth for us, because that could be the guiding principal for the types of recommendations that we're making.

**DR. YOUNG:** So there's a paper that was an attachment to my written statement that discusses the plan of safe care and the options and what that plan of safe care would look like or could be.

The accountability issue is interesting because of the fact that CAPTA doesn't have an enforcement, but the law is ambiguous as to who's responsible for the plan of safe care. I think that that is something that could be changed, making public health accountable for having the plan of safe care.

It's interesting because you're probably familiar that the law says child welfare must assure that hospitals -- that they have a system in place that hospitals will refer. So that's sort of a conundrum in and of itself that needs to get fixed with the way that there isn't other -- there isn't present a way of sort of passing the buck on that.

But -- so the accountability issue with public health. Medicaid, as you know, pays for at least half of the births in the country. If Medicaid were screening for pregnant women, and this was not a gotcha screening, this was an engagement strategy, which is a very big difference in how you create that engagement of families into that way of change for their addiction or their substance abuse.

So Medicaid is a huge lever, as is the parity act. Parity is just starting to be realized in some of the states. We still have state substance abuse agencies that are doing the battles with third-party payers of insurance companies. The insurance Commissioners need to be involved with enforcing the parity law that says that mental health and substance abuse must be provided in the same way that other healthcare is. That would go a long way.

There was a question asked about, is there priority access for substance abuse treatment? It's a long, involved history with that. The block grant in the early 1990s had a set aside for pregnant women to have access to treatment, pregnant and parenting women.

It was based on the -- the maintenance of efforts. So states had to declare what their funding at that point was to provide to pregnant women. And states had to increase their maintenance of effort about access to services for pregnant and parenting women for a certain number of years.

In some ways, it acted in the long run as a cap because there isn't necessarily an incentive to continue to increase that. I know folks in the substance abuse agencies may be unhappy with me saying that right now.

But, in fact, it meant that the substance abuse agency was making their maintenance of effort, and as need increased, there wasn't necessarily the way in the block grant to be able to pay for those services.

As you know, substance abuse services across the state prior to the Affordable Care Act was completely up to the state plan for Medicaid. So now that we have parity, and now that we

have Medicaid in most states, not all -- expansion, there's the possibility of expanding treatment for that population of pregnant women.

So yes, there's priority access for women -- pregnant women and parenting women to have services within 10 days under the block grant.

As far as we know, there isn't any place where that's enforced. States have systems that they have women's treatment coordinators that are sort of the person, the last resort to call if a pregnant woman can't get into treatment. But there's no accumulated data at the federal level to find out how often that happens. So they have priority access under the block grant in order to get, within 10 days, services.

The block grant in this era of the healthcare reform is becoming a smaller portion of Medicaid and third-party payers in terms of what that possibility is for this population.

**COMMISSIONER RUBIN:** You know, I just hope I think -- and those are great comments -- that maybe your state Medicaid program and your governor's office was listening. Because if they actually calculated the return on investment, it's not just the fact of the federal participation for that Medicaid expansion, but if they actually thought about the return on the investment for a serious investment around treatment in that postnatal period --

**DR. YOUNG:** Right.

**COMMISSIONER RUBIN:** -- it would be an easy decision to expand Medicaid.

**DR. YOUNG:** Just two comments. I wasn't asked to speak specifically to the opioid issues, however, I --

**CHAIRMAN SANDERS:** Why don't we -- we'll hold that -- because we have a number of questions up here, so.

**DR. YOUNG:** Yes.

**CHAIRMAN SANDERS:** Commissioner Martin, then Commissioner Petit.

**COMMISSIONER MARTIN:** Thank you very much for your comments. I have a variety of questions, particularly, since we just started a family treatment court in Cook County. So it would be lovely to sit down and talk about prenatal care, and it would be great to talk about medical treatment programs and the whole bit.

But relative to the Commission work, I would like to direct this question to Dr. Modell.

You know, if I had to say anything about Tennessee since I've been here, this is like the state that has, like, adapted CACs. You know, you've taken this model and you've put it in different areas in terms of helping families.

I don't mean that derogatorily. I mean it very, very positively, that you've taken something that you found in one area and you are adapting it, it appears, around the state to address other issues.

So my question to you is the big question, the elephant in the room. If, in fact, you own the world and resources is not the issue, tell me how you would adapt your CACs or your interdisciplinary approach to abuse and neglect fatalities.

**DR. MODELL:** Thank you, Commissioner. And I think that's an excellent question. So with brevity as my guide, I'll try and answer that.

I think we are very fortunate in this state to have a very wonderful partnership with our children's advocacy centers. They're outstanding. And we have been moving more and more to the co-location model where we're sitting under one roof with our law enforcement partners, our district attorney partners, our juvenile court partners, our child advocacy center partners, as well as children's services.

I think there's opportunities to expand, and I think Chris Newlin alluded to it earlier about react -- reactive versus proactive. So the trigger to engage with the children's advocacy center, for the most part, is through allegations of abuse and neglect and severe abuse, in our state, for the most part.

So expanding that and really looking to how can we improve and be proactive, I think the one-roof concept can be expanded. And there's things that our governor is looking at and our Commissioner is looking at through what they're calling alternative workplace solutions.

And part of that is, how do we reconfigure some of our offices to embody that one-stop shop? Because a parent, in general, doesn't care what acronym their services are coming from, whether it's DHS, DCS, TDH and so forth. We even get confused. TDH is our Department of Health. Some call it DOH. DHS is also Homeland Security. I mean, there's so many acronyms.

But to have our state Medicaid provider next to us in our office with a -- someone from the Department of Health and somebody from mental health and substance abuse services, somebody who works in human services with SNAP and TANF, and that would be really powerful to have those folks under one roof.

And the things that we could get done for children and families to stop them from going down that pathway, we think could be very powerful.

**COMMISSIONER MARTIN:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** Did I hear you say that you're not -- you didn't opt to expand Medicaid? Is Tennessee a state that did or didn't expand Medicaid?

**DR. MODELL:** Tennessee has not expanded Medicaid.

**COMMISSIONER PETIT:** Okay. And, of course, Tennessee knows that 100 percent of the expansion costs relative to services for children will be paid for by the federal government?

**DR. MODELL:** You're talking to the wrong people. I think we agree.

**(Speaking over one another.)**

**COMMISSIONER PETIT:** Let me ask you this. Leaving that, we've heard excellent comments in reports and materials and programs and everything else from you all.

Is there any indication that any of it is reducing childhood fatalities?

If I look at your 2009 numbers, it says there were 46; 2013 says there were 40. That, in my mind, is probably not statistically significant. It might be, but I don't know if anybody's looked at it. Some place else in the report you said there were 106 kids that died in 2013. And I think you made the comments about 213 kids that died of the 800 or so study that you did?

**DR. MODELL:** Well, so it's every -- we count the numbers and we go by the calendar year. So it was 871. And of those, there were 232 allegations of abuse and neglect. That didn't mean that those kids died of abuse and neglect.

**(Speaking over one another.)**

**COMMISSIONER PETIT:** Right. Allegation of abuse and neglect. Out of 213 reported, there were 46 that you said did die of --

**DR. MODELL:** Out of the 232 investigated, yes, 46 were substantiated for abuse or neglect.

**COMMISSIONER PETIT:** So it is very surprising to me that 80 percent would have not been substantiated, that only 20 percent would have been substantiated. That strikes me as a very low rate.

What did they die of? They were -- they were alleged to have been reported abused -- they were alleged to have been abused or neglected. You said 80 percent weren't. What did they die of?

**DR. MODELL:** So I don't have the -- that's a good question. I don't have those numbers in front of me. I mean, there's a number of times where we'll get a call from a hospital -- some hospitals routinely call us when a child dies and they have no explanation.

So there's a number of kids medically fragile. Sometimes there's -- the hospital just calls our department and we get a referral for it.

**COMMISSIONER PETIT:** Well, let me ask you, what is -- what do you now believe to be your substantiation rate on cases that are reported to you as being abused or neglected? What's the substantiation rate now?

**DR. MODELL:** So a substantiation rate for all cases?

**COMMISSIONER PETIT:** All cases reported, all reports.

**DR. MODELL:** Right. It varies, but it's around 30 percent, which is consistent nationally.

**COMMISSIONER PETIT:** Okay. So in this particular case, of these children that died, only 20 percent were substantiated, 80 percent were not.

I'm just wondering if this -- looking at who that population of children is, if there isn't reason to believe that with that many allegations, was there more abuse or neglect?

But just coming back -- that's a different question. Just coming back to the logical piece for any of you, have you seen with any of these programs a material reduction in child deaths?

**DR. MODELL:** Yes. Yes. I alluded to -- yeah. Go ahead, Dr. Warren.

**DR. WARREN:** I was going to say -- so I just pulled up our latest child fatality report. So from 2008 to 2013, we've seen a 21 percent, which is statistically significant, decline in the overall mortality rate for all children.

And we've seen -- while not an elimination of the racial disparity in our child deaths, we have seen a reduction there. A big portion of that has been due to reductions in infant mortality.

**COMMISSIONER PETIT:** Right. And sleeping and so on.

What about physical abuse? Has physical abuse dropped at all as a cause of death of children? Has that shrunk? Do you know?

**DR. MODELL:** So that's a really good question. So I came to the department with Commissioner Henry in 2013. And when I started collecting data, we were very deliberate, precise and thoughtful about how we collected the data.

And the reason why I say it like that is, is the data that we're -- the way we're collecting and analyzing it wasn't done that way before we got here.

**COMMISSIONER PETIT:** I'm not asking you any of this unlovingly, right. I think that you're doing a lot. The issue is, is it having a material impact on children dying from the kind of physical abuse that we've seen all over the country that gets reported to us every day?

**DR. MODELL:** Right. I'm trying to answer. I think it's a good question. I was just setting it up with "I don't know" because the numbers that we're looking at that we believe are material numbers and important numbers to look at to analyze changes, I have one year's data worth.

**COMMISSIONER PETIT:** I mean, that's been an issue for us across the country. No one is really able to produce the numbers. And so in looking for models, it's a challenge for us to say, this is the model, look what it's done.

**DR. MODELL:** Yeah. I think the challenge is, is looking at -- and if we're talking about -- and we've been to a number of the predictive analytics conferences and people talking about it. Most -- I haven't seen anybody who's doing predictive analytics in the true sense of predicting something in the future.

What groups are doing is they're making decision or labels -- labeling existing groups of data, children high risk or medium risk.

One of the biggest challenges is, of those 46 kids who died of abuse and neglect, their profiles look similar to 40,000 other kids who are not dead. That's, as I know you know all too well, is the challenge.

**CHAIRMAN SANDERS:** Commissioner Dreyfus, then Commissioner Covington.

**COMMISSIONER DREYFUS:** Yes. Very quickly. First of all, Dr. Young, thank you for those very concrete and specific recommendations. I just wanted to assure you, we're going to be looking at each one of them. And I just thought it was great the way you got it down to that kind of specifics.

**DR. YOUNG:** Thank you.

**COMMISSIONER DREYFUS:** So thank you very much.

Two quick questions. Ms. Aaron -- Aaron, right?

**CARLA AARON:** Yes.

**COMMISSIONER DREYFUS:** Ms. Aaron, I was just talking with Phil Fisher out at University of Oregon. He's a part of work being done at the Harvard Center for the Developing Child. And we're all making the connection between adverse childhood experiences, what that's doing from a child's development standpoint around brain function, and the development of these executive function, adult functioning skills.

And we were talking about the lack of a good assessment instrument from the standpoint of being able to measure adult function, right. And then, being able to track change in adult function, right.

Do you -- are you guys anywhere close to that, using anything that you think is close to that, of your ability to assess adult functioning skills, right, and the ability to then assess change over time in the further development of those skills?

**CARLA AARON:** We're actually looking at and reviewing the assessment tools that we've been using. We have a family advocacy support tool that we're using to gauge the need for services and connect within the resources for the family. So it doesn't mean exactly what you're outlining.

I do know as we get in deeper with that, we're also exploring other options that may further enhance our ability to assess, you know, not only the safety, but also the services and certainly --

**COMMISSIONER DREYFUS:** Right. I just think that when we think about what this executive function -- executive science -- executive function science is telling us, right, the real -- the adult capabilities has a lot to do with a lot of the risks that we see kids under, and yet, those skills can be learned. Okay. So that's question one.

Dr. Warren, we were out in Colorado Springs and Gary Melton from the Kempe Center came and did a beautiful job. And he cautioned the Commission about not making the fatal attribution error where we get so focused on what we're going to do for the person, how we're going to change the, quote, unquote, person, but we're not influencing the context within which they live their lives every day, really getting to the social determinants of health.

Help me understand, in this work that you're doing around NAS, how the social determinants, the context within which these women live their lives every day is also being brought into consideration. And that's it for me.

**DR. WARREN:** So it's a great question. And I think of -- whether you think about NASs and outcome or whether you think about any of a number of other adverse outcomes, you have to think about those social determinants and what they are.

I think for this particular issue, in general, programs like home visiting where these families are being connected to for services really take that holistic approach.

And it's not about just connecting the family to the medical services that they need or even the substance abuse services that they need, but looking at underlying issues of education and employment and really trying to address those.

And it's one of the things I think is really exciting the federal MIECHV funding. Many of the benchmark areas that we're required to report on get at those social determinants of health in a way that is different than historical public health funding has been, and also in a way that's a lot more accountable, right.

So states were told if you don't show demonstrable progress in these areas, you're not guaranteed funding moving forward. And, in fact, they said in at least half of the areas, you've got to show improvement on multiple constructs.

And so there's really been that focus. And I think that particular funding stream has really helped us to think about social determinants. But it really permeates public health programming, in general. So there is certainly an effort.

**COMMISSIONER DREYFUS:** Thank you.

**CHAIRMAN SANDERS:** Commissioner Covington.

**COMMISSIONER COVINGTON:** Oh, a couple things. I think I might have a clear -- an answer, Michael, to help clear up Commissioner Petit, the confusion between the 106 that you read, and then, the 40 or 50 in the substantiation.

There's two reports. And I think it goes back to the issue we've been having about measurement, because we've been doing a lot of work on measurement.

The 106 came from the local child death review teams that are looking at it from sort of a public health perspective. You know, we've talked about sort of those kids where it never ends at being substantiated, but the team sort of felt that abuse or neglect was a -- and I bet most of those cases, that it was neglect that never came to a level of being substantiated.

So that would be my suspicion on that. And it goes back to our real need to try to create some sense of the measurement and how we measure these things.

But I had a couple things. I -- someone had mentioned the difficulty in reviews not having information or not knowing about the substance abuse history. I think one of the biggest problems in that is that teams aren't able to access substance abuse histories on families

because of the federal restrictions on sharing substance abuse histories. So a lot of times people aren't able to access any kind of history on substance abuse, and I think it's a problem.

You might want to --

**DR. YOUNG:** So 42 CFR has an evaluation exception. So if you were looking at the substance abuse records because of doing an evaluation of the programs, there's an exception. That's 42 CFR, the exception.

**COMMISSIONER COVINGTON:** Okay. That's really good to know. I'd love some more information on that.

**DR. YOUNG:** So it should not be an issue unless you're asking about a particular person's current history or current participation in treatment. But when you're looking, you know, why -- that's why 42 CFR evaluation exemption is there.

**COMMISSIONER COVINGTON:** I also -- I've been thinking a lot about this child death review, and it's something I -- I know, Dr. Warren, you said that NAS, in and of itself, is not fatal for babies.

But one of the things I suspect when I look at reviews around the country, and I look specifically at the work that we were doing in Michigan, is where I think there's a missing -- where we're really missing some knowledge is to look at babies who die within a month or two months of death from medical causes.

We oftentimes, if we really look back in those cases, find that they were born drug exposed, maybe not NAS, but they were born drug exposed or their mothers had significant substance abuse problems, and then, they go home.

And there's -- you often find, if you ever get a chance to actually look at those cases, that they weren't following care plans that were prescribed when they were -- you know, left home. Nobody was doing case management with theses moms. Nobody was really keeping an eye on them. There weren't eyes on these families.

And I'm wondering if you have any programs in place that might address that.

**DR. WARREN:** So I think it's a really good point. We do know very well from the literature that, particularly babies with NAS, have a much higher rate of readmission within the first day of life.

There's a real need for that kind of care coordination. And so I mentioned briefly a work group that has come together to look at really a system of care around kids once a diagnosis of NAS is made.

I think the work that DCS has done to place liaisons in the hospital has been huge to help with that. As a provider in the hospital, especially if you're in a regional referral center that multiple counties refer to, it can be really challenging to keep with who's the particular worker from this county and how are they going to approach a case. Having that liaison has helped.

And we've recently pulled together a work group to say, once that diagnosis occurs, what's the care plan beyond that. And much broader than child welfare, but what are the community supports? So are there evidence based home visiting programs? Are there treatment programs where Mom and baby can both go? Those, unfortunately, are very limited. But what are those resources and what does that plan of care look like? So there's a defined algorithm.

And just like General Dunavent was talking about the approach to drug endangered children in methamphetamines settings, can we do something similar for a diagnosis of NAS? So it's very early work, but a group has come together in middle Tennessee to look at that.

**COMMISSIONER COVINGTON:** Can I just ask one more question? Because we were perplexed. Did we hear you say that methadone -- I mean, not methadone, but methamphetamine is not part of the 2014 law that was passed?

**MIKE DUNAVENT:** That's correct.

**COMMISSIONER COVINGTON:** What's the rationale behind that?

**MIKE DUNAVENT:** I don't really know.

**COMMISSIONER CRAMER:** And there was an opportunity to correct that and that was not done.

**MIKE DUNAVENT:** That legislation was proposed and defeated in the house committee as we sat there, watching and supporting it, yes, sir.

**COMMISSIONER CRAMER:** Wow.

**CHAIRMAN SANDERS:** Just one question of clarification. Scott, you mentioned the significantly -- significant reduction in -- was that in co-sleeping fatalities?

**DR. MODELL:** It was in sleep related infant deaths. And some of those were co- sleeping, some of those were because infant didn't have a safe place to sleep, they got wrapped up in covers.

And it was through that partnership with the Department of Health that we were able to not only get -- set goals -- and we've just expanded to Shelby County -- set a goal of 100 percent of the time, we will not leave a home without a safe place to sleep for every child in the home.

But it goes beyond that, because it's not just having a safe place to sleep. We call it a safe sleep bundle, and it's getting safe sleep information. But, yes, it was sleep related infant deaths, which would include co-sleeping.

**CHAIRMAN SANDERS:** And you -- Dr. Warren, you mentioned that from '08, was that the time frame of -- the same time frame for the co- sleeping?

**DR. WARREN:** The Safe Sleep Campaign actually began in 2012. So that statistically significant decline in overall child deaths actually predates that.

But to follow up on what Scott was talking about, so about half of all our sleep related deaths are babies who are not sleeping on their back. Two-thirds to three-quarters are babies who are either bed sharing or have unsafe items in the crib.

And that's where that child fatality review data is so helpful to be able to get that granular information so we can go after those specific causes.

**CHAIRMAN SANDERS:** Thank you. Thank you very much. Thanks for the incredible panel. Thank you very much.

And we will move into our last panel. And Scott gets to remain at the table and is joined by a new group on safety culture in Tennessee.

**DR. MODELL:** Thank you. I'll be joined by Dr. Michael Cull and Noel Hengelbrok. Dr. Cull is our deputy Commissioner for the office of child health. And Noel Hengelbrok is our director of safety systems. So I know we're on a --

**CHAIRMAN SANDERS:** We'll play it by ear.

**DR. MODELL:** Okay. I know we're on a time frame, so we'll move through this. And we're excited to be able to share this information with you.

**DR. CULL:** Hi, thank you. Thank you. I think what we wanted to do today was share with you some of the work we're doing applying a safety science approach to child welfare.

And so a little bit of this will just be describing how we make that translation out of other industries. We'll reference a lot in healthcare. It's sort of our closest cousin that's had some success -- some success applying this. So we're kind of translating out that system in a lot of ways.

Safety science tends to be kind of a bucket term that represents the work of a lot of disciplines coming together. It's draws on psychology and engineering and business. We'll also talk about a safety culture, which is sort of how organizations express this work. And I might even toggle back and forth between those two terms.

We -- one of our colleagues at Vanderbilt published a model that we think does a really nice job of capturing our journey and where we are on this journey. We'll talk about some specific things we're doing, but I think the important message we want to communicate is that this is about culture change, and culture change is a fairly slow process.

What Tim Vogus's article describes is this idea that go through this process, organizations kind of go through these phases of enabling the culture, enacting to go and actually work on problems, and then, sort of elaborating what they learn.

You know, we think largely we've done a lot of work in enabling. We're working to enact, to kind of move resources towards the things that we've identified that need improvement.

But examples would be that when Commissioner Henry is up here talking to you, he's talking about a safety culture. He's making it top of mind., he's elevated the conversation. When he

presented on our budget to multiple hearings, one of our budget priorities is a safe and engaged workforce, a critical component to safety culture.

So we're elevating the conversation and making this a part of sort of moving our culture in a certain direction.

It's not uncommon to see this work arise out of a crisis. We had actually begun this work sort of in earnest in I'd say early -- late 2012, early 2013.

But last fall, late summer, we had a series of significant events happen in our youth development centers. We had two successful suicides in one of our YDCs, and then, a series of escapes and what we would -- the media was terming of riots.

We had what anyone would consider to be sort of a crisis happening in that part of our system. And it was significant and it tested sort of our resolve around this work. But I think we came out the other side of it being more convinced that this is the right approach and that these tools that we can draw from safety science are going to help us improve.

What we think we also see going on nationally is a bit of a crisis in child welfare that Scott's going to take a moment to sort of describe for you that you're probably actually really very well aware of, that we also think safety science has some solutions for them.

**DR. MODELL:** So I'm going to take you through a brief journey of child welfare across the United States. So if we look at Florida and we look at May of 2011, we see headlines, Florida cutting about 48 million from its budget.

Fast forward a couple years, you see media about child deaths, high profile child deaths. And then, you see people getting fired. And May 2011, 48 million was cut, March 2014, you see this expose, and by April, 47 million was restored.

Let's see what's going on in Arizona. Budget cuts, 2009. Few years later, we see stories about child deaths. We see positions getting realigned. We see people getting fired. We see more money.

Let's look at Georgia. From 2007 to 2012, budget reductions. 2013, media about high profile child deaths. People get fired. More money.

Let's look at Vermont. Money cut. High profile child deaths. People yelling in the media. More money. More media. People get fired.

South Carolina. Budget cuts. High profile deaths. Legislature gets upset. People get fired. More money.

Let's see if you can follow Massachusetts. What happens? We start with budget cuts. Then what? High profile deaths. More media. People get fired. And what's the next slide going to be?

**COMMISSIONER COVINGTON:** More money.

**DR. MODELL:** More money. And some states, multiple states, have repeated this twice. New Jersey, 2003, high profile deaths, money cuts. You have new agencies created, people getting

fired. Then you see more money 2004. 2010, money's cut again. High profile deaths. More media. People get fired. More money.

So who's next? Is it us? Is it another state? We're following this pattern across the country time and time and time again. And I think a better question is, is what's next?

And we think that the safety science approach, the safety culture, creating a safety culture in child welfare agencies, is what's next. It's the next frontier, if you will, in child welfare.

And let's highlight this through how, in a sense, we sometimes do it to ourselves. And we are going after level three Baldridge. And one of the things I really like about Baldridge is that they look at, what do other successful companies do? What do successful agencies do and you can replicate that?

They call it swiping, S-W-I-P-E, stealing with integrity, pride and ethics.

And so we look to what's going on in aviation. We look to what's going on in healthcare, nuclear power, in the military where they've been successful. And we hope, someday, folks will look to child welfare and say, let's do what they're doing in child welfare.

So let's look at this review from aviation, who does safety systems better than anybody. The Turkish Air flight received erroneous information from the plane's radio altimeter system, crew's response resulted in a fatal crash claiming the lives of nine people, four crew members, five passengers. Okay. So we have that incident.

And then, we have a two-year-old girl is left unattended by her foster parents and drowns in the family's swimming pool.

So the report out of the expert findings from the Turkish Air flight was, the length of the aircraft and type of training, as well as the procedural compliance, matched industry standard. Captain had close to 11,000 hours on the Boeing 737 alone. That combination of training, standards and experience is apparently not enough to protect crews from the subtle effects of automation failures during automated human monitored flight, auto-pilot.

The documentation and training available for flight crews of the Boeing 737 leaves important gaps in the mental model that a crew may build upon which system and sensor inputs are responsible for what during an automatically flown approach.

Now, let's look at the experts in our child welfare system, and the two-year-old drowning in the pool. It's indisputable that Oklahoma Department of Human Services was well aware of the hazard. The home should never have been approved without a specific and shared understanding between Oklahoma DHS and the foster parents.

The pool should have been removed or a suitably protective fence should have been placed around it. No children should ever have been placed in the home before one of these things happened.

By failing to ensure this hazard was either removed or mitigated, Oklahoma Department of Human Services violated CWLA and COA standards and its own policy.

You can see the stark contrast between how critical incidents are reviewed and the thoughtfulness that goes into how we look at incidents and how humans interact with systems. And Noel's going to talk a little bit about that with -- in the context of retrospective and prospective and forward looking and backward looking accountability.

**NOEL HENGELBROK:** Thank you. One of the words that we use -- that we've used a lot today is accountability. And I think accountability is a perfect word to use here because when it comes to safety science, accountability is very much tied to the resilience and safety of an organization.

Now, embedded in that is the way any agency learns and improves. The way an agency learns and improves is what your safety culture is.

Now, different agencies use different types of accountability. What we see a lot and what was highlighted by Dr. Modell just right now is that we typically use backward looking accountability. We use language like "should have", "should never", and we also blame. So this typically goes to the most easily identified -- identifiable source of malfeasance, which is your front-line social worker.

What you also have is that the executive staff of an agency isn't immune from this either. You have the tops of organizations being wiped out because from a public perspective, we feel like we're dealing with the problem.

Now, the best organizations at this, healthcare, aviation, where we want to get to, and like Dr. Modell alluded to, we want other agencies in the future to say, hey, we want to be like child welfare, they use accountability in a forward looking sense, to where they see front-line staff, the integrators of our safety services with children and families, as being the source of success instead of being the source of failure. And they bring them in to help agencies rebuild after mistakes may have been made in context of a child death.

In addition to that, what agencies do is they incorporate information about the system, child welfare system, that hasn't ended up in some bad event, like a child death. That's done with use of reporting systems.

The next slide or next video that I'm going to show you really highlights a backward looking approach. And I want to be clear that this four-minute video does not give the whole picture of this -- of this situation. And in fact, Dr. Cull had done a little bit of work with the agency that's going to be highlighted. So I'll share that now.

**(WHEREUPON, THE FOLLOWING VIDEO WAS PLAYED FOR COMMISSION:)**

**PAUL FOLGER:** But first, another state agency joins the investigation into a little girl's death. I'm Paul Folger.

**JESSICA SHAMBOCK:** I'm Jessica Shambock. Sean Brooks is accused of killing his five-year- old daughter, Serenity Deal. Investigators claim DHS withheld important information about the case, so now they're asking OSBI to investigate. Eyewitness News 5's Jessica Holloway is live with this big story. Jessica.

**JESSICA HOLLOWAY:** Well, it all started when Serenity's mom was accused of molesting a young boy, so DHS intervened and placed her with her father. But now a district attorney has filed a letter asking OSBI agents to figure out why that ever happened when he says there were signs of abuse and Serenity had been injured twice before when staying overnight with her father.

The investigation may one day come to an end, but for Serenity Deal's former foster mother, the pain will never stop.

**UNIDENTIFIED SPEAKER:** She, in the beginning, was excited to have a dad. She'd never had a dad.

**JESSICA HOLLOWAY:** Five-year-old Serenity was found with injuries to her face, head, back, stomach, and bruises all over her body. Police removed a bloody child's mattress from her dad's home. Sean Brooks said Serenity fell in the bathtub. Prosecutors charged him with beating and killing her.

According to an internal DHS investigation, caseworkers failed to look into the father, Sean Brooks' history. Specifically, they never questioned the child's mother until after the five-year-old died.

**UNIDENTIFIED SPEAKER:** And employees will be held accountable for not following policy.

**JESSICA HOLLOWAY:** Pottawatomie County District Attorney Richard Smothermon believes DHS withheld information from his office, like stacks of concerned letters written by her foster mother. Smothermon's calling on OSBI to assist in a criminal inquiry.

In a letter to OSBI he writes, quote, the focus of the investigation will be on the actions and inactions of all the parties involved in the custody and placement of Serenity Deal prior to her death.

**MR. SMOTHERMON:** And that information was never given to the Court, was never given to my office, which is inexcusable.

**JESSICA HOLLOWAY:** This case enrages the State Speaker of the House, Chris Steele. He's calling for an agency-wide investigation as a result of Serenity's death.

**MR. STEELE:** Hopefully, we will be proposing policies next year that will not only address this situation, but make sure that Oklahoma is doing everything it can within its power to protect -- to protect our children.

**JESSICA HOLLOWAY:** It's too late for Serenity, but this foster mother hopes the efforts of all these adults will help save another child.

**UNIDENTIFIED SPEAKER:** But the caseworkers are told to close the case, you know, get this child back home.

**JESSICA HOLLOWAY:** And Chris Steele says several lawmakers here are on board with trying to make new policies in regards to this case.

Now, I tried contacting several of the employees that were put on administrative leave since this happened to hear their side of the story. So far, they have not returned our calls.

Reporting live tonight, Jessica Holloway, Eyewitness News 5.

**JESSICA SHAMBOCK:** Thank you, Jessica.

And four caseworkers were put on leave after Serenity's death. One resigned, another committed suicide. The other two are now going through the termination process.

**(WHEREUPON, THE VIDEO WAS CONCLUDED ANDTHE HEARING PROCEEDED AS FOLLOWS:)**

**NOEL HENGELBROK:** So here you see the backward looking approaches that we've been highlighting. There's a large emphasis on the failures of front-line social workers who are certainly subject to the systems that they work in.

And when -- there was also a moment where the foster mother was starting to talk about some of those issues, and they were quickly skipped over to talk about other more simple understandings of the events.

Now, Tennessee really wants to depart from that, and we've taken steps to do that. A few things that we've done is we've tried to enhance surveillance.

Now, enhancing surveillance is our ability to really keep our finger on the pulse of the organization. So this is done with our child death review where we are engaging staff to tell us about the issues they face. It's involved with the newer reporting system that we're trying to build so we can, again, hear from front-line social workers about the constraints that they continuously face.

With this information, it allows us to build more reliable systems and allows us to engineer better issues that may be embedded within our system.

Now, we definitely want to increase resilience and safety at the organizational level, but we also want to do it at the local level, too. So this includes things like better communication. So the ability to work as a team better within social work -- social workers. Also, being able to work between different agencies in different areas of the department like front-line CPS and health units.

So our first step into this was really with the child death review. The child death review we started back in August of 2013. And we really started from scratch with this, and we knew we really needed to do a really great job. So embedded within it are very strong safety science principles.

And carrying it out, we have four safety analysts across the state who are really social work experts, and they also have expertise in human factors engineering. So this is a really unique skill set that these individuals have that are carrying these out.

One of the important things that we do with our child death review, which is different from any system, is we conduct debriefings. These are incredibly important because, one, it's

giving us a really robust understanding of all the case work that we've had with the family associated with a child death.

And also what it does is it creates really valuable learning opportunities for our front-line staff. Because our safety analysts are going over any issues that may have been found across the life of the case, and then talking about those with the front-line staff and ways to avoid them.

Now, one thing I do want to highlight is that in 2014, we reviewed 149 deaths -- or 149 cases, eight of those were near deaths. But during that time, we conducted 348 debriefings. Within those debriefings, we talked about 625 different findings.

Now, each of our debriefings lasts at least an hour. So at a minimum what we did was we spent 348 hours, that's 14 and a half days, that's 48 full working days, talking about issues within case work with front-line staff, which I think is a really fantastic achievement.

Now, this information from debriefings becomes part of an overall context that's provided to our review team members.

So if you look here, what we have is a facilitation guide. This is an accident model that we use to review the case work with any child death or near death that's reviewed.

What you see is that starting at the bottom, you have more the topography of our work with the family, so this is our front-line interaction. And we talk about the issues that were experienced there. We also talk about some of the influences all the way up to government and regulatory bodies on how that affects front-line case work.

Now, all these boxes are turned into really rich narratives about how we may have -- or how we may, you know, improve with our care for children and families to hopefully reduce the risk of child deaths in the future.

Now, with any good system, with healthcare or aviation, what they do is they're able to take out information from these real qualitative findings and turn them into ones and zeros and graphs.

We built a tool to do just that. Right here, you can see the findings from our 2014 reviews. Consistent with a lot of different agencies, what we find is we have a lot of trouble with team work and coordination.

A great thing about our tool is it allows us to, one, pull data out of our -- or pull quantitative data out of our qualitative, but then it allows us to really dive back in and figure out, let's say, in a category like team work and coordination, you know, what teams are having the most difficulty.

In 2014, what we saw is that CPS workers were having difficulty working with health units. This may be a CPS worker investigating something like medical neglect, going into a home and experiencing some type of complex medical information and not necessarily knowing how to handle that.

And so this information here is presented to what we call a safety action group. A safety action group is a central team made up of decision makers in the department who are able to really enforce change that can go system wide.

Specifically, in this example of CPS and healthcare workers, what we did is, one, is we're working towards improving the visibility of the health units. And also, we're trying to increase the ability for our health units to work as a bundled system of care for our front-line staff members.

That way, we have services and systems in place to quickly get the information that we need to our front-line staff, which can help support children and families.

In addition to that, what we talked about is how do we get at the information, the constraints that front-line social workers face, before a child death occurs. This is what I would say is truly preventative.

What we did is we passed a law. So in different agencies, they have reporting systems. What we know from the literature and from real- life examples is that people aren't going to participate in these systems unless they feel relatively safe to do so.

For example, if a caseworker wants to report that they haven't slept in 47 hours and they just responded to a removal, they may not want to talk about that because they feel in fear of their job.

And so, in order to accomplish a system for reporting that would be useful, we needed to keep it confidential. To do that, we needed a law. On March 27th of this year, Governor Bill Haslam signed into law Public Chapter 21, which allows us to be able to protect the confidentiality of any reporter into a safety system that we're currently developing.

With that, thank you for listening and I'm going to pass this back to Dr. Cull.

**DR. CULL:** Thanks, Noel. It occurs to me in Noel's description of one of our important findings, and the example of one way that we took that very actual information and did work in our system.

Our health units -- so we were looking specifically at team work and coordination between our CPS workers, what we call a health unit, which is these regionally distributed experts, so it's nurses, psychologists, special educators. So it's sort of their clinical expertise in the field that they can consult with. And we recognized through this process a gap in that communication. So that's what our -- when we're referencing a health unit.

We're really proud of Public Chapter 21. We think it's a significant tool that we're going to add to our sort of surveillance system. It's also symbolically very important that we're able to advance what is a standard tool in other sort of safety critical industries, like healthcare and aviation, where if a nurse makes a medication error that maybe doesn't result in harm for a patient, she has a place to go report that safely. And that's the kind of information we want to be able to pull out of our system.

Another thing that we're doing that we would call part of our surveillance system is a safety culture survey. And so like -- like all measurement, it's done for the purposes of communication.

So we measure temperature outside so that you and I can go outside and agree upon what 75 degrees feels like. And we've done an assessment of our organizational culture, specific to these concepts around safety, so that we have a common language and a common understanding of what we're talking about.

We did this in 2013. This is not a picture of the Commissioner. We were quite nervous. We knew we were going to be taking -- you know, asking questions of our staff that we were going to be a little uncomfortable probably with some of the responses.

We were asking questions about things like, you know, how does your interaction with your supervisor promote safety? How do you feel - - do you feel safe speaking up? Do you feel sort of psychologically safe? So we knew we'd be asking questions that were hard questions.

So, again, in the interest of sort of enabling the culture, the Commissioner was very, very excited about doing this. And we'll be redoing it, we'll be doing our second administration next month.

We did it. The Tennessean wrote an article about it. The article was picked up by the AP and republished kind of all over the country. Governing Magazine did a second story about it.

And what it really resulted in was a really positive media experience for us where we were talked about as being -- having given voice to our front-line. We gave them the opportunity to sort of tell us what they thought.

So the data has been great. It's been extremely useful. And, again, it had this effect of communicating that we were very interested in what they had to say, and we've been acting on the data.

We didn't ask a lot of demographic questions, and I didn't include many, but I'm going to orient you a little bit to the data. This one's important for what I'm going to focus on in the data, which is this somewhat not expected shift that you see over time.

The darker lines are our case managers, our front-line workers, and the lighter lines are our supervisors, team leaders, team coordinators. So you see the years' of experience goes up as they shift into those supervisory roles.

Not completely unexpected, but we need to be able to keep experienced workers in the field also, because we lose experience and we need experience to build sort of a resilient, safe workforce.

So this is our survey. Positives, good. What you see on the vertical axis is percent positive. So this is within these scales, people who responded positively to the questions. Each scale has from four to nine questions within it. We took validated scales from other industries and adapted them, with help from Vanderbilt, to replicate this in a child welfare setting.

We put these benchmarks at 60 and 90 percent because there's some evidence that those are useful for helping drive change in your organization. You generally would want more than 50 percent of your people responding positively on these measures, so 60 is kind of that threshold. Below that, you would view as actionable.

We don't have anything to compare this to for child welfare because no one's done these scales in child welfare, but we suspect better than 50 percent is a good goal for us, too.

The safety climate measure measures staff perceptions of how safe -- how do the policies and practices of the department support safe care delivery. Leader member exchange is about how does my relationship with my supervisor support those safe practices.

Psychological safety is a really important construct in this work, and it's about members of our workforce feeling safe and a part of a team, accepted and free to take interpersonal risks. So this is kind of the, do you feel free speaking up when you're challenging someone's decision making.

Safety organizing is a measure of how do our staff think our teams and our organization works to respond quickly to unexpected or unanticipated events, and then, how do we come back to normal operations?

And then, stress recognition, I'm going to highlight is the idea that does the workforce recognize the effects of stress and fatigue on their decision making and on their work? It's a really, really important thing for them to be able to do. And generally, they don't.

Across all our regions -- and then, this is our 12 regions, plus our special investigations unit, no one really gets out of the 40s. So we're, you know, in that range of being less than half the people or one out of two don't recognize the effects of stress and fatigue on their decision making. It's an absolutely sort of essential element in a safety culture that people understand their limitations.

We -- we're sort of redoubling our efforts and focusing a lot in the coming year on our sort of building a resilient workforce, and we're looking at ways to do that. And this is a common metaphor that people who talk about wellness and self care in the context of our workforce use.

This idea of, you know, when you're on the airplane and the cabin depressurizes, put the oxygen mask on yourself before you put it on the child next to you. So it's take care of yourself so you can take care of the people you're out there to take care of.

We use it, but we extend it because we think it only tells half the story. And in the slide I showed you previously, we know that our staff don't actually recognize the effects of stress and fatigue on their work.

And so what they don't say when you're on the airplane and the stewardess is telling you what you're going to do if the cabin depressurizes, is that when you -- they don't say when you get light-headed, you're a little confused and the kid next to you is turning blue, push a button, the oxygen mask will deploy, put it on yourself, then put it on the kid.

Because they've engineered all that into the system. It's automatic. The plane knows what to do. It's mitigated the effects of bad decision making by making that process automatic.

And those are the kinds of things we need to do for our workforce. It's not enough to do what we've been doing, which is these kind of self-care models. We need to engineer into our system ways to protect our workforce from the effects of trauma, from the effects of burn-out and from the effects of bad decision making that we know can happen naturally as a result of stress and fatigue.

So we also added to -- this would not be a typical part of a safety culture survey, but we did add a burn-out scale. And this was a time, as the Commissioner talked about as he was coming in, of pretty significant turmoil in our organization.

And it's -- we weren't necessarily surprised by a 45 percent rate on our burn-out scale. And that's consistent. You can find that in the literature of child welfare, that about 40 percent is not unusual.

But it's concerning, and it's concerning of what we're going to do next to start working on how to make them more engaged. So if engagement is sort of the opposite of burn-out, if an engaged rocket is going forward with a lot of power and a burn-out rocket has no more energy, no more fuel, we need them engaged. We need to figure out ways to get them fuel again.

But we can't depend on models that say, it's up to you to know and to recognize when you need to get help, and here are the tools for you to go access. We need to, again, engineer a smarter system.

Because we also know that much of this stuff just lies in our biology. And this is just as a sort of to drive home a point, these are FMRIs of sleep controls, so people who have had a normal night's sleep and people who are sleep- deprived, they've been up for over 24 hours. And the regions of the brain that light up are, as it happens, the same regions that light up on FMRIs of schizophrenic patients. But also, it's the emotional control centers of the brain.

So I imagine you've all had the experience of being up too long, making too many important decisions and working too hard, and having to make a healthy choice between a donut and, say, a bowl of fruit. And people tend to choose donuts.

And it's -- it's not just because they're bad decision makers or they're lazy or unable to take care of themselves. It's because we're just wired to make worse decisions in those moments.

And I want to illustrate how a culture can affect that kind of finding. This is -- our data is on the right. You've already seen it. This is just the aggregate of our child welfare data in Tennessee on this stress recognition scale. So, again, this is how well do our staff recognize the effects of stress and fatigue on their decision making.

The other two bars are from a study from David Gaba at Stanford. This is from 2003, so I suspect if you repeated this measure, you would actually see healthcare in a better place.

But aviation is better than 90 percent. Pilots understand the effects of stress and fatigue on their decision making because they have to. It's baked into their system. It's not that they're

more attuned to their bodies. It's that when they've flown too many hours, they're pulled off the airplane.

It's in their pre-professional training. They do it in flight simulators. It's -- it's -- all about their work is recognizing the effects of these things. And so they don't really have to think about it. It's just baked in.

And you're starting to see that in healthcare. The reason I said I think that would be different is we're starting to see, you know, work hour restrictions on residency programs and in nurses and all areas of healthcare.

**DR. MODELL:** So in conclusion -- we'll try to wrap it up for some questions. Thank you, Michael.

In conclusion, there's a number of things that we are doing. And our ultimate goal is to really have a safe and engaged workforce with the right tools, skills and abilities as a precondition for child welfare work.

We think nothing about telling a truck driver, creating laws, regulations that after a certain amount of hours, you can't drive. Most law enforcement agencies have rules of how many shifts a police officer can work, nurses, physicians and, of course, pilots.

And we need to start thinking about our staff that way because they, too, make high profile, high consequence decisions. And we know -- it's very clear in the literature, in psychological literature, that we make different decisions based on fatigue, based on decision fatigue, based on stress. It impacts our decision making.

So a couple of the things that we're doing is we're using our death review process. And the system that we're using, the safety approach, to really get at how do we improve our practice? How do we really improve workforce?

And our workforce. We're looking at smaller teams. We're looking at a number of different things. Commissioner Henry alluded to some of them earlier about the right tools. We got Windows based tablets in the hands of over 2,000 of our staff, I think about 2,500. We're training them better through our training academy, but we need to do more.

And we really believe the valuable and rich information we're getting from our multiple surveillance systems, one being our child death review and the debriefing process that Noel explained, and then, also because of now Public Chapter 21, our ability to gain information from our confidential reporting system, will really help us move our system forward and really take us one more step towards having that safe and engaged workforce with the right tools and skills, and I would say attitudes and energy, as a precondition for child welfare work.

So thank you for having us. I know you've listened to a lot of testimony. And hopefully, we shared some new and innovative things with you today. And we're happy to answer questions as long as they're easy. I'm just kidding.

**CHAIRMAN SANDERS:** Thank you.

Are there questions? Dr. Rubin.

**COMMISSIONER RUBIN:** So one of the things we talked about when I had a chance to talk to you guys last night was about sort of as we -- we haven't spent a lot of time on workforce and thinking about what can and can't work, and thinking about sort of turnover and the inability to really -- to really get a handle on this.

And you know, I think the Commission, we're looking for sort of actionable recommendations, whether they play out from a regulatory standpoint or legislative standpoint, state or federal, of how to address the workforce boondoggle in terms of its relationship to child safety.

**DR. CULL:** I think -- I think we need a little bit better science. I do think a lot of what is out there is in -- specific to the -- and we haven't seen changes. The data on turnover and burn-out and child welfare has been pretty consistent, so I don't think that we're making great strides. And much of what you see is sort of the wellness self-care approach.

Certainly important to identify secondary vicarious trauma, those kinds of issues. Certainly important to identify burn-out. But I think this, you know, how do we affect our systems to support safe care is where the gold is.

And the way aviation -- pilots didn't want to be safe. Pilots before the, you know, safety was introduced in the way that it is now to modern aviation, they were cowboys. They wanted to fly fast and low. It wasn't something comfortable for them. It wasn't comfortable for surgeons to adopt checklists and time-outs in the OR.

What moved it along was, I think, two things: Federal levers and that they have -- they have a professional accountability model. They're trained in a profession, a discipline, that has with it things like licensure.

Some of the things that you see in healthcare that I think have moved it -- because you know, it's been almost a 20-year process of people in healthcare starting to talk about, you know, this idea of a hundred thousand lives lost in hospitals from -- you know, from errors, basically, sort of unnecessary deaths in hospitals.

It's been about 20 years that we sort of recognized that number now. And it's only been probably the last five to eight that we've gotten a lot of traction in hospitals.

And that's largely because through CMS as really the biggest payer -- less about regulation, but just about them being the biggest payer, and joint Commission as an extension of that, accrediting hospitals who bill for joint -- for CMS, requiring these things of hospitals to be accredited and starting to take money away from hospitals with patient safety related outcomes.

So now the CFOs are at the table, the CEOs are at the table. And it's not just the chief quality officer in their office down the hall, you know, screaming about infection rates. It's gotten its way into C-suite in a different sort of way.

And I think those are the kind of levers that we don't have currently in child welfare that would help us advance this kind of work. So if we really did want to focus on workforce in a different sort of way, I think we need those kind of levers.

**DR. MODELL:** Right. And I think two of those easy levers would be things like supporting the workforce through a confidential reporting system, like joint Commission requires of hospitals. I think that that's a mechanism for staff that really has a lot of value and there's a lot of evidence for.

And then, something like measuring your -- your safety culture like, again, joint Commission requires. And they also, as I understand it, require you to share it with the board of directors of a hospital, as I understand.

So those types of things that have already been successful, I think could be very meaningful for child welfare. And we really have a unique opportunity here. You know, I think I used the word sentinel moment in time, I think, to really make a difference in workforce.

**DR. CULL:** There -- the confidential reporting is a great example because there's actually federal legislation, and I think most, if not all states, have some form of state legislation that also protects quality improvement information, data, in hospitals, recognizing that there's -- the public interest in hospitals being able to keep confidential things like reports of medication errors.

You know, we had to pass a law just to protect their names, you know, just to create this system. We don't have a similar sort of national infrastructure for protecting that kind of information.

**CHAIRMAN SANDERS:** Commissioner Petit.

**COMMISSIONER PETIT:** Yeah. A couple of things. One is, it sounds to me when I look at the airline stuff and the truckers, it's trust, but verify. They do not allow the pilots to make decisions themselves on whether they're fatigued or not, and truckers don't make those decisions themselves. There's a rigorous requirement that they produce written paper that they are attesting to the truthfulness of it.

It speaks, though, to the fact that you can measure what those indicators and standards should be. Is there any such thing on the child welfare side? What exactly would those standards be that you would measure ahead of time and build in some redundancy?

And just before addressing that, the other question is, what are your caseloads now of workers? What are your caseloads of supervisors? And what are you paying people?

Because those two things, manageable caseloads and adequate compensation also, I think, go into retaining workforces, keeping a workforce alert, continuing education, et cetera. So if you could just speak to both of those.

**DR. CULL:** I think I'll take a stab at the first part, and then, let Scott speak to the caseload issue.

I don't think there is. And I think there's variability, as I understand it. I don't know all states and, certainly, some states have county run child welfare agencies. But there's variability in how long people do work.

So I know that -- I think -- I'll be wrong about the state, but I know that some states have a second shift. Some states stop work at a certain hour.

We have a situation where our folks might be out until 2:00, 3 o'clock in the morning, or all night, and then, we're expecting them to be into work the next day or into court and making really critical decisions.

So I don't think -- I think the lack of sort of a standard model, I suspect there's not, I've not seen it or found it, a good child welfare specific number, kind of a pitch count or, you know, number of hours they can fly.

But I think we could draw on, you know, healthcare. And the joint Commission would say beyond 14 hours is -- that you see decreases in safety outcomes.

So while I don't think it's there -- well, this is another thing that I should have put in my list because this is something I think we also need. The other thing that advanced healthcare significantly over the last five to eight years is a national research agenda.

And things like the Patient Centered Outcome Research Institute that funds patient safety, comparative effectiveness patient safety research that really looks at what things actually get good safety patient outcomes. We need similar sort of vehicles for doing this kind of research in child welfare.

**COMMISSIONER PETIT:** And the caseload question.

**DR. MODELL:** Yeah, the caseload question and the money question, I think those are both excellent questions. And I think I saw a graphic the other day that said, I do it for the money said no special worker ever.

And Commissioner Henry says if you want to come work for him, raise your right hand and swear an oath of poverty and long hours. I don't know if he's still here, but I hope he appreciates that comment.

But I don't think we pay them enough. We have made efforts in our state to raise their salaries. And starting salary is probably somewhere around 30, and the vary all the way up to 60 for front-line staff and supervisors.

But our data and other data, I think nationally, shows that money is third or fourth on the list. Number one is somewhat of that support and feeling like they're making a difference.

And I think you bring up a great question about caseloads. I will tell you on paper, our staff allocation of number of staff per the number of cases that they get per region is absolutely within line of CWLA standards, COA standards, in terms of the number of cases that they get.

And I specifically say it that way -- and I'll reveal all of it -- is we have enough staff for manageable caseloads. What happens is the turnover is what kills us. So if the five of us, you, myself, Commissioner Dreyfus, Noel and Mike are all on a team, and Noel's burnt out and leaves, well, we get his 20 or 30 cases on top of what we're doing. And then, I get burnt out and I dump the cases.

And our HR models are all out dated. So it takes us forever to get somebody to replace them. All the while, 150,000 referrals are coming in throughout our year. That's where we run into high caseloads, and then, that begets more burn- out. And our focus has been a lot on that workforce piece.

So the staffing is only one piece of that. So we have enough staff currently to have manageable caseloads. If we can get them to be retained longer, that's going to be the key. More seasoned staff handle more cases with lower overall caseloads and more effectiveness than newer staff. That's just what we see. And that's an excellent question.

**CHAIRMAN SANDERS:** Commissioner Covington, and then Commissioner Dreyfus.

**COMMISSIONER COVINGTON:** I have a question for you. And I don't have an opinion on this, I'm just curious how you've thought this through.

The notion -- and your new law that sort of allows people to safely, you know, report concerns, how does that balance against this increasing demand from the public for transparency in child death review cases and how do you guys balance that?

**DR. MODELL:** I mean, that's a great -- any one of us could answer that and spend a couple hours engaging you in that. I think it's a great question.

So one of the things that we said is that the name of the reporter is what's confidential, but not the information. And there's precedence for that, whistle blower laws, child abuse reporting laws. Our laws are very specific on the referrant's name is redacted under subpoena from -- you could get it only under subpoena.

So there's already existing systems in place that account for that, so we -- we leveraged up those systems. We didn't get as much resistance as we thought. And partly -- and I've used this example before, and I don't know if the Commissioner is back in the room, but the Avengers -- my kids love the movie the Avengers.

And there's a scene in there where one of the guys go, well, we have an army. And one of the guys looks over and he says, yeah, we have a Hulk. And it's a really cute line in the movie because, you know, the Hulk's pretty awesome in the show.

Well, we feel that way, like we have a Hulk, we have a Commissioner Henry. Because he has so much respect across our state and in the country that there's a lot of belief in his honesty and his integrity and his support, we didn't get a whole lot of resistance as we explained this through our legislature.

And that's one of the reasons why we were talking about, and I think Dr. Rubin asked a good question. That's why we think we're not always going to have a Hulk. We're not always going to have a Commissioner Henry to be there.

So having some of those federal levers to say, states, you need to do this, and it's tied in some way to refunds, Medicaid funds, however it looked. So some of that resistance we address through our leader, who has that clout and has that level of trust.

And then, we got better at explaining it. It didn't work the first time we...

**DR. CULL:** And it's specifically not anonymous. They have to tell us who they are. It'll be filtered through our safety analysts and we have an attorney assigned to that team. So we sort of are building in processes for, you know, identifying the stuff that doesn't need to be in there, you know, someone did something that truly was wrong and we need to act on it.

But the -- and then, the information will be sort of scrubbed of their name and used for our quality improvement efforts, and that information will be publicly available just like everything else.

**DR. MODELL:** I mean, one thing I would just add to that --

**CHAIRMAN SANDERS:** Let's -- let's -- we have still a couple more questions.

Commissioner Dreyfus.

**COMMISSIONER DREYFUS:** You know, it's real easy to go into this issue of child fatalities from abuse and neglect and find the first technical fixes we can to fix what really is a larger adaptive challenge.

And I just have to thank you guys, all of you, for what you're doing to take on what really is a larger adaptive challenge. And looking at this through this workforce perspective of professionalizing this work.

Healthcare is a very -- is viewed in a very professional way. Aviation is viewed in a very professional way. The public views it as that. And I was out in the field one time with our home care worker in the Milwaukee system years ago, and young, bright, you know, just like just the kind of person you'd want to see up on that higher end of being with us 20, 25 years. And she told me that she didn't like telling her friends who she worked for, what she did.

So you're going to change that. And I just have to say, the whole country's got to learn from this.

But I also love, and I think the Commission needs to hear, how you guys are talked about, the levers. The levers that get pulled that hard wire change into systems. And if we don't pull all four levers as a Commission, then no real change happens.

And so I would just encourage you guys over these next months, be thinking about those federal levers and help us. Because what you're doing is you're taking on the true adaptive challenge that is this issue, and I just commend you for it and thank you.

**DR. MODELL:** Thank you very much.

**CHAIRMAN SANDERS:** And let me ask one last question. For -- in the utilization of safety science, you've obviously looked at both airline industry and health industries.

In adopting what has been done to your department, how much of that have you taken directly from the airline industry, for example, and how much have you had to make modifications to apply to child welfare?

**DR. MODELL:** I've been hogging the mic, so I'll let one of my colleagues answer.

**DR. CULL:** I think -- I think it's hard to answer. I think in a general sense, a fair amount of it is -- has sort of already been translated through healthcare and probably got its roots in aviation or other safety critical industries.

We have -- as I said at the beginning, you know, safety science sort of borrows from a lot of disciplines, but it's also -- there's an emerging discipline that is sort of human factors and safety science. And we've benefited from Noel having just completed a program and getting that training.

So he's -- so we're also really sort of applying pure science directly to child welfare without sort of borrowing it. So some of it's -- it's a little bit of both. It's a little bit of borrowing.

We've piloted and are thinking about how to spread the idea of, like, huddles that are similar to the huddles that would take place in an operating room, and that was borrowed from kind of a crew resource management model in aviation.

So this would be a translation through healthcare to child welfare, how do we apply that? But the Axi map model is sort of just applying -- and then, we're using the death review, it's kind of taking that pure science and applying it directly to child welfare. So I think it's a little bit of a mix.

**CHAIRMAN SANDERS:** Well, thank you very much.

**COMMISSIONER DREYFUS:** Outstanding.

**CHAIRMAN SANDERS:** I think that was outstanding. Thank you.

**DR. MODELL:** Thank you.

**CHAIRMAN SANDERS:** So we are concluded this morning's session. We have concluded this morning's session. And we have an hour for lunch. And we'll reconvene at 1:45.

**(WHEREUPON, A RECESS WAS TAKEN FROM 12:42 P.M. UNTIL 2:06 P.M., AT WHICH TIME THE HEARING CONTINUED AS FOLLOWS:)**

**CHAIRMAN SANDERS:** So for the rest of this afternoon and tomorrow, we have opportunity for the Commission to deliberate. And there are going to be two primary subjects, although, we probably have some room to add others, depending on the conversation, if it goes quickly.

One is the outline of the final report, a draft outline of the final report. And the other is the child protection sub committee. And I think for the child protection subcommittee, we're looking at tomorrow with Jennifer out today.

So that -- so we will spend the rest of today on the outline for the final report. And I sent -- I had committed at the last meeting to draft an outline and sent a copy earlier today. And I know that you have a copy in your -- in your folder.

And just a couple of things. The -- we've talked a little about the process. And I believe Commissioner Horn raised the idea of we really wanted to have a vote on the full report at some point, and not recommendation by recommendation.

And that's really what I'm recommending is that we begin to try and see if we can develop some consensus around the content of a final report, as well as the level that we want to talk about, and allow the staff then to actually put pen to paper and have something for us that we can talk about in more detail in the next meeting.

So my intent is that we would actually vote on the full report, and then, we may reach a point where there are parts of the report that people don't like and want to pull out, different sections, but that we have a full document in front of us to debate and to discuss. Because we really do need to tell a story about what we've heard, and not just have a set of recommendations.

So this -- the purpose, then, of the outline really, is just to begin to stimulate the conversation. And hopefully, today we can come to enough of a consensus that we can direct staff to begin putting some -- some words to this. And if not, then we will continue to work on the actual outline.

So this is not intended to be any -- something that we vote on, but really have a discussion and hopefully come to some consensus that this is generally the right direction and people can live with it, and we should begin to write some things out. The --

**COMMISSIONER PETIT:** There seems to be some kind of an echo effect on your -- now there is on mine, too. With you guys back there, there seems to be some kind of echoing, answering twice.

**CHAIRMAN SANDERS:** I like that.

**COMMISSIONER MARTIN:** David, I have another question.

**CHAIRMAN SANDERS:** Sure.

**COMMISSIONER MARTIN:** There are -- excuse me -- there are a couple Commissioners not here presently. Do we have anyone on the phone today?

**CHAIRMAN SANDERS:** Yes. Dr. Bevan is on the phone.

**COMMISSIONER MARTIN:** Okay. And the Commissioners who are not here, did they get copies of the --

**CHAIRMAN SANDERS:** I sent this to everybody, so --

**COMMISSIONER MARTIN:** Okay. Thank you.

**CHAIRMAN SANDERS:** -- Commissioner Rodriguez and Commissioner Zimmerman. And Commissioner Rodriguez will join us tomorrow. I believe Commissioner Zimmerman will not be part of the conversation, but perhaps it would make sense for me to also go over it with them individually after today's meeting.

**COMMISSIONER MARTIN:** I just want to know if we've given every Commissioner an opportunity to have some input in this, since this is such a vital part of our work. But it seems to me that you've actually e-mailed it to everyone, so everyone has had a chance to either call you or someone else. Thank you.

**CHAIRMAN SANDERS:** So what I thought I would do is just to go over this at a very high level. I think this incorporates many of the recommendations from the different subcommittees. I think that there are things that clearly are missing. There may be things included in here that people are uncomfortable with, and I think we need to have a conversation about all of that.

But what I thought I could do is just go through at a very high level my thinking, and then, come back and go, perhaps, chapter by chapter in a little more detail to see where people are.

And the structure itself, I don't know that we'll end up having 11 chapters or things like that. It was just to try and kind of form this in some way to break it up so we could have some conversation.

So unless there is objection to that or additional questions, I'll just go through very high level, and then, go through in a little more detail each section.

**COMMISSIONER HORN:** So you want us to hold questions until you go through the whole thing, and then, we'll go back?

**CHAIRMAN SANDERS:** I think after kind of go through the high level, and then, hold questions, and then, go back. And if there are questions about kind of generally, and then, we can have the more specific conversations, yes.

**COMMISSIONER COVINGTON:** So are you thinking that by the end of that, this would become our outline? Because it's a lot to digest in a short amount of time.

**CHAIRMAN SANDERS:** Well, I think that we -- that if there are things that we're completely uncomfortable with, then we wouldn't provide direction to staff to do something with it. I think we'll need more detail to actually have conversation. Because these are kind of thoughts off the top of my head.

So if there are areas where there's general consensus, we should probably ask staff to pull together the evidence they have and to actually write something up.

So I think I would ideally like to have yes or no to this is a general direction or with modifications. But if we can't get there, then let's see if there are pieces that we can direct staff to begin to work more on.

Does that get to your question, Commissioner Covington?

**COMMISSIONER COVINGTON:** Yeah, I guess. Okay.

**CHAIRMAN SANDERS:** So let me just start with the beginning, Chapter 1. And you'll see here that it starts with story. And I think we have -- we have heard a number of stories of individual children, and I think we need to highlight that throughout the report. Some of them are quite compelling, both about the urgency, but also I think demonstrate some of the challenges that we've seen.

The idea in this chapter at a very high level is really to provide a context. And part of that context are the -- you can see the two sections in the beginning, the policy subcommittee

recommendations, which are we consider political feasibility and start with current policy and look at policy clarification, effectiveness, accountability and efficiency.

And then, secondly, that throughout -- and we heard it today in the conversation from Tennessee, that we really try and classify at a very high level the different types of child abuse and neglect fatalities.

And most particularly, separating out the neglect slash accidental, which just my loose term, includes some of the cosleeping fatalities, drownings, the improper positions, the sleeping positions, those kinds of things, from severe neglect and abuse that are known to the system and severe neglect and abuse that are not known to the system.

And I'll come back to that, but I think that we want to make sure that there are likely to be some different strategies for them, and that it's not just one monolith of childhood abuse and neglect fatalities. And then, the final part is just to lay out what our charge is.

In Chapter 2, mention really two over arching themes. And I think this is -- these are my conclusions. And so, obviously, plenty of room for debate here.

But that -- and this is based on what we've heard. That we -- first over arching theme is we know who's at risk, but that the child protection system is really not designed to serve them and can't serve them alone. And that that's a point that we've heard over and over. I think we heard it today to -- at -- to some great length.

And, second, that -- on the next page -- that children fall between the cracks. That they are known to somebody. If we think of the system more broader than the child protection agency, they are known. They're known to healthcare providers. They're known to law enforcement. They may be known to child care providers. And that they really fall through the cracks. It's not that the children are not known.

So really kind of laying that out as something that -- those two areas as things that we need to address, and really behind much of the -- many of the issues that we see in the fatalities that we reviewed.

Chapter 3 is what works. And, again, there's much room for debate. We've heard some about home visiting and some of the research there. I think there's some debate about how far we can go in saying that it works.

We've heard from at least four communities a anecdotal reduction in fatalities, although, it's not necessarily statistically significant, nor is it scientifically supported. But these are communities that have done work that I think we can learn from.

Third, we heard some about the airline industry.

And then, fourth, I just identified -- again, these are my own thoughts about some of the common themes that -- that we heard that seem to support the successful reduction in fatalities.

**COMMISSIONER MARTIN:** David, the airline industries to indicate the safety survey?

**CHAIRMAN SANDERS:** Yes.

The next is what doesn't work. And I think that we do not have, as far as I have heard thus far, research that identifies what does work. And I think that that raises questions, certainly, about the need for more research and evaluation of approaches.

And I think that was, again, apparent in some of the questions today, that there's more information we need to know. And that while it's hard to say what doesn't work without being able to say that we have research or evaluation behind this. So really asserting the need for more research and evaluation.

The next chapter, Chapter 5, is really a compilation of the recommendations from the measurement and counting subcommittee, that it's very difficult to fix what we can't count. And so, this is just a short summary of those recommendations.

And then, Chapter 6 is just, again, some thoughts of what we have heard about the areas that we might want to address in looking at how do we make sure that children don't fall through the cracks and how do we do a better job of addressing who's at risk?

And we have talked a lot about the public health approach, which is obviously critical, and also talked about at the same time the immediate needs of the child protection system. And so in looking at our recommendations, it seems that we've talked about somehow combining the two. And that's what I touch on on the top of the page. And I'll go over the specifics a little later.

Chapter 7, I think we need to talk about special populations, and particularly, American Indian children. There may be others that we want to talk about, but I think there are some very unique issues with American Indian children that we've heard about that we'll need to address.

Chapter 9 is what congress can do. And many of these are themes that we've talked about, particularly starting with the sharing of information and the strengthening of the oversight rule.

Chapter 9, we've not really talked as much about what the administration can do, but I think there are some specific recommendations there.

Chapter 10, what states and localities can do. And these are ideas that I think have emerged in some of the different areas, and particularly, the idea of eyes on the child. And that making sure that physicians, schools, others, are -- begin to be more expert in identifying who's at risk.

And then, finally, Chapter 11, neglect and accidental fatalities. I think -- and actually, Pat and I were just looking at the box from Finland is one of the strategies to impact cosleeping fatalities. And it appears that there are other fatalities -- other strategies that have been effective, including some of the work done in Tennessee, and that there's more work that we need to do there.

And this, again, isn't intended to be kind of a full outline, but just to provide enough direction for us to begin to have a conversation and to direct staff. So it kind of ends abruptly with neglect and accidents. And I'm sure it will end more eloquently as we work on this.

So that's really just very high level. And maybe stop and see if there are either major things missed, if there are questions of clarification, then begin to go into more detail.

Dr. Rubin.

**COMMISSIONER RUBIN:** Thanks, Commissioner Sanders.

You know, I think there's a lot of details in here. And so we could end up presenting a report that we get kind of lost in the weeds in some ways.

And so, you know, I think for me, Chapter 1, there are two pieces of it. Chapter 1 should really sort of, what are the largest -- what's the overriding themes that we feel like we pulled together at the forest level -- you know, separate the trees from the forest.

And I wrote down before -- you know, before coming here, sort of concepts that have been playing in my mind in pretty much every meeting we've had locally.

Number 1, this idea that child welfare is not a child protective services response, it's a community response. And so that helps frame the nature of how we're going to envision what we're trying to create.

Number 2, that this issue -- that, you know, that -- that if we are truly to impact this issue, we need to move towards a much more public health framing and figuring out how we're going to create a public health response rather than a child protective services response to address some of the underlying risk for serious injury and fatality.

That means that there has to be accountability beyond CPS, and real levers that actually incentivize states at the highest level of government to prioritize this from a state planning and resource issue.

The next one I had was giving states greater flexibility to position their resources to respond to whatever plan that they develop.

And then, finally, I think we should come out and say there is no magic ingredient. That there wasn't a single program that is the magic ingredient, but that what we've learned from all of our travels is that there are common elements of how states work together. And it's about interdisciplinary management and bringing disparate systems together to coordinate a response that includes some level of transparent data sharing, but also, you know, to some degree managing what you measure, and then, developing responses and actually taking on whether it's a safety or QI frame to how they can work.

So -- and then, finally, at the very end, I say, how would we know if we were successful in all of our work? I think we'd know we were successful if we could look back and say that at the end of this whole process, every state in this country had a plan, was coordinated at higher levels of the governor's office to position resources across systems with some common elements that we might help -- have helped define, and that they were measuring whether

there was impact and they were able to use their resources effectively to change the nature of the response that they were having.

And so that might be that final chapter, which talks about what does success look like as a result of these efforts.

**CHAIRMAN SANDERS:** Dr. Horn.

**COMMISSIONER HORN:** So I'd like to suggest a little change in the emphasis of the report. So according to the child maltreatment report of 2013, 50 states reported that there were 1,484 deaths. Of those, a little less than half, 46.8, suffered physical abuse. Which means that a little more than half died of something other than physical abuse.

And while it's mentioned up front, the neglect and accidental deaths, it's not until sort of at the very end of the report that we have anything that sort of talks about neglect and accidents that cause kids to die.

Yet, what I heard, for example, today and I've heard other places, is we actually know how to prevent a lot of this. And there was some data today where they said, we did certain things and, actually, certain kinds of deaths were reduced. There was in the physical abuse cases they couldn't show that there was clear evidence that they were -- they were reducing child deaths.

So I would suggest that -- that the report should be much stronger on how do we go about reducing the number of kids who are dying because of neglect, both because it's at least half and also because it seems that we actually have, in contrast to other areas, some actually fairly strong evidence about how we can go about reducing those kinds of deaths.

**CHAIRMAN SANDERS:** Let me just throw something out because I think that that's exactly what we should be looking at. A couple of things. One, I was intentional in separating out severe neglect, and I'm not sure what percentage that is of the overall neglect cases because I think it's more closely aligned with what people traditionally think of with -- with -- with physical abuse and severe neglect. Not taking away from your point.

The other, though, is -- and I wrote it here a bit cryptically, but we heard from the testimony this morning the reduction in infant mortality here. And that's a pattern across the country.

And I -- it would be helpful to know how many of those -- what the level -- with the reduction in infant mortality, how many of those are what historically might have been neglect fatalities? Because it's possible that we've seen a downward trend. I don't know because we don't know it from NCANDS, but the overall infant mortality has declined.

And thinking that it doesn't, again, take away from what you're suggesting, but it might be a context for us to consider.

**COMMISSIONER HORN:** So just a question for you. So do we have -- I haven't seen it and maybe I missed it. So do we have clear data on severe neglect versus other neglect cases?

**COMMISSIONER COVINGTON:** Can I just say something about that?

**CHAIRMAN SANDERS:** Yes.

**COMMISSIONER COVINGTON:** I don't know what the heck severe neglect is anymore.

**COMMISSIONER HORN:** That's my question.

**COMMISSIONER COVINGTON:** Because, to me, if a child dies from neglect, it's severe neglect. So I guess I have a -- you know, and I think I know where you're getting at in terms of the accidental stuff, you know, poor supervision or failure to provide adequate safety devices or something and --

**COMMISSIONER CRAMER:** Or chronic neglect.

**COMMISSIONER COVINGTON:** Chronic, versus chronic neglect where you maybe would starve a child or there's medical neglect that would cause something. So I --

**CHAIRMAN SANDERS:** Well, let me just -- actually, let me give an example. So a situation where a drug dealer hides his infant beneath the guns, I mean, which happened frequently in Los Angeles. That would be to me -- that is not the same as a rollover fatality. I think that's much closer to physical abuse.

**COMMISSIONER COVINGTON:** Right. But I guess my concern is that we're separating them into a separate category. And I -- I would rather -- I don't -- I guess I'm not a fan of that.

I would rather -- you know, if anything you could create a continuum if you wanted an arrow, for example, and I could create that real simply. I mean, I could figure out what that would look like where you really had, you know, really -- I think of it as egregious where there was something -- you know, at one end, you have willful, physical assault, planned assault on a child, for example, all the way over to somewhat benign negligence.

And I mean that goes into that whole measurement piece. But I get worried that we're separating them out differently in a report rather than just showing that there's continuum and we're trying to address different pieces.

**CHAIRMAN SANDERS:** And I think, Dr. Horn, you were saying something a little different. So I just want to --

**COMMISSIONER HORN:** Yeah. So continuum suggests that people move up and down the continuum, and I'm not sure that's completely true. I think that there is a difference between someone who tortures their child to death --

**COMMISSIONER COVINGTON:** I do, too.

**COMMISSIONER HORN:** -- and somebody whose phone rings and they go to catch it in the kitchen.

**(Speaking over one another.)**

**COMMISSIONER HORN:** So -- but I guess my point is that I think that when it appears at least half the cases are due to neglect, and my guess is that a lot of those cases are cosleeping

cases, they're drowning cases -- accidental drowning cases and so forth, and we know there are effective interventions for those kinds of things.

My only point was rather -- it seems like it's an afterthought by having it listed at the very end as opposed to something that's really core. I mean, this is half the population that we're talking about.

**COMMISSIONER COVINGTON:** Yeah. I would rather integrate it into our -- I would rather integrate those successes into the whole body of the report rather than making them a distinct component. That was my first reaction.

**COMMISSIONER PETIT:** But why not just state the problem in the opening chapter? Forget for a moment an executive summary, forget an introduction, forget a cover letter, but just going into the substance of content.

Why wouldn't we just begin by saying there is a problem of child fatalities, it looks like this, and recount what that is. And then, the sequel is, the system is only able to protect some and not the others.

I mean, then you get into some of the findings of that. And I don't know how you want to approach this, David, in terms of the back and forth.

**CHAIRMAN SANDERS:** I think this is what we want to do.

**COMMISSIONER PETIT:** Okay. But David just laid out three or four things. Do we respond to that? Do we just keep focusing on --

**CHAIRMAN SANDERS:** Actually, I wanted to --

**(Speaking over one another.)**

**CHAIRMAN SANDERS:** -- because the child protection subcommittee, I think, has said something different. So it would be helpful if in terms of the -- the overarching issues that Dr. Rubin raised, including specifically the public health approach. I think I've heard something different from the child protection subcommittee, so it would be helpful to --

**COMMISSIONER PETIT:** Yes. No. I think we have to have a conversation about it. What's that?

**COMMISSIONER DREYFUS:** It's both. We need both.

**COMMISSIONER PETIT:** Yeah. That's right. I don't think they're mutually exclusive and one isn't -- doesn't trump the other. I would not start out by saying this is a public health issue. It is a public health issue; it's also a public safety issue. It is very much a public safety issue.

And it's not like we can say what necessarily works or what doesn't work. Some things work; some things don't. Some things work some of the time; some things don't.

I mean, I don't think there's a categorical rejection or adoption or reversal. Right now, to me, the public health piece is an important add on. It's an important addition, but it doesn't deal with the legal rights of parents who are maybe losing a child or somebody who's living with an ex convict.

I mean, it's not that. The public health is lot to be said. I thought we heard some of the things from Doctor -- was it Warren this morning? You know, when he was suggesting -- I'm not sure if it was the public health guy, but he was talking about the teen pregnancy issue, you know, and the good parenting question. I mean, that goes into aspects of this as well.

I just don't want to automatically in a two-minute discussion roll past this question of, what are the dominant themes? I mean, David, you mentioned something. I think it's a conversation that we all have to have about where it fits in.

**COMMISSIONER DREYFUS:** Can I ask a follow-up to Michael? Michael, can I ask you a follow-up question?

**COMMISSIONER PETIT:** Please, please.

**COMMISSIONER DREYFUS:** So, you know, we started out talking about months and months ago, you know, what is child welfare, right? And everybody I think in the country oftentimes thinks child welfare begins and ends with the child protective services function, and I think everybody is understanding that child welfare is this larger community responsibility.

Well, then we started talking -- we started moving into this public health frame. And people hear "public health" and they go right -- they go one place, right?

Well, I remember years ago reading Fred Wulczyn and several other people's book called, Beyond Common Sense. And it was one of the first times as a child welfare director that I realized that we had to reframe child welfare and understand that CPS, that public response system, was an integral part of it. It didn't sit outside of it. It wasn't, here is this public health approach, and then, here's this CPS response.

Is there a way for us as a Commission to do something pretty radical? And that is to redefine how our nation views child welfare through this larger kind of public health frame, but not -- but sees and anchors an effective, consistent, accountable CPS function as an integral part of it, not sitting outside of it. And I guess that's a question to you.

Is there a time now where the public health work that we're calling that and the CPS work starts to converge because it's part of an integrated system? It's not two separate things.

**COMMISSIONER PETIT:** Yeah. I think it needs to be more so. I do think that there's an issue about fatalities versus abuse and neglect generally. And I still maintain that our principal charge is not stopping child abuse and neglect, it's stopping child abuse neglect fatalities.

There's an important part of that. But, David, on the public health side, I don't think that public health is going to reduce mental illness, is going to reduce substance abuse issues. I mean, you know what I'm saying?

I don't think -- I mean, there's a lot of issues that affect -- it's 4,500 people we heard today working in Tennessee DCS. I think that's what I heard, 4,500, something like that, right? I mean, they're involved with hundreds of thousands of children who are facing specific issues of abuse and neglect.

So I think the public health piece is long gone in that in some fashion or it's integrated with that in some fashion, but it's not in lieu of or is dominant or anything else.

**COMMISSIONER DREYFUS:** But let me say, we've done a disservice in calling this "public health" because I would say under the -- under what we're talking about, yes, substance abuse, mental health, you would start seeing this true -- a much more integrated approach similar to what, I think, Tennessee is moving toward.

You would start seeing a more integrated approach. And so yes, you would start seeing movement on services being available for mental health and substance abuse and you would see movement under this.

**COMMISSIONER COVINGTON:** I think it's a linguistic issue because I think it's the term "public health", makes people, like you said, you automatically gravitate thinking about a public health department or a public health agency.

And, you know, and I think in the report that's what might happen as well. And maybe we need to think about language in a different way and see if we can construct a different term because I think that's what's causing -- causing the dilemma.

**COMMISSIONER MARTIN:** So I think -- I have envisioned this report starting just a tad bit different. And maybe I'm the only one on this Commission, but when I got here, I did not realize how difficult it was to ascertain what a number really looked like for our kids who died.

I didn't really understand how, within a state, within a jurisdiction, different parts of the state would count child abuse and neglect fatalities differently.

And so I would suggest we kind of lay out the fact that this -- lay out what the problem is, so this is why we don't have a good number, this is why it's hard to define what child abuse and neglect fatalities is.

But utilize some of these examples of cases in which we've determined that there are promising practices like the box, the Finland box for kids that have parents who are abusing drugs and sleeping and rolling over them and the kids are suffocating.

But then -- because that does take half of the number of deaths that we have found. And I think we should explain why we didn't spend a year trying to define what child abuse neglect fatalities are. Because my first question would be, heck, if you don't know what the number is, find the number. I mean, why aren't you trying to find the number?

I'm not sure I would use the term "medical health" or "healthcare approach". I think everything we've heard, we keep referring back to CACs. But really, when you think about it, what I've envisioned is more of an interdisciplinary investigatory team that goes and actually determines what the risk and protective factors are for the family, more like an MST team that they've utilized on juvenile justice side, right?

It's an interdisciplinary team that actually goes into the placement, the house, and ascertain what the risk factors are for that kid that's aged three and that kid that's aged 13, and they

then determine what the services are that you need to put into the home to protect that family, everyone in that family, and you branch out from there.

And so all I'm saying is, I don't know if it's a public health approach. I don't know if it's a child protective approach. I would suggest that we're talking about a different approach completely.

And identify the approach, define approach, but I don't think we need to call it -- because I'm telling you, it took me a couple months to understand what you meant by public health approach. And when you tell me something like that as the presiding judge of a court, I'm going to close up a report because I don't do anything in medicine.

**COMMISSIONER RUBIN:** Yeah. I guess, you know -- and I hear you. I hear you. I'm listening. And it could be word choice like Commissioner Covington sort of said.

But I won't back off the premise that I think in the same way that the charge to this Commission was to think about, quote, child abuse and neglect fatalities, we're sort of splitting off a bunch of children who die from the other children who die with preventable deaths, right? This gets to the comments about neglect.

And so I'm not saying we're going to have a different response for anyone. I actually think that the approach to infant mortality is one of the fundamental state responsibilities across this country.

And whatever we do, number one, from a sense of accountability, right, needs to elevate this at the highest levels of government, whether you want to call that a public health approach or a higher level of accountability. Because within that includes different public health approaches and public safety approaches, et cetera.

But I have not heard a single testimony that tells me we can -- this is the line where these kids go over to right and the other kids are part of a public health system and the response.

And the other reason why I sort of -- I illustrate when I call it public health is because that's where the money is. That's where the levers are right now. Because, you know, states - - their biggest budgets are around health.

And what I don't see is a level of accountability on the health side that I see CPS struggling with on their own often in a lot of these cities and states.

So that -- so I don't know where we end up there, but I want a higher level of accountability.

**COMMISSIONER MARTIN:** So I'm not suggesting that kids that we ascertain that their risk is lower, that they go to one program and the other kids go to another program. I'm looking at home nurse -- for instance, when a child is born and there is a screening done, maybe it's a toxology that indicates that this child or this family's at risk, then there's like a home nursing program goes in and you ascertain what's needed for that family and you go down that road.

**COMMISSIONER RUBIN:** All right. So where does that live in state government --

**(Speaking over one another.)**

**COMMISSIONER RUBIN:** -- I guess, is the question? Where does the organization of that live in state government? So I -- I -- so what I'm arguing is that the organization of that program --

**(Speaking over one another.)**

**COMMISSIONER MARTIN:** That's the MST team. The team has a responsibility. That's what I was talking about last night. You can't expect the Court, the prosecutor, to be involved on this team without making me have some skin in the game. And so that's that MST team.

And I don't know how you organize it yet because I don't know how you get the prosecutor convinced that they have to do it, right? I don't know how you -- you've obviously figured out how to get, you know, the medical professionals in there.

But yeah, you also need law enforcement. You also need prosecutors. Those are separate offices. And they have to -- they have to have something at risk to make them keep coming to the table and trying to improve their ability to work in this environment.

**COMMISSIONER PETIT:** At the CPS subcommittee that we've written up on specifically speaks to that kind of multi team approach to going out on the initial call. And so, I mean, I think there's a number of places where we've written exactly or implied exactly what it is that you've said. I think --

**COMMISSIONER MARTIN:** My only concern was to David. I wasn't specifically talking about one segment of kids going in one door and another segment going into another door.

**COMMISSIONER HORN:** I'm going to speak out in favor of two different doors, at least. Because I do think there are different categories of kids who die because of abuse and neglect. And I don't think for -- for people whose only sin is they cosleep, and then, they roll over and they smother the kid, I don't think we need a multidisciplinary team to go into those person's homes prior to that and say -- you know, I think that a public education approach that informs people of the dangers of cosleeping is probably sufficient for a lot of those kinds of cases.

So -- but there are also other cases that need something much, much more than just pubic education. And I think for those that we're talking about, some of them are going to need a multidisciplinary team going into the home, some of them are going to need a CPS response that includes a multi --

So I actually think there is not -- I think there should be a multi-level response depending upon what problem we're trying to solve.

**COMMISSIONER MARTIN:** How do you determine that Pat's in the public, you know, public announcement category or Pat needs the MST team to come to my home?

**COMMISSIONER PETIT:** Well, one of the things we're proposing is the pre-mortem look at each kid's situation, have a multidisciplinary team look at that and determine whether it falls into something a public health nurse would do or you actually need a prosecution situation because the situation is -- is a felony offense.

**COMMISSIONER MARTIN:** But what I keep asking is, assuming I agree with you, right, when is that determination made what group Pat falls in and who makes that determination? Because right now, if we leave it up to the social worker at the hospital, I will tell you in Cook County, those are vastly different results depending on what hospital I go to.

**COMMISSIONER COVINGTON:** Well, first of all, I don't think you do it post-mortem. I think we're talking way upstream so that we're identifying kids at risk early. There's different things you can do to identify kids that are at real risk of serious harm or kids where families aren't following good safety practices. So you do something like --

**COMMISSIONER MARTIN:** But how and where do you make that determination is my question?

**COMMISSIONER COVINGTON:** Well, I think you get smart about it. I mean, if you know that a child is leaving the hospital and you do a nice assessment and find out that they don't have safety protocols at home, they don't have a place to sleep safely, you make sure they go home with a place to sleep.

I mean, there's ways to do that. But I don't think -- the Commission has to figure that out in terms of where -- where we assess these families differently. I think that's getting into the weeds.

**COMMISSIONER HORN:** And there are certain things --

**COMMISSIONER BEVAN:** That's already current law as we heard this morning from Nancy. If you have -- an infant care plan is required, it's not followed. So I mean, we don't need to reinvent the wheel there. It's a current law and it's not followed.

David, you know, you said -- a long time ago you said, oh, there's a big difference between infant mortality and infanticide and homicide and, you know -- and you never really went beyond that. I mean, and now you're talking about infant mortality. But that's not the same as what we're talking about, right?

**COMMISSIONER HORN:** So, Cassie, it took us a while to even identify who was speaking, let alone what you were saying.

**COMMISSIONER BEVAN:** Infant mortality is within the first 30 days of life, right?

**CHAIRMAN SANDERS:** Cassie, we're unable to understand you.

**COMMISSIONER BEVAN:** Okay. Never mind.

**COMMISSIONER HORN:** There's something wrong with the audio. That's why.

**CHAIRMAN SANDERS:** We're going to check and see if we can make some --

**COMMISSIONER HORN:** So, for example -- look, only because there are certain a-has for me and part of this was, you know, that so many kids are dying because of neglect -- what we define as neglect, and public education campaigns are fundamentally different.

I'm not talking about going -- you need a public education campaign, you don't. Public education by definition are public education campaigns. And the way that you know success with public education is it becomes part of the culture.

So when I was growing up, you know, nobody wore seat belts. And then for decades of messages about seat belts, now, when my kids were small, if I didn't click mine, my kids would go, put your seat belt on, Daddy. That's what success looks like.

So what success looks like in cosleeping is, people go, oh, you can't -- no, you can't no, you can't do that, that's really dangerous for your child. And it seems to me that that's not happening. I wouldn't know that.

**COMMISSIONER MARTIN:** But that's the point. It's not -- cosleeping is not the problem. It's cosleeping while you're drunk or high and roll over the kid. So -- and the reason I say that, in New Zealand, they have boxes where they encourage cosleeping. So that's the point I'm trying to make.

**COMMISSIONER RUBIN:** I would also -- you know, just to change the lens of this. You know, I don't want us to be too prescriptive, right, because one of the things I've enjoyed about going around this country is finding what people are doing locally, how people are solving their own problems.

What I'd like to see -- and look, I believe that the best place to organize the kind of collective response across multiple domains of this issue is a public health department. That's where I come from. I understand that not everyone will agree with me, but I think the idea of having a higher level of accountability is there.

But I'd like to think about a solution where every state in this country has developed a plan that disaggregates the different types of deaths that they have, right, and articulates an approach that we actually provide for that scale to not what you're going to do, but you need to address a public safety issue and give them the constructs that you're looking for in the evaluation of that plan.

That you need to address how you're dealing with substance abuse prenatally. That you need to address your approach to domestic violence. That we can come -- that we agree on the core elements of what a state plan might look like and who's going to evaluate it and hold states accountable for it, but that we try to avoid being too prescriptive because the multisystemic -- the interdisciplinary team is going to look different in Chicago than it's going to look in Memphis, right?

And so that's the only way I can envision us playing this out. And then, we can be happy at the end of the day if we're evaluating how the success of these states are doing across the continuum of their plans.

**CHAIRMAN SANDERS:** So let me try a few things that it seems like I'm hearing there's actually some consensus on. And thinking about this as a Chapter 1.

So first really start with stating the problem very clearly, and that includes a variety of things related to counting, includes this issue of the strategies that might work for neglect that aren't being utilized, but to lay out what the problem is.

Then to follow that with five or six themes from what we've heard. And, I think, David, you laid some out. I mean, obviously, there would be debate about that, but themes of what we've heard.

Third, and we obviously need to talk about our charge because that has to frame what we do.

Fourth, that we talk about it in the context of infant mortality or child mortality, a broader context, but that there is a group that we are charged with primarily addressing. And there's a couple of ways we can do it.

We can do it trying to address the entire issue of infant mortality or child mortality or we can try and do it more narrowly. But that this is part of a larger group of children who die, and that's one of the things that we've seen.

And that, in fact, the infant mortality rate is going down, homicide rate is going down and so forth, which I think is an important context. That what had seemed to work to this point to reduce the infant mortality rate is a multisystem approach in that we're -- that we actually not necessarily use the words "public health approach", but that we lay out exactly what we mean with that and what we've observed that seems to have made an impact and what hasn't.

**COMMISSIONER MARTIN:** And then, do we finish up with what Rubin just said, that we then take to the states the opportunity for them to develop their plan with these key components that address the issues that you've just laid out --

**CHAIRMAN SANDERS:** So I'm thinking more this is just the introduction, that's there's much more that would go throughout. But kind of, is this how we want to frame what we are saying in our report?

**COMMISSIONER COVINGTON:** And I guess I wouldn't -- I wouldn't couch it within the context of comparing our child abuse neglect with infant mortality because I don't think that that's why the reductions happen in infant mortality. They're not similar. They weren't multi systems.

**CHAIRMAN SANDERS:** But hasn't it been the public health approach to addressing --

**COMMISSIONER COVINGTON:** For infant mortality, no. You could argue it was medical technology. I mean, there's all kinds of things. I think it's a bad comparison. I wouldn't go there.

**COMMISSIONER RUBIN:** Meaning non- perinatal deaths? You're meaning like preventable child deaths, right?

**COMMISSIONER COVINGTON:** Right. I mean, the real reductions in infant mortality were because of technological advances in medicine and we keep kids alive longer and we just do a better job reducing fatalities.

**COMMISSIONER PETIT:** Yeah. No one's talking about infant mortality, right? David, you didn't mean infant mortality as in mother is pregnant, gives birth?

**COMMISSIONER RUBIN:** Yeah. I sort of dichotomize it as you have these prenatal deaths and deaths from congenital anomalies. They're kind of off to the side. Then you have all these other deaths, which people are now classifying as preventable child deaths, right? -

**CHAIRMAN SANDERS:** I'm sorry. say that again. Say the last part again.

**COMMISSIONER RUBIN:** They're classifying it as sort of preventable infant morality as opposed to perinatal mortality.

**CHAIRMAN SANDERS:** I'm still not clear. Are you suggesting that the reduction has nothing to do with actual preventable child mortality?

**COMMISSIONER PETIT:** Well, it's not abuse and neglect.

**CHAIRMAN SANDERS:** No. I understand that.

**COMMISSIONER COVINGTON:** No. I'm saying that -- I would just be careful that we -- I think we're getting ourselves into a quagmire that would take us a lot of time to sort out in terms of comparing what we're trying to do with child abuse and neglect fatalities as a comparison to the reductions in overall infant mortality. And I don't think that's the way to frame it.

**CHAIRMAN SANDERS:** I mean, I partly was trying to hear what David was saying. But I think separate from that, it seems that from everything that we've seen, the infant mortality rate has gone down, the homicide rate has gone, but the numbers in NCANDS have remained the same. It seems that there's something there that we need to understand better.

**COMMISSIONER COVINGTON:** Well, there's been some good papers written on why there's been a huge reduction in infant mortality. I can pull those up. But it's not necessarily because we're doing a multisystems wrap around with families and what have you. It's other things.

**COMMISSIONER PETIT:** It's a very different problem.

**COMMISSIONER COVINGTON:** It's a different --

**CHAIRMAN SANDERS:** We have infant mortalities and homicides that have both gone down for children 14 and under, but the numbers in NCANDS have remained the same.

**COMMISSIONER PETIT:** Right. They're different problems. They lend themselves to different interventions.

**COMMISSIONER COVINGTON:** And I wouldn't trust the NCANDS number.

**CHAIRMAN SANDERS:** It's a subset of homicides, the fatalities, as well as a subset of infant mortality. So those trends are down, but the trends in NCANDS are stable. It seems that that's information that we have to -- we have to, in some ways, understand.

**COMMISSIONER PETIT:** Well, if so, I don't think it belongs in the first chapter on this thing. And if I could just state, it seems to me that it needs -- this issue needs to be introduced with a sense of urgency that the Commission imparts to it that the public is going to respond to.

And I would just suggest with every finding that we have that we are unhappy with, that we illustrate it with a specific case piece that shouldn't take but an inch or two paragraph as a way to illustrate. Because it's too -- it won't be accessible to the public, to the press, or lawmakers if we write this for our professional colleagues.

So I think the introduction of each finding, there are this many kids killed or the systems don't work, we use a case to illustrate it. And I'm not talking about a long case. I'm talking about something very tight on this.

The other piece, David, is on the child mortality -- the overall abuse, neglect fatality rate. I do think we need to state right at the beginning that we think it's substantially higher. I hope we think it's -- we are all persuaded that it's substantially higher than what it is.

**CHAIRMAN SANDERS:** Well, that's -- I mean, we can state it, but we're restating what congress has already stated. I mean, they stated in the legislation that there's an under count. So I mean --

**COMMISSIONER PETIT:** Right. But we're not going to tell people who open it, see a congressional report of four years ago. You know, I mean, we can say it in a sentence or two.

**COMMISSIONER BEVAN:** That's what I was trying to say before. We have to prioritize this. If we're talking infant mortality, then we have to explain what that is. Because the risk of mortality where the mother kills the baby on the first day of life or within the first 30 days, we can't just ignore it, but we have to explain it. And these different terms have to be explained.

**CHAIRMAN SANDERS:** Cassie, we can't understand a word. Is there a --

**COMMISSIONER BEVAN:** Still? All right. I'll shut up. All right.

**CHAIRMAN SANDERS:** We'll see if we can actually --

**COMMISSIONER PETIT:** We're going to move you about 40 feet so that the microphone is placed differently.

**CHAIRMAN SANDERS:** Michael is saying we're going to move. I don't know that our technology people are saying the same thing.

**COMMISSIONER BEVAN:** I'm muting it.

**CHAIRMAN SANDERS:** Is there anything that we can do to move it over here, Susan?

**COMMISSIONER DREYFUS:** So Teri, David, one of the things that I get a little bit concerned about is this abuse, neglect and that we could find ourselves being interpreted as understating the severity of neglect that can lead to the fatality of a child.

I get the cosleeping, but then there is the cosleeping with substance abuse, you know, going on. And then, there's the horrific neglect cases that I've had responsibility for where, you know, kids being willfully neglected by their parents, right, leading to the death of that child.

And so I get a little bit nervous about somehow putting some kind of a wall between neglect and abuse. So I just -- that would be one of the questions.

So to Teri and David I ask, how do you get at -- because you said, let's not define -- let's not separate out severe neglect -- I don't even know how to quite, you know, define it. But how do we make sure that we don't lose sight of what Wade thinks? I don't think this is about a continuum. This is about there's a range of ways that kids are killed through abuse and neglect.

And some of it is a big public health. We've got to change how society views sleeping with kids, right? I get that. But I just don't want us to then understate what else sits in that neglect bucket.

**COMMISSIONER COVINGTON:** I don't either. And that's --

**(Speaking over one another.)**

**COMMISSIONER COVINGTON:** I don't either. And that's, I guess, my concern was that's why I didn't want to take one chunk of it away. I do feel -- I mean, I guess that's why I didn't like - -

**COMMISSIONER DREYFUS:** But there's a range of responses and ways of talking about --

**(Speaking over one another.)**

**COMMISSIONER COVINGTON:** There is a range of responses. But it's a range. And it's like you say, it's hard to put a dividing -- you can't put a dividing line onto one or the other. I mean, they're all circumstantial. I just get concerned that in the report we're separating a chunk of it out.

**COMMISSIONER DREYFUS:** I just want to make one last pitch on health because I think we have an opportunity as our country right now is rethinking health. Not healthcare, we're rethinking health.

And I -- you go back to 1948 when the World Health Organization defined health, they didn't define -- they said clearly, it's not just the absence of infirmity. It's not just medicine and the medical -- in the medical lens. It's this -- it's this biocycle social intersection of health. And they talk right clearly about social, mental and physical well-being of people is health.

Commissioners sat here today and talked about the health of children in the State of Tennessee. I think we are missing an opportunity as a Commission not to be just one more Commission who's looking at everything through our typical lens of child welfare intervention, right, to this larger idea that what we're sitting in is a health issue in our nation, and that the well-being and the safety of someone is as integral to their health as whatever's happening in a doctor's office.

So I just want to -- before we all just pass over because we're not comfortable with it because it's not been our history, I also think we're at a point in our nation where we are going to see in the next 20 years an absolute focus on what was that 1948 definition of health is very true.

**COMMISSIONER RUBIN:** Amen. I mean, I'm going to second that because I think, you know, public health -- you know, using the word "health" or "public health" is not a radioactive term, you know.

And we can either get on the bus or we don't get on the bus. All the money and a lot of the investment at the state level is occurring around improving the health of populations right now. And safety and the reduction in this type of morality is part of that solution.

So we can try to carve it out and call it something different, but I would -- I would advise that that would be not the right way to go.

I do think that when I think about the organization of these state plans at a federal level, they're right where MIECHV is, right, they're at HRSA, right, which organizes the public health response in this country and I believe is going to be growing in the next -- you know, as we move forward in terms of their collective impact in terms of how we structure that response.

And then, ultimately, I think that we want -- the word "accountability" is probably the word we can all agree on. We want a higher level of real accountability at the state level, right? But where is that going to exist near the governor's office? It's going to exist where the money's at and where a lot of the investment is going on, and that's going to be closer to the public health departments.

**COMMISSIONER MARTIN:** But I thought the whole point was to have the shared responsibility.

**COMMISSIONER RUBIN:** It is, but I'm just talking about who organizes it. They -- their responsibility is to bring it. I would rather the public health department or the Medicaid program at the state level be organizing that cross system response than asking the child protective service system, we -- like, for example, going down to the basement and saying, CPS, this is your issue, take care of it.

**COMMISSIONER MARTIN:** So my question is, we've talked about the fact that we can't define child abuse and neglect fatalities. It's kind of like you see it when you -- you know it when you see it kind of thing.

But we've sat here for an hour almost and tried to differentiate different types of child abuse and neglect fatalities. And what I'm concerned about is, however we draft the report, I think we have to get across the sense that so many of these things, so many of these deaths are -- kids are dying in so many different ways, even though we can't have a universal definition of what child abuse and neglect fatality is.

**COMMISSIONER COVINGTON:** I think we can define child abuse and neglect fatalities.

**COMMISSIONER MARTIN:** So how do you define it?

**COMMISSIONER COVINGTON:** There's a lot of different ways. I mean, it's -- to me, it's -- I mean, I -- a really general term for me would be when someone under the care and custody -- a child under the care and custody of someone commits an egregious act that causes them harm, that leads to their death or is negligent in such a way that leads to their death. And then, there's a whole thing around that.

I mean, there's good definitions out there. I don't think that that's our problem in terms of coming up with a definition. It's then learning how to count them within that is where we struggle. But I don't think the definition's hard to come up with.

**COMMISSIONER HORN:** But I agree with your point, which is -- I mean, somewhere we should recognize that there are a range of ways that children die. They're not the same. And so they require different interventions in order to attack the problem holistically. There's not just one answer. There's multiple answers.

And so, I think that's what the resistance is to calling it a public health problem or calling it a public education problem or calling it a CPS problem, that there's a range of ways kids die, we have to recognize that, and that there's different interventions that are going to be required in order to address the different ways that kids die.

**COMMISSIONER PETIT:** And the initial visit by child protection worker with, say, a public health nurse and/or a law enforcement officer helps to determine and classify what that problem is and what the beginnings of an intervention should be, dealt with a local multidisciplinary team that says, here's what we found. The three of us looked at it, here's what we've concluded: It's a mental health issue, it's a substance abuse issue, it's a bad boyfriend issue, it's a sex abuse issue, whatever it happens to be. Or it's a public health issue. This mother doesn't know enough to not sleep with a kid, you know, in correct kind of way. I guess just coming --

**COMMISSIONER HORN:** So I agree with you. And I think we're saying the same thing, because I want to make sure before you go to your next point that we are agreeing.

So in case in which -- it sounded what you just described is somebody who's been reported to CPS --

**COMMISSIONER PETIT:** Correct.

**COMMISSIONER HORN:** -- in which there is now a response that is demanded of the system, which is different than the kid's in a well baby visit and they should be looking for certain signs or a public health response around that. So --

**COMMISSIONER PETIT:** Right. And let's not confound the two or confuse the two. They are separate.

**COMMISSIONER HORN:** We're not going to substitute that for this, or that --

**COMMISSIONER DREYFUS:** It's part of one integrated system.

**COMMISSIONER PETIT:** It's separate -- well, one integrated system of child well-being? You know, we're a long ways away from that. What?

**COMMISSIONER MARTIN:** I don't think we can -- I don't think we can wait until we've heard a report. That's what I think the issue is, at least for me. I want to start before we get to the report.

**COMMISSIONER PETIT:** At the point of pregnancy? At the time of delivery?

**COMMISSIONER MARTIN:** Well, why aren't we talking about when you leave the maternity ward, there is some basic public education going on?

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER MARTIN:** And I love the idea of a home visiting nurse, at least for the first whatever, to ascertain whether there needs to be additional attention focused in that family.

**COMMISSIONER PETIT:** Sure.

**COMMISSIONER RUBIN:** I think another element here and the reason why, you know, if you actually conduct surveys with families, they trust a health response in a different way than if that interdisciplinary team is organized, let's say, at the foot of the child protective service system because they see those services as voluntary, and that's on behalf of the health of the child.

And it's pretty strong data that articulates that sort of voluntary willingness to respond in that way. So you could have the same integrated team. I'm just talking about where you organize this within the context of state government.

And so -- but -- so I think we have to take that into account because that also gets at some of the issues of disproportionality in terms of where this is located.

**COMMISSIONER MARTIN:** And it has to be for every family. Because just like the Walgreens in Illinois are throwing kids over balconies, but they're not coming to my court building. And so I want the Walgreens getting whatever care that the Pat Martins are getting on the south side.

**CHAIRMAN SANDERS:** So let me -- it seems like we actually have some areas that we're in agreement on. So going back to thinking of this as an introductory chapter, we start by stating the problem, including what we just said and I think others agree with, that children are dying by a number of different ways, that we've divided them into abuse and neglect. They may be the right categories, maybe not, but the issues of counting and so forth and really laying out what the problem is that we're confronting.

That we follow that with some of the themes of what we've heard. That we also talk about our charge again, but that we focus on the fact that this is a complex problem that does require a multisystem response beyond one agency, that that becomes clear because of the multiple ways that children are dying.

I think the question is who the lead is, who the organizer is. And we could state that it's health because of all of the things we've talked about. We could state that it's elsewhere.

But that the logical conclusion from the complexity of what we've seen is that one system is not going to be a supersystem to respond to everything, and that that really is laying out part of the framework of what we're talking about.

**COMMISSIONER DREYFUS:** So, David, to your multidisciplinary response. So, again, I just get a little bit concerned when it's just about response because I'm envisioning similar to what Marc Cherna is doing in Allegheny right now where he's working with the pediatricians who are serving the vast majority of the Medicaid populations and really changing -- not pediatrician,

obstetricians -- and really changing their practice prenatally, right, that it isn't just about a response to harm, it's changing your system.

So I think about these multidisciplinary teams, I think about how the law enforcement -- separate from if there's a report to CPS or there is concern, and the way in which they -- their policy and their practice as set as law enforcement to be -- to be mindful of this issue, to feel a sense of shared responsibility for this issue, to be on the lookout for this issue, and their effectiveness of the response, the healthcare community, the education community.

So I hope that this isn't just about a response, but also a sense of shared responsibility that gets at just how they function as an independent organization who, in time, might have to come together in multidisciplinary teams, but who are a critical part of this larger system of child welfare.

**COMMISSIONER PETIT:** David -- yeah. I'd endorse that, with this big caveat. What you've just talked about in terms of transforming our healthcare system and whatever stage they're at, David, we still have a long way to go, right? It's not going to happen overnight.

So we've got a model like you've just described, who could disagree, but that isn't going to do one thing in the short term for kids who are identified right now as being really in deep trouble. There's not going to be any prevention of the guy that's an ex-con that comes out is a pedo -- is a pedophile or whatever it happens to be.

There is an immediate piece that we have in front of us right now in which we largely know the 3,000 or so kids, somebody in our system knows right now the largely nearly 3,000 kids are going to die in the next year.

What's the response to that? That is more of a public safety issue than a public health issue. And if somebody can figure out how to stop people from sexually abusing kids, long term, terrific.

But in the meantime, there is a criminal offense that's being conducted -- that's being committed here. So I think we need to speak to that equally or forcefully and the other comes in behind it.

**COMMISSIONER HORN:** So if I were writing this report -- and I am not volunteering to write this report -- I would see it as a funnel. And I'd start by saying, there's lots of different ways kids die. And I would say, the biggest part of the funnel is public education. Then you start to move towards a public health response, includes things like home visiting and all the other kinds of things.

And then, you've got down here this small -- this much smaller group of kids who are known to somebody, that are in serious trouble and at great risk, and that's much more of a law, CPS, child welfare response.

So I'd see it -- and you start at the big part and say, if we can take care of some of the issues up here, then we go down here and more of these kids are going to be prevented from dying.

But down here at the point, something's different. It's not public education. It's not just, you know, public health response. There's something very specific that has to happen for this at the very bottom of this funnel. So that's the way I would sort of --

**COMMISSIONER CRAMER:** But if you would yield, we've got to get to all of those levels.

**COMMISSIONER COVINGTON:** That's right. I agree. You're right.

**COMMISSIONER DREYFUS:** And I don't think that's inconsistent with anything that we've been saying. I think what you just described beautifully is what I see as this -- as this system, right? And it's not that it's chunk, chunk, chunk, but it is the system, and it's got to be part of -- and this is all an integrated part of it. So I couldn't agree more.

**COMMISSIONER RUBIN:** I liked -- I liked the way you said that, too. And I also think as you formulate the response where you're higher on the funnel, that's where you want to be less prescriptive. You want to give the states flexibility.

As you go down to that small part that you talked about -- what you're talking about, Commissioner Petit, you want to be more prescriptive. How are we going to put the protections in place to ensure that kid who has all those red flags, what are the explicit things we need to have changed both federally and at the state level to ensure that kid's not who's at imminent risk of death, right, is protected.

**COMMISSIONER PETIT:** Yeah. And when you talk about the big picture piece, there isn't a whole legal framework that permeates that results in an individual being sentenced to prison, which is really a very specific piece in terms of how you organize that. And that's where the CACs can come in on this piece for a particular population, right?

In other words, there are certain protocols that are constitutionally protecting the rights of individuals so that when you tackle that question of who's doing what to a kid and you're going to intercept a guy and maybe put him in prison, that is a very specific kind of a thing. That specific protocols have to be followed.

**COMMISSIONER COVINGTON:** I also -- I don't know, David, if I am in total agreement with this concept that the bigger you get, the more we want to be less prescriptive to states. I guess I haven't been sold on that piece yet either, because I'm not sure that we're all there.

I'm not sure maybe that we don't want to be completely prescriptive on some of this stuff from a national level at the top. I guess there seems to be an assumption that that's how we're going to go, and I'm not sure I'm there yet.

**COMMISSIONER RUBIN:** Yeah. When I say "less prescriptive", I just want to allow for local and regional variation in terms of how people like we -- we can't assume that we have the working knowledge of how these systems work together, but we can define core elements of what their plans need to address and give them flexibility to design around their -- their knowledge of local issues, you know.

And population issues. Like, you know, we heard about methamphetamines down here in the South. That's not necessarily going to be an issue in other areas, but they may focus a state plan down here on addressing some of those issues.

But I do think we can define core elements that -- that really span the gambit of all of our different subcommittees that we would like to see states address as part of a coordinated, comprehensive response.

**COMMISSIONER MARTIN:** So I'm still having difficult -- I mean, I like the funnel theory, but I'm still having difficulty understanding how, you know, the Martin family -- who's going to evaluate my family to determine whether or not I need to go further in that funnel or not? Do you understand what I'm saying?

So presumably the services at the really general level, at the very top level, are public information services, right? And then, the lower you go down in that funnel towards the peak, then we're talking about more interventions, right?

**COMMISSIONER HORN:** I would see it as -- as you get farther down the funnel, they become more mandatory interventions as opposed to voluntary.

**COMMISSIONER MARTIN:** Okay. Okay. Then who tells Pat that she's further down the funnel and I have more --

**COMMISSIONER PETIT:** CPS.

**COMMISSIONER COVINGTON:** CPS.

**COMMISSIONER MARTIN:** He's not saying CPS.

**COMMISSIONER RUBIN:** Well, I was going to say, for the Martin family, we're just going to put you guys off to the side because we have a really famous judge in that family and she'll hopefully take care of her kid.

**COMMISSIONER CRAMER:** But if it's CPS, it can't be CPS in isolation.

**COMMISSIONER HORN:** I agree -- totally with that. I agree with that. But I don't think every family in America needs to be evaluated for their risk level.

**COMMISSIONER MARTIN:** But how do -- but when -- that's my problem. I think -- this is why I'm asking the question, okay? And I'm sure your state is a lot different than Illinois and you do it a lot better than Illinois.

But if you just talk about children who are exposed to opiates at birth, if you go to north -- if you go to one hospital by the Gold Coast, they don't do toxicologies very frequently, even if the birthing mother is under 20, under weight, has no prenatal care and comes in at 2:00 in the morning higher than a kite.

Because the social worker there -- and they've told me this, they assume that she has protective factors that will allow her to take that baby home and the baby will be fine. But you come over to the hospital right by my courthouse and every woman that walks in underweight, 2:00 in the morning, higher than a kite, no prenatal care, she gets a tox.

**COMMISSIONER PETIT:** Is that good or bad?

**COMMISSIONER MARTIN:** Well, it's bad because I would prefer every kid -- but wait, let me finish. You asked a question. I would prefer every mother who comes in 2:00 in the morning to get a tox.

**COMMISSIONER PETIT:** Sure.

**COMMISSIONER MARTIN:** The reason, though, in my humble opinion, at Cook County Hospital, Stroger Hospital, it's Medicaid, Medicare. So no one's going to call them on every -- if they do 500 toxes this month; whereas, at another hospital where it's Blue Cross/Blue Shield, they're going to call and question why toxes are done if you have an increase in tox.

So my point is, I hear you. You don't want every family subjected to an intensive evaluation. But I need for every family to at least be seen. I need for every family to be treated the same way and seen.

So I would prefer something along these lines: In the State of Illinois when you're delivering a child, before you leave the maternity ward, I would expect some kind of public education, whether it's a video, whether it's a nurse coming to my room, telling me how to take care of my baby. I would love for them to send home with every mother a box with a onie (sic) and a, you know, diapers and a bottle. And then, for a nurse to follow up the first week after the birth.

And if I don't need any more care, that's great. Tell me good luck with my child, have a great family, populate the world. But if I'm having problems, then I want there to be more direction about what I need to do to improve the well-being or the opportunity for my child to have a better life.

**COMMISSIONER HORN:** So I think what you saying -- and so, data will -- somehow, data gets collected, and you sift through the data to determine which families maybe need more interventions than others. But what you want is you want that data screen as people are collecting -- to be consistent across everybody. Is that what you're saying?

**COMMISSIONER MARTIN:** What I want to catch is, I want the families who have protective services at Stroger to take their baby home. I want the kids at Northwestern who don't have protective factors, for people not to assume they have protective factors and I want DCFS to be called.

**COMMISSIONER HORN:** I think everybody here would agree with that. And I think that --

**COMMISSIONER MARTIN:** And so I think you have to start off with everybody being treated the same way at the top of this funnel, at that broad base, broad entry of that funnel.

**COMMISSIONER PETIT:** Pat, so I've been involved with a situation where every newborn, every single one before they left the hospital, an obstetrical nurse made an evaluation, an assessment as to whether the mother was bonding with the child, whether there were services to help the family when they got home. There was that kind of an eyeballing.

If it looks like, gee, this mother is not attached to the child, she's angry that she had the baby, she's blah, blah, blah, I'm going to call CPS or a public health nurse to make sure that when she gets home, someone's going to be there to work with her.

The vast majority of cases, whether they're white or black or anything else, the vast majority don't need anything. They've got family, they've got something going on and they're going to be okay. And I'd say, prior to the obstetrical unit is the obstetrician. There's something that's going on during the prenatal phase that somebody may be able to pick up on.

So I think what you're saying is, take a look at everybody, make an assessment as to whether there needs to be an intervention, do that with the ones that do and don't do it with the ones that don't require it.

You're more concerned that the hospital where there is an occasional tox, that they be run through the same process as the families that do get the full treatment, right?

**COMMISSIONER MARTIN:** I want to make certain -- I want to make certain every child who gets -- every child who needs to have their mother get a tox, gets a tox.

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER MARTIN:** Whether it's at a hospital that's a private hospital or a public hospital.

**COMMISSIONER PETIT:** Does anybody disagree with that?

**COMMISSIONER RUBIN:** Yeah. I'm just getting a little nervous here. We're actually moving in the direction of a public health approach here. I'm just kidding. No.

But here's what I would say, because I want to answer in that context. I think -- I totally agree with you, Commissioner Martin. I mean -- but I think one of the ways we're doing this -- one of the ways on the health side this is actually occurring is that we're starting to reimburse for standardized screening.

And so we're doing it, let's say, you know, right now for developmental screening, both commercial and Medicaid payers are both paying for universal developmental screens so we can get kids DI and so we can actually reduce racial and ethnic disparities in terms of who actually gets to early intervention services.

Same way with post-partum depression. Those are now being reimbursed. So how are the health systems and all these different programs responding? They're measuring it. They're actually doing the screening.

And my understanding talking to our speaker this morning is, it's not a toxicology screening. They're actually doing a brief interview. And I said, wouldn't it be great as part of a pediatric quality measures program within our paper performance contracts, we actually had to do -- or for the contracts with the obstetricians that they, you know -- they were incentivized to do universal screening for folks with substance abuse issues.

And so they can do screening and referral on a voluntary basis. And that way, it gets away from disproportionality, becomes more of a matter of routine practice. And so I think that's how it's been actualized. And it's actually linked to real accountability in terms of pay for performance.

**CHAIRMAN SANDERS:** Let me just for a second -- because I'm trying to think about this in the context of the report. And it seems like we actually have an introductory chapter, that there's general agreement on the direction, which might help to provide for staff to be able to put something on paper for us to then review. And.

I think I'm going to suggest what you're describing, Commissioner Martin, is beginning to get into what the recommendations we would make. And I think that actually should come up next as part of our conversation.

That we would start with a statement of the problem, including the fact that one of the things we've observed is children die from a multitude of causes. There has been attempts to define that in NCANDS and through other means that have been inadequate to this point, but there are differences, and there are differences in how -- what the interventions might look like. And so I think we lay that out. We lay out all of the problems with counting and measurement. So that's one section.

A second section is that we talk about some number of themes related to what we've heard.

Third, we have to include things on our charge.

And then, fourth, we talk about the idea that a multisystem approach is necessary. And we describe the funnel that I think Wade used the language for that that -- that it really is much more complex than just the children ending up at the bottom of the funnel, but that it really is a complex issue that requires a multisystem response. And that -- that becomes the bulk of our introductory chapter.

**COMMISSIONER CRAMER:** Yeah.

**COMMISSIONER COVINGTON:** I like it.

**COMMISSIONER PETIT:** David, one way of illustrating that is the opposite of a funnel, which is the pyramid.

**CHAIRMAN SANDERS:** I'm sorry. Is the?

**COMMISSIONER PETIT:** The opposite is a pyramid in which you have the bottom two-thirds of the pyramid is basically public health, the next quarter or so is CPS, and that last two or three percent is CPS and child protection.

**COMMISSIONER COVINGTON:** There's --

**COMMISSIONER PETIT:** Yeah. Yes. Law enforcement and child -- and CPS for that tiny percentage of cases that -- overall you -- all children benefit from a public health model approach, immunizations, well-baby clinics and everything else.

Then, there's another level that requires more than that, it's more a child protection, neglect kind of thing. And then, you've got that small, small, tiny percentage of cases that law enforcement is directly involved with. And I say small, it's a tiny percentage of a big number.

**COMMISSIONER CRAMER:** But that's at the level of the multidisciplinary team, right? You're talking about the small -- when you say law enforcement and CPS --

**COMMISSIONER PETIT:** Yeah. That's --

**COMMISSIONER CRAMER:** The multidisciplinary team?

**COMMISSIONER PETIT:** Yes. Yes.

**COMMISSIONER DREYFUS:** I just want to say with all -- with all respect, I think we're sitting here with very differing understanding of what is public health. My experience with public health, like in the state of Washington, was yes, there was this broad, but when there was -- when there was a specific outbreak, right, our public health system was all hands on deck, multidisciplinary teams. We were working across the state agencies, right, to deal with a crisis, right, whatever that was.

And so part of me just feels like before we all just make determinations of how you define public health, I define public health, because, see, I look at child welfare as a larger public health system in this country. And a strong, effective, accountable and responsive, well-resourced CPS function is a part of that system. I don't see it as separate and distinct from that system.

So I think part of this is, we just have a very differing immediate definition based upon whatever's our past history and experience of what is public health.

**COMMISSIONER AYOUB:** And if we have that varied definition, the people reading this report are going to have varying definition.

**COMMISSIONER DREYFUS:** Right.

**COMMISSIONER AYOUB:** So if we're going to use that, we need to define it --

**COMMISSIONER DREYFUS:** In the right frame.

**COMMISSIONER AYOUB:** No. If we -- we can use -- I believe we could use that phrase as long as we define it in the opening the first time that we use it.

**CHAIRMAN SANDERS:** So why don't we try and do that. I mean, it seems like -- and then, we could get that in front of us, and then we can decide, is this something we like or not?

**COMMISSIONER COVINGTON:** That's what I agree with.

**CHAIRMAN SANDERS:** Try and define -- because I understand it, it's a public health approach, not the public health system.

**COMMISSIONER COVINGTON:** I also think, too, you know, I sort of heard maybe -- maybe I heard wrong, that as you get down into this pyramid or funnel, whatever we call it, that you start getting more MDT-ish, for lack of a better - - I'm not being very eloquent here.

But I don't -- I don't see it there. I see at the very top of that funnel or pyramid as well, we're looking at multisystems working with families. It's not just that you come together when there's a problem. You come together --

**COMMISSIONER CRAMER:** Yeah. It's a bigger team up here, though. It's a bigger system up here.

**COMMISSIONER RUBIN:** Yeah. And think about the data sharing. So think about how Washington uses their prison system. I mean, there are tremendous needs at the federal level to really define the permissibility for states to really -- to use really actionable data.

Our best example of predictive analytics was in -- was in a town in Tampa Bay where they were sharing schools' data and process data from their child welfare system, health data, to elevate, you know, red flags of the kids who were at imminent risk based -- you know, and the more data they were able to input into those models, the more satisfactory the red flag system was going to be. And so -- so it operates on both levels. You know, I totally agree.

**CHAIRMAN SANDERS:** So I had proposed for Chapter 2 that we actually do the themes, but it sounds like we would incorporate the themes into Chapter 1. So for Chapter 3, I had proposed that we look at what we heard that seems to work and -- but we can revisit that to however people think we should follow.

**COMMISSIONER COVINGTON:** Yeah. I guess my initial reaction may be when we talk about the different communities is maybe not talk about what works, but some models -- promising models. Because I don't know that -- some of them haven't been out there long enough. I mean, the one --

**CHAIRMAN SANDERS:** Yeah. I would use -- the term was used loosely. It was mainly --

**COMMISSIONER COVINGTON:** Yeah. I just - - that's important to me.

**CHAIRMAN SANDERS:** -- to try and see are there common themes across. Because there are others that we -- I mean, Oregon talked about the --

**COMMISSIONER COVINGTON:** Yeah.

**CHAIRMAN SANDERS:** -- blending of funding and different pilots. I mean, hose are themes that I think we want to capture. But, yeah, certainly don't want to over state.

**COMMISSIONER RUBIN:** I think you start with those promising models, and then, you can appraise in that chapter, what are all -- these are very different models that we saw, whether it was a military, civilian model in El Paso or what Oregon was doing or what they're doing here in the public health department with respect to substance abuse treatment.

But then you actually appraise, well, what made those things hang together as even though those projects were very different? And those are the core themes that we're working towards.

**COMMISSIONER PETIT:** David, when you go back to Chapter 1, which apparently we've left, but what's the -- where is the position on policy clarification, effectiveness, accountability, efficiency? What are we prepared to say on that?

**COMMISSIONER HORN:** I'm part of that subcommittee. I don't think it belongs in Chapter 1.

**CHAIRMAN SANDERS:** Yeah. I think what I just read would be Chapter 1, that we would relook at everything else that was -- I mean, my draft was for -- to generate this conversation.

**COMMISSIONER HORN:** So I might suggest, again, just a difference in emphasis. I think Chapter 2 should be about measurement.

**COMMISSIONER PETIT:** About what?

**COMMISSIONER HORN:** Measurement and counting. So it's kind of like the Chapter 1 kind of sets the frame, Chapter 2 is what -- what do we know? Just --

**COMMISSIONER COVINGTON:** Put measurement on it.

**COMMISSIONER HORN:** You know, what measurement? And then, you know, once we deal with all those issues, to then move to a chapter that, what do we know about what we're doing currently that seems to be working? So that just seems to me to be more natural flow than to come back to counting later.

**COMMISSIONER COVINGTON:** I agree with you.

**COMMISSIONER RUBIN:** And I also think that maybe when we talk about CAPTA, because I think we have to address out why CAPTA's not working, right, and why it's not being enforced, right, and how we're going to think outside the box to how to really create that level of accountability that CAPTA intended, but wasn't able to pull off, right.

**COMMISSIONER HORN:** I'm not quite there, yet, but it's the outline.

**COMMISSIONER CRAMER:** And I would assume when we get to Chapter 3, that's when -- under What Works, that we would use the CAC model in there somewhere.

**COMMISSIONER MARTIN:** But we have to be careful when we say what works. We're talking about fatalities. I don't think CACs work towards reducing fatalities, right?

I think CACs work great towards improving investigations. I think it works great in terms of getting services in for families and children, particularly kids who are sexually abused and the severely child abuse, but do we have any information that would tell us that CACs work towards fatalities?

**COMMISSIONER CRAMER:** Well, look, what we've heard not only here, but elsewhere, has been -- and what we've -- what we've seen when we've heard about children slipping through the cracks, is that when you have CPS working in isolation and not working in a multidisciplinary team and not sharing their information with other agencies, which is the heart and soul of what goes on at a CAC, then when you do see those multidisciplinary teams working effectively at a CAC, I think inevitably they have to be preventing fatalities.

**COMMISSIONER MARTIN:** But see, with the utmost respect, okay, because I think CACs are the best thing since sliced bread, okay. But my concern is that we don't have any numbers -- and like I asked yesterday, do we have anything to show us that the work that's done at the CACs, no matter how good it is and I applaud the work, if that has actually reduced the numbers in Memphis for fatalities? And I don't think we can draw that line yet. I think it feels good and I think it should result in --

**COMMISSIONER CRAMER:** But we can say that that evaluation needs to be done because those teams are working effectively.

**COMMISSIONER MARTIN:** Oh, yeah. Now, I agree with that.

**COMMISSIONER COVINGTON:** And I think, Judge Martin, we have to be really careful about saying anything works because the counting is so screwed up. So it's really hard to measure success around child abuse fatalities because we didn't really have good baselines anywhere.

**COMMISSIONER MARTIN:** But I think as far as we're -- I thought we were going, and that is that the CACs are bringing a lot of positive information about the need for an integrated system and the working together, as opposed to the isolation and silo working. And then, I agreed, because I definitely would like some evaluation done at that point then.

**COMMISSIONER CRAMER:** And they're in a great position to --

**COMMISSIONER MARTIN:** And that's great.

**COMMISSIONER PETIT:** But even if they don't have anything on child abuse deaths, which I don't think that they do, because we've asked them that and on the specific question of deaths. Since we haven't found anything else that is -- that operates with any certainty in preventing deaths, some of the stuff that we may propose is actually going to be new or a modification or built on a history that says, it worked there, we think it's going to work here if you make these kinds of refinements and let's try it.

So, otherwise, we're not going to offer anything because we haven't found anything that says, this is a sure-fire way of doing it, right?

**COMMISSIONER DREYFUS:** I just want to agree. I think CACs do belong in that chapter, though, because I think it's under what we've seen as promising that works, and we have really seen as promising these multidisciplinary, you know, team approaches. And it's a pretty mature model in CACs, right? They know how to do it.

So I don't think you put it down as what works and that we know it works to reduce fatalities. But we've identified a number of themes here, and I think the CACs could beautifully into a couple of themes as examples of those themes.

**COMMISSIONER MARTIN:** I agree with you.

**COMMISSIONER HORN:** So may I suggest, rather than what works, this chapter, because that sounds a lot like we're getting into recommendations. It's more a chapter in my mind about, what do we know, which also implies what do we not know, based on our hearings and so forth, that then moves towards chapters which are about recommendations.

Because we can make recommendations that are based upon speculation and our best guess based upon what we know and what we don't know, but this chapter is really -- but we don't want to confuse our recommendation -- we want to be -- when we make recommendations, we want to make clear when we're making recommendations based upon real evidence versus a reasonable guess.

And we have to set that stage with a chapter that says, these are the things we know and these are the things we don't know, and then, move to recommendations in future chapters.

**COMMISSIONER MARTIN:** The only thing I want to be clear about is, what do we know. When we talk about what we know and what we talk about what works -- and I heard you -- we have to be clear about what we're saying works. We can't say it works to reduce fatalities. What we can --

**COMMISSIONER HORN:** Of course.

**COMMISSIONER MARTIN:** What we can say, though, is, for instance, that the CACs work to improve investigatory and work to improve understanding what's going on in families, and however we want to word it. And because of that, we then make the recommendation for a multidisciplinary team to look at --

**COMMISSIONER HORN:** Yeah. And we also can make the point by saying what doesn't work. What doesn't work is working in silos, not sharing information, you know, having a public health system that is totally disconnected from the CPS system. I mean, so you're setting up the rest of the stuff, which is all about recommendations.

**COMMISSIONER RUBIN:** I've also imagined, you know, if we arrived at a place where every state had to elevate a response and actually submit a very comprehensive plan, wouldn't it be great to have an innovation fund that -- you know, because we acknowledge that we're not sure what the magic ingredient is, we want to actually support states in their implementation of their models with measurement.

Now, in that space, there's flexibility to say, well, who can apply for those innovation funds? Well, we're not -- we're going to let the communities decide how they want to -- if this community wants to organize their -- their grant application around a CAC centric model, that's fine, you know, as long as it actually fulfills what we're trying to do, which is integration desiloing, and all that other stuff.

So I think we can be pretty wide in terms of the types of folks who can apply. It could be a law enforcement in response; it could be a public health department response. But the idea that you cast a nice, wide net on who can be a part of these interdisciplinary teams, and then, let the communities decide what works best where they are.

**CHAIRMAN SANDERS:** So a couple of things. I wonder if it would be better to talk about what was promising versus even what we know.

**COMMISSIONER PETIT:** But it's not either/or, right? I mean, you could do both.

**COMMISSIONER MARTIN:** But promising for what?

**CHAIRMAN SANDERS:** Promising as a potential strategy to reduce fatalities.

**COMMISSIONER PETIT:** Well, do we know what those are yet?

**COMMISSIONER MARTIN:** Yeah, I don't know what those are.

**COMMISSIONER PETIT:** We're recommending several things here.

**CHAIRMAN SANDERS:** I mean, there's something -- I think we heard things that are promising.

**COMMISSIONER PETIT:** No. I'm saying what I think. Let's put them together.

**COMMISSIONER MARTIN:** We've heard communities that have said that a multidisciplinary team, whether it's called -- whether it's housed in one house and it's a CAC or it's a multidisciplinary team that's coming together like they did in Vermont I guess it was - - was it Vermont -- we realize that fewer kids fall between the cracks of that system than when you work in silos.

But that doesn't necessary -- what I'm trying to say is, I hope that that -- I hope plugging up the holes in a system and keeping eyes on a kid actually does reduce the fatalities, but I don't know that yet until they come back --

**CHAIRMAN SANDERS:** Right. That's why I'm saying we shouldn't say what we know.

**COMMISSIONER MARTIN:** Right. And so what I'm saying, though, is, but when I asked you, so what are -- promising for what, I don't think we can say promising to reduce infant fatalities. I think we can say --

**CHAIRMAN SANDERS:** The communities said that they did. They felt that their strategies contributed. That doesn't mean that they did. There's no scientific evidence. But it seems its's enough to say that's promising. If El Paso County says their approach seems to reduce fatalities--

**COMMISSIONER RUBIN:** I actually think it's okay to concede in this report that we don't have strong evidence of what works and that's why we're developing -- we're developing an approach that allows --

**COMMISSIONER MARTIN:** The states to find it out.

**COMMISSIONER RUBIN:** -- the states to define how they're going to reach certain core competencies or core elements, and then, evaluate it and provide some innovation money to help them test those.

So that when we -- so that it's almost like a sequence. Like, if we do that, we test some promising models, it's sort of -- there's a long tradition of states looking to each other for promising models, and then -- and then, piggybacking off each other as that develops.

And then, later on, you can actually go into a -- once you know, quote, what works or what's actually worked in certain areas, then you can start to think about sustainable funding mechanisms, whether that's through Medicaid or elsewhere, because you have evidence of, you know, performance.

**COMMISSIONER COVINGTON:** I still think we have to be careful, though, that we're not conceding this entire report to the whims of the states coming up with plans. I'm just concerned that that's what we're doing.

So I think we -- because I hope that we're going to have recommendations that are really affecting federal policy and federal action. That's actually what our charge was. So I just want to be careful that we're not considering --

**COMMISSIONER RUBIN:** Absolutely. You can do both. You can do both. I'm not saying one versus the other. I'm also saying there's got to be accountability where there has to be some level of assessment and incentivization and accountability in terms of real teeth.

And I think there will be -- there will be certain recommendations here that are a matter of, look, these are our recommendations we need -- because maybe that's a chapter, sort of what's state versus federal in terms of areas that absolutely need to be accomplished to move us in the right direction versus areas that are a little bit more unpredictable and need to be tested.

**COMMISSIONER HORN:** I also think there's power in saying what doesn't work. So -- and we can illustrate that with examples of case studies. So what doesn't work is a guy with a history of violence, he's in jail, he gets let out and nobody tells the family that the guy's been let out of jail. There's no communication between law enforcement and the child welfare system. That doesn't work, okay.

A woman who has -- shows signs of post- partum depression, who has no -- there's no father around, is almost floridly psychotic leaving the hospital, is it any wonder leaving her alone doesn't work, something should happen? I think we can illustrate these kind of things, but these things don't work, so stop doing those things.

**COMMISSIONER COVINGTON:** I think we could come up with a really nice list of things from Tom Morten's newspaper stories. I mean, we could definitely do it.

**COMMISSIONER DREYFUS:** I like that a lot, but we did see -- hear examples in communities that did take this issue on, right? And I think you can synthesize from that what clearly was promising from that.

But I just want to remind us all, it wasn't just about their interventions. It was about the generation of a collective will of a community that we all share responsibility for this issue. And it's not their job, it's our job.

So that's promising. That's not -- everything doesn't have to become a program, a service, to make it into our report about what we found was promising and critical to making a dent in this issue.

I just wanted to bring up one thing before we start moving through, okay, now we're getting into the recommendations. There's been previous Commissions. There's been a host of previous recommendations. I've yet to see that. I hope we will see that.

But I'm just wondering what we need to do to at least demonstrate to congress is that -- is that this requires a different response. This cannot just be going back over the same old kind of recommendations that we've seen before that weren't -- that weren't moved on, for whatever reason.

I'm just wondering, what do we have an obligation to do of looking at past -- at past recommendations, whether or not our recommendations are consistent with some of those and hope they get even more attention, or that we really are looking at this differently than has been looked at in the past. But it just seems to me that that history, some -- fits somewhere in here. I'm just not sure where.

**CHAIRMAN SANDERS:** We do have that -- staff has put together a compilation of reports over an extended period with recommendation. And you're right. I mean, they are pieced together in different ways, but a lot of the themes will be very similar. That they're probably not the first time they've been considered.

**COMMISSIONER RUBIN:** I just want to make sure, the staff, you guys ready to write? You got it all down?

**LIZ OPPENHEIM:** It will be done tomorrow.

**COMMISSIONER RUBIN:** All right.

**COMMISSIONER CRAMER:** I thought Wade was writing it.

**COMMISSIONER COVINGTON:** He had a lot of experience with this. I thought he was, too.

**CHAIRMAN SANDERS:** Well, we -- so we're agreed that Chapter 2 will be more on measurement and counting, and we have a set of recommendations, at least tentative, that we can put in there. And then, we will look at what we know or what's been promising to this point.

**COMMISSIONER DREYFUS:** One more question. Where will be the guaranteed federal protections and the requirements of CAPTA? I mean, part of this is -- you know, as a former state person, I can't believe I'm saying this, but at some point, there is something missing in terms of the federal -- the feds holding states accountable for compliance with federal law.

**COMMISSIONER COVINGTON:** We've heard it. And I think --

**COMMISSIONER DREYFUS:** Both in terms of the protections that have been given to children in our country, as well as CAPTA requirements.

**CHAIRMAN SANDERS:** So maybe in the second -- because I think what Wade was describing -- and I think it's exactly right -- is that we have to build the case for the recommendations.

And it seems what doesn't work is to have laws that have no teeth to them. And that CAPTA is a good example. And we should use those examples in that as much as we use, if you operate in silos. I think we would have to --

**COMMISSIONER RUBIN:** Yeah. I also think it would help, like, so we're doing from the top - - you know, top down, right, where we're thinking about a vision coming in. It would also be nice, and maybe we can do this at a future meeting, like at the next meeting in Utah when we're deliberating to do bottom up, there are a list of specific things that even one I wrote down today, enforce the mental health parity law, right, where we've had a lot of these tidbits come through and actually write them down. You can put them into categories and

make sure as we filter this up into the chapters, we know where all those explicit recommendations are going.

That's going to answer Commissioner Covington, your question about, there are some specific things we need to do. The issues around data sharing don't neatly fit into the comprehensive plan. The states need more guidance around what's permissible in terms of data sharing, right?

And so I would like to see that list generated, and then, somehow, how that's attributed back into this global approach.

**CHAIRMAN SANDERS:** So why don't we take a break for 15 minutes, and then, come back and continue the conversation. We'll break until --

**COMMISSIONER PETIT:** David, we haven't covered the accountability question, right? Right. We haven't dealt with the accountability question. Have we addressed -- we haven't addressed the accountability question yet.

**COMMISSIONER DREYFUS:** You did -- you did kind of get at it with -- with -- when I asked about CAPTA and the federal protections.

**COMMISSIONER PETIT:** Yeah. Well, there's more. Do you want -- we'll just wait until we get back?

**CHAIRMAN SANDERS:** Yeah.

**COMMISSIONER PETIT:** Okay.

**(WHEREUPON, A RECESS WAS TAKEN FROM 3:42 P.M. UNTIL 4:07 P.M., AT WHICH TIME THE HEARING CONTINUED AS FOLLOWS:)**

**CHAIRMAN SANDERS:** We're missing a few people, but we'll go ahead and get started.

We have, I think, then, an outline for Chapter 1, for Chapter 2. Chapter 3 would be titled What We Know and include information about victims, perpetrators, promising approaches, include what we know doesn't work, as well as what kind of evidence we have, what research evidence we have. And then, a Chapter 4 would be what we don't know.

And I think unless there's more to add there, we should probably shift into some thinking about recommendations. But are there areas that we've missed so far?

**COMMISSIONER PETIT:** David, an issue that I wanted to speak to at the end of the last session was this issue of accountability and the respective roles of the government -- federal government and state government. So I don't know -- I mean, there's a recommendation side to that, but there's also a discussion on it, and see if we're in the same place or not on it.

And fundamentally, I would argue that this issue is placed way too low within the federal government. It needs to have a much higher profile, which speaks to different federal agencies, but also the domestic policy council and certain committees of congress.

There is far more attention paid to much lesser issues. That's an opinion. But on this one, we've also seen the -- I want to introduce this notion.

In Ferguson, where all the decisions are local, eventually, the Department of Justice was asked to come in. And the Department of Justice had the right to come in. I think we need to look and see exactly -- and, Liz, I think, you spoke to this with a memo that you sent to me when I asked you, what is the scope of responsibility and authority that HHS or the federal government generally have for going into a local jurisdiction on this child welfare thing.

So you have some states who do a much worse job than others or, to state it more positively, there are some states who do a much better job than others. But they're supposed to have a plan that they put together in order to receive substantial federal monies, and there's supposed to be in compliance with that plan.

There's a real question as to whether they are. So I'm asserting that we should take a position that says the federal government needs to be authorized to go into -- and I'm not sure, Liz, if they are authorized now or not. Do you believe that they are authorized under current law to go into a state, if a state, say, is not -- you know, is way below national standards, David, somebody should be able to go in, other than to say, try writing a new plan.

They should be able to come in as needed and take actions on that. That this is a national issue, it's not a state specific issue. There are states -- the states have to do their part, but there needs to be a stronger federal oversight role.

Similar to DOJ on Civil Rights and a bunch of other interventions that the -- that the federal government is able to exercise. We're not seeing it with children.

**CHAIRMAN SANDERS:** So that would get into the recommendations. Are you thinking that there should be something specific about that under what we know, like there needs to be greater federal oversight, or how are you thinking --

**COMMISSIONER PETIT:** Yes. It is not simply a collection of 50 states. These are American kids first. That's the argument that we would make, they're American kids first. There are severe racial imbalances on this issue across the country as well. And we've had a recent report, America's Shame or Shame US, that also documented a lot of these kinds of things.

And I don't know where we are with that particular piece at this point. I think we said we'd raise it here and decide on what you want to do with it in terms of all of the Commission members taking a look at it or getting a presentation made on it.

But I do think this is a critical piece. And I would argue that there's receptivity in the congress on this by virtue of the vote that they gave this Commission, 330 to 77 in the house, 100 to nothing in the senate.

I don't think it's a Democratic or Republican bill issue. I think it's by -- nonpartisan issue. But there has to be an ability to intervene in a state when a state is not performing to national standards.

So there could be a finding earlier. And, you know, I think I mentioned this before, on the 50th anniversary of the Children's Bureau, JFK was the speaker. On the 100th anniversary, an administrator within ACF was the speaker.

So I think greater authority, elevating it further, gives us more visibility, because this is a political question.

**COMMISSIONER DREYFUS:** Michael, can you be a little bit more specific? So when you said not meeting national standards, you kind of lost me there. But where I could see is, you know, as states go through the Child and Family Service reviews and they have to put in place performance improvement plans --

**COMMISSIONER PETIT:** Correct.

**COMMISSIONER DREYFUS:** -- the idea is that they're going to make improvement. And if they're not making improvement, I don't think you're calling for the same thing as Eric Holder going in to conduct a massive investigation by DOJ in Ferguson. But I think what you are saying is, there ought to be some greater teeth with the Children's Bureau HHS --

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER DREYFUS:** -- to hold states accountable for improving their systems.

**COMMISSIONER PETIT:** Right. And there are standards that do exist in that review process, and most of the states do not meet most of the standards.

**COMMISSIONER DREYFUS:** Okay. So you're talking about CFS, okay.

**COMMISSIONER PETIT:** And whatever else. I mean, I don't want to limit it to what my own knowledge is, may be other than that. But the scope and scale is to be determined. I mean, whatever it is that is necessary.

What we know is that there's thousands of children killed. In some states, it's five or six or seven or eight or 10 times the rate of other states. So I can think of some states that I've been into that just did a very, very poor job resulting in 10-year-old children being in jails because the state provided no foster homes or group homes for these kids.

Who could the kids turn to on this one? All the decisions that placed them in that situation were local and state officials. So what was the recourse? What was the appeal when the law was not being enforced?

**COMMISSIONER DREYFUS:** This is the frustration, I think, some advocates are having when we're talking about federal finance reform, right, and wanting to have a stronger accountability system. And what do you do with those states that aren't making improvements, right? And what is that federal recourse?

**COMMISSIONER PETIT:** Well, there's a series of sanctions that could be brought. There could be positive incentives, negative incentives. I'm not saying the federal government should be taking over the state operations, but there ought to be sanctions that can be brought against it.

I know when I was the Commissioner, if I had go to down to the legislature and said, listen, we're going to be fined $10 million because we're unwilling to correct this problem, the legislature would have said, we don't want to lose the $10 million. Now, some states will say, we'll lose it, that's fine.

**COMMISSIONER DREYFUS:** And you're gone.

**COMMISSIONER PETIT:** But -- no, that's right. But I'm saying that these kids, there has to be when they have a weak family situation where they can't have their best interests represented, and the state is treating them poorly, there ought to be a means by which they -- that can be challenged.

And that is federal court or -- and other elements in the federal government. And what we've heard in various forums, as well as a formal -- I mean, as well as a study that was done, is that that's working very poorly. And many of us have experienced it.

I'm just saying that that is a finding, and then, what the recommendation is, is something different on it. But I think that the analogy with DOJ isn't off. For a lot of these kids, their only chance is the correct intervention by government. There's nothing else that will help them.

**CHAIRMAN SANDERS:** So we would include the federal oversight as one of the areas that we know and as part of our findings, and then, looking at what the range of --

**COMMISSIONER PETIT:** Yeah, and a finding which we could convert easily into a recommendation. A finding is that the congress does not hear enough about this reported to it on an annual basis. And we've talked in the past about -- about creating a situation in which the principal federal agencies have to stand before the congress and explain what they're doing or not doing to implement federal law.

**COMMISSIONER MARTIN:** Just -- just as a practical matter, we know that there's no child court on the federal level, right? So just to keep that in mind. So the analogy with DOJ, you know, has some difficulties when you start talking about as a practical matter.

But that doesn't preclude your recommendation. I'm just saying as a practical matter, you need to think through how that regulatory or re- -- whatever would take place.

**COMMISSIONER PETIT:** Well, there are a lot of, you know, bright lights in the congress that could figure that out. I agree that there's a practical issue, but that's how we get progress is to solve those practical problems.

**COMMISSIONER DREYFUS:** But, you know, you -- I wish Cassie was here because I think she's been really eloquent in all of these meetings about what, at times, I think is her frustration around states' compliance with laws congress has passed.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER DREYFUS:** They have -- there's a lot of these things we're still talking about that she gets really frustrated with, because she's going, we fixed that. We -- we --

**COMMISSIONER PETIT:** You sound just like her.

**COMMISSIONER DREYFUS:** Well, but I'm just saying I think what -- I think what Michael's getting at, and I would agree with this, is how does congress know? I think the question we've got to say to them is, okay, so you embraced these recommendations, how will you know? How will you know if they're being implemented, if there's accountability on the part of federal agencies for the implementation of these, and the fact that they're making a dent in these numbers?

So I think it gets back to the -- David, for me it's like you've got to have a progression, right? And that progression has got to be somehow that congress is holding federal agencies accountable for the full implementation of the laws that congress passes and the accountability of states for compliance.

**COMMISSIONER PETIT:** And there's a principal progressive discipline which you can apply that says you incrementally crank it up. You're able to incrementally increase the federal prerogatives in bringing states into compliance with federal law.

**CHAIRMAN SANDERS:** Yeah, I think -- well, let's -- do we have enough for those first four chapters? Is there enough general agreement that staff will write something in the next week and we'll have --

**COMMISSIONER DREYFUS:** Yeah. The only two things I just want to make sure would be in here that fits in -- just tell me if they fit in or not -- is CQI. I think -- you know, so when we talk about what, can congress can do, you talked about, you know, strengthening that oversight role.

But I didn't see anywhere in here where would -- where would what we're learning about what we're hearing about today, right, the continuous CQI loop, continuous quality improvement, just continuous like they're doing here in Tennessee, right? They're putting in place the right mechanisms for this continuous quality improvement based upon what they're learning from the good and the bad, and how that's fitting into a continuous quality improvement loop. So that was the one piece I didn't see here.

**COMMISSIONER RUBIN:** Yeah. I was just going to add that, you know, so when you think about accountability, one is through, obviously, you know, legal oversight and congressional oversight like you talked about.

The other accountability that I -- is regulatory. And so, I think of that in terms of how we tie the purse string at the state side to some level of accountability.

So one of the reasons we mentioned the maternal child health block grant is there was a precedent with MIECHV which required states to articulate their plans. And so you have some precedent legislatively to do this.

And so if states were on the hook for their MCH block grants around -- unless they actually fulfilled the requirement to develop a comprehensive plan and this was located in HRSA, then you could get some accountability.

Now, even that I would argue, given your -- what I think is -- I agree with you is the urgency of the issue, may not be enough. And so one of the things we've been trying to do is, well, are there precedents or mechanisms to do this with respect to their Medicaid funding?

So if the purse string is big enough and the state's at risk enough, then they're going to work harder and they're going to elevate it. So that's -- that's the other way we can kind of tackle this.

**COMMISSIONER PETIT:** Right.

**CHAIRMAN SANDERS:** So do we want to move to recommendations, then? And how might people -- go ahead.

**COMMISSIONER COVINGTON:** Can I ask you a question real quick? Under -- and I don't even know if it's going to be in this chapter anymore, Chapter 1. But when you wrote under Our Charge, federal policy approach working, but missing a group, what does that mean?

**CHAIRMAN SANDERS:** Yeah. So I can certainly -- the way that I'm seeing this in the conversation we're having today is shaping what's in each of the chapters. So what's in there was really for purposes of our conversation, not that that's now going to be included.

What I was saying, though, was that I think we need to present some perspective that that -- if the infant mortality rate were increasing or if the homicide rate were increasing, that's a different environment than if it's not. And that we seem to have some policy success -- and maybe it's purely related to medical treatment -- but some policy success, but this population is not -- it's not changing.

**COMMISSIONER COVINGTON:** Okay. You're talking about -- that's related to the mortality reduction. I see. I didn't know what that meant. Okay.

**COMMISSIONER DREYFUS:** And then, David, one last -- one question. Where in this would fit the conversation regarding federal financing? We've talked about that several times at several Commission meetings and --

**CHAIRMAN SANDERS:** Well, it seems like we should lay something out in the findings and what we know works or doesn't work. And -- because if we're going to think about that as a recommendation, we should probably have talked about it in not what works, but what we know and what we don't know.

**COMMISSIONER DREYFUS:** Okay.

**CHAIRMAN SANDERS:** And so, is there something that we want to say -- we've certainly heard a number of people talk about the restrictive spending that can go with IV-E, but I think the question is, do we want to -- do we want to mention something about that or not?

**COMMISSIONER DREYFUS:** I just personally don't see how we can't, but I guess I defer to my other fellow Commissioners if they feel differently. I don't know how we can spend all these months talking about the child protection function, the importance of it, the importance of the safety culture, but have the predominance of federal dollars being all geared not to the very things we've been talking about, earlier identification of families, more services being

put in earlier and smarter, as well as just more effective CPS response, and yet, have federal funding that's not at all aligned with that notion.

**COMMISSIONER MARTIN:** Well, personally - - and this is Pat personally, I'm not sure that I'm prepared to make -- I mean, I certainly have heard a lot of testimony and a lot of people talk about if they owned the world, they would talk about and encourage congress to look at finance reform.

But that doesn't necessarily mean that Pat's prepared to make that part of our recommendation. And the reason I say that is, if we had finance reform, does that necessarily lead directly to the reduction of fatalities? In my mind, I'm not sure it does.

**COMMISSIONER DREYFUS:** Well, I would agree with you on that. But I'd also say, there's four levers of systems change, you've got to pull all four or you're not going to get it done. And this Commission's got to pull all four, from my perspective.

Yes, there's practice changes that have to go on. Yes, there's policy changes that have to happen. But the holy grail of systems change is when you pull the regulatory and the fiscal levers. You pull those, now I'm going to give you a systems change that's going to live beyond any of our lifetimes.

And I would say in fairness to past Commissions, part of the problem is their recommendations were not pulling all four levers. So I just have a hard time backing off of what we know to be a significant part of the financing of our country's, quote, unquote, child welfare agencies. That it is a version of the past, not of the future.

I'm not saying we should say how it should be done, but the fact that it's an issue and incongruent -- the financing is incongruent with what our recommendations are, I think at least should be put in front of them.

**COMMISSIONER PETIT:** Susan, I presume at this point, we're not mixing together the question of what it would cost to fund systems versus what a financial vehicle could look like.

**COMMISSIONER DREYFUS:** Right.

**COMMISSIONER PETIT:** So I'm open personally to the question of financing -- refinancing, but that doesn't close the door in any way to the notion of costing out what it will take to do the work that we're proposing.

**COMMISSIONER DREYFUS:** Absolutely.

**COMMISSIONER PETIT:** Now, there's nothing that says doing more CPS comes out of the hide of foster care.

**COMMISSIONER DREYFUS:** No. It's not an either/or.

**COMMISSIONER PETIT:** Yeah. It's not an either/or.

David, can I say one thing about the document itself? And, you know, I strongly believe that we have to have excellent graphics and excellent short stories that accompanies all of the major points on this thing.

So as this is being written, whoever's going to be writing it, and we may want to just discuss it amongst ourselves as to this would be a good chart that shows this, this would be a good illustration of what that case is like.

But I think we need to tell a short story and we need to really draw visuals into some of these things. So, you know, there's a lot of work associated with that, but I just want to raise it.

**CHAIRMAN SANDERS:** Teri, I think you had raised some concern about the finance piece, so are you okay with --

**COMMISSIONER COVINGTON:** I'm okay.

**CHAIRMAN SANDERS:** So we should mention something about the -- the current funding system as one of our findings.

**COMMISSIONER DREYFUS:** Right. And just tell the ability for like Tennessee to do what they're trying to do requires a waiver.

**COMMISSIONER PETIT:** So without addressing a specific financial reform, you could say that Tennessee and the states need additional resources to do this. They may -- it may or may not be through the route of a waiver, but we're saying we want to build that piece up.

**COMMISSIONER MARTIN:** I just want to have a conversation -- and maybe I'm the only one. And if I am the only one, just let me know. But I did not, when reading our charge, think about things that tangentially may affect whether or not our recommendations will produce results in terms of eliminating fatalities.

And so until someone can explain to me how finance reform, in general, is going to lead to reductions in fatalities, I'm kind of not on board here yet.

**COMMISSIONER DREYFUS:** Well, and in fairness to you, we -- we -- we have not talked about it as a Commission.

**COMMISSIONER MARTIN:** Then how can we put in our recommendations if we haven't talked about it --

**COMMISSIONER DREYFUS:** But -- but -- but -- what I'm saying to our chairman, right, as he's putting together a draft, is we're not done yet, right? I mean, we've got months to go. We need to talk about financing.

**COMMISSIONER MARTIN:** Well, then, who's going to testify and who's going to give us evidence that there are some portions of finance reform, whatever you guys are thinking about? I mean, I assume -- I trust that when you put that on the table, you have some clear aspects of finance reform that you think are beneficial.

So who's going to come and give us the information that doing finance reform A way is going -- A, B, C way, is going to lead to reductions in fatalities?

**COMMISSIONER RUBIN:** I think we're also holding it to -- you know, first of all, we've requested that panel. And so I think that -- I would say that's a priority for one of our future meetings to have -- to summarize for us the debate on finance reform.

But I think that's holding that particular issue to a standard that we can't accomplish for almost anything that we -- that we're talking about because we -- what I see the finance reform is a facilitator.

We've had every state DHS director come in and ask for flexibility in the way they use IV- E. There's also historical -- we also have $500 million I think was the estimate, every year that is dwindling out of the IV-E budget because they've not corrected the 1996 look back.

And so money matters. And so at the end of the day, they're not going to be able to pull off what we want them to pull off without the proper finances or the flexibility.

And so I do agree we need to have a presentation, but I'm not looking from that presentation to say, I've proved that that -- already that that has reduced fatalities. It's more that it's part of a comprehensive state approach to repositioning the resources, and then, with the proper evaluation and sort of that quality improvement framework, that they now can start managing what they're measuring.

**COMMISSIONER MARTIN:** I don't disagree that we heard the term "finance reform" all throughout our presentations. But -- and maybe I missed it, so you'll have to explain it to me if I missed it.

But I didn't hear anyone say that finance reform done in A, B, C way is what I need, and other people saying the same thing. So unless I'm going to have some general overview of really what needs to be reformed and how it needs to be reformed, I'm not prepared to put down under my Johnny Hancock that we need finance reform and just leave it like that. You have to tell me how that is remotely going to address --

**COMMISSIONER RUBIN:** I agree. We need specificity. I totally agree.

**COMMISSIONER MARTIN:** Yes.

**COMMISSIONER RUBIN:** I think we're saying the same thing.

**COMMISSIONER DREYFUS:** But I just want to say, I was never envisioning that this Commission would have a specific way in which they thought congress should do finance reform. I think what we've heard was that there are current features of the current financing system that are incongruent with what we believe needs to happen.

I don't think this Commission is set up to say, and this is the right way to do it. I think it's more the issue that it is an issue. Because it doesn't -- the current financing is allowing for this, but is not allowing for this.

So I want to be real clear. I'm not asking the Commission to consider getting into the depth of what should the proposal be.

**COMMISSIONER PETIT:** But related to that, David, I do think that a group of us, one, two, three, five or all 12, ought to sit down and do a informed projection as to what it would take financially to meet what it is that we're recommending.

I don't think it's our job to find where that is, but I do think we need to say, we're talking about, you know, increasing workers, increasing treatment services, increasing whatever it is, and that's going to cost something.

**CHAIRMAN SANDERS:** And that's one of the reasons why I keep trying to push us to get to recommendations, because we have none yet that we're even -- agreeing to as part of the paper.

So because I think what the finance piece was really one of our findings is that the current funding structure doesn't support even the promising interventions. And I think that link can possibly be made. I think beyond that, it's different. And I don't know that we have a recommendation at this point.

But do we -- do we have enough for those couple of chapters that begin to talk about our findings? And do we want to move to recommendations or do we want to continue to kind of focus on building on some of the findings? Because --

**COMMISSIONER PETIT:** Building on some of the what?

**CHAIRMAN SANDERS:** Findings. So the what we know and what we don't know, those two areas.

So are we -- do we feel we have enough there, at least for the initial draft, to be -- for us to begin now to move into conversation about where we want to go with recommendations?

**COMMISSIONER MARTIN:** I think we should go to recommendations.

**CHAIRMAN SANDERS:** So we have -- we have the public health subcommittee recommendations that have been laid out. We've already talked about the measurement ones.

Do we want to start with the ones that public health has proposed or is there another way we want to organize the conversation about recommendations?

**COMMISSIONER COVINGTON:** Well, can I just make a comment about the outline as proposed in terms of where the recommendations fit? Because I was a little confused when you --

**CHAIRMAN SANDERS:** We're -- Teri, we're starting from scratch. So what's in here --

**COMMISSIONER COVINGTON:** No. No. I know. But it's -- it goes to that. It goes to starting from scratch. Is thinking about the recommendations by each of our subcategories, like the measurement ones or public health, versus thinking about them in terms of federal versus state, versus other? I mean, do we cluster them that way or do we think about them in our categories?

**CHAIRMAN SANDERS:** So part of the reason why I suggested that we do it that way is because it seems that it should be a set of recommendations from the Commission and not subcommittee recommendations.

**COMMISSIONER COVINGTON:** Right. Right. No, I agree.

**CHAIRMAN SANDERS:** So that's what I was thinking. But we can do it either way.

**COMMISSIONER COVINGTON:** And then, within each of those -- because there will be topic areas, though, won't there?

**CHAIRMAN SANDERS:** I think so.

**COMMISSIONER COVINGTON:** I mean, just to help some -- I mean, I think it's sort of a -- I don't think we just want to list 20 recommendations and not have them be tied to something more specific in terms of problem area.

But I think you're right. We don't want them to appear that they're coming from a committee. They come as a whole. But I'm just thinking of the organization of it.

**CHAIRMAN SANDERS:** I do think there are distinct responsibilities that states will have from congress. And I think we should make sure that's clear in our -- in how we structure it. But others could see it differently.

Public health, want to start or --

**COMMISSIONER RUBIN:** Yeah. We can start. So I'm looking at the -- do we have -- have we passed out the documents?

**UNIDENTIFIED SPEAKER:** You want the most recent one or --

**COMMISSIONER RUBIN:** The most recent one because I think we started to try to add a little bit more specificity in the most recent document.

**COMMISSIONER COVINGTON:** Does the most recent one have just one paragraph at the top?

**COMMISSIONER RUBIN:** Yeah. We tried to distill down to one page some of the things that we're organizing around so that we -- people understand them accurately.

The first recommendation for the public health subcommittee was around this development of a state plan and requiring states to implement a comprehensive state plan.

We talked -- we talked a little bit about in here sort of trying to find the right fiscal mechanisms, those fiscal levers through which to create accountability.

And so we're -- although we mentioned the maternal child health block grant because of the precedent there, we're also looking at -- you know, we're open to considering other ways to mechanically do this.

And so we're interested and we're still trying -- we've talked in the subcommittee about, are there ways and precedents in which Medicaid has been brought to the table through similar kinds of actions?

Now, the second one we're calling leveraging opportunities and different public systems to improve the identification of children and families at risk. And this is some of that interdisciplinary team management.

And, you know, I spoke -- we speak here from the health perspective, that there are specific opportunities in Medicaid, ensuring that health information exchanges, which are now being required for meaningful use through healthcare reform, that they, at the very least, provide information sharing to emergency departments around children with injuries.

So that's on a -- that, I would put, Commissioner Petit, for example, on an imminent risk sort of scale, sort of getting very specific about the needs for ERs around this country to be able to identify children who are at high risk.

There are opportunities to develop new pediatric quality measures for family risk assessment and failure to thrive and early childhood injuries.

To date, the Pediatric Quality Measures Program, which I believe was reauthorized with the CHIP reauthorization last week, I'd have to double check with some of my folks here. But to date, they actually -- the measures that they're developing, which are ending up in pay for performance contracts are around healthcare. They're not necessarily around health.

So I even thought today as we had our testimony, wouldn't it be great if one of the pediatric quality measures that was part of contracts was family risk assessment, right? Or substance abuse assessment or domestic violence assessment, and it actually became more of a routine practice that was incentivized through pay for performance wherever -- for EPSDT services through Medicaid.

Third, identifying new payment strategies that might reimburse family based services. For example, parental mental health services and meeting the responsibility of EPSTD for a child.

So that's that dual generation reimbursement, that idea of when is it permissible -- and we're still exploring this -- when is it permissible, particularly where a parent is uninsured, to provide services for a parent when it's in the best interest of the child?

All right. And then, four, capitalizing in state and payer investment in primary care medical homes and health homes to increase access to trauma informed programs, home visiting services and other family based social services within primary care settings.

I separately serve on Pennsylvania's state advisory council for primary care medical home as they're putting their plan together. But states are -- their Medicaid programs right now are focusing on enhanced payment when communities come together around a health home, which is broadly defined.

It's not about healthcare. And these may be nonprofit providers. The biggest experience we have in health homes is probably in the behavioral health community, is in mental health communities. And so enhancing payment to pay for an interdisciplinary approach to the provision of health related services, and that includes social services there, to a family.

And so we need to be mindful of that train because there is going to be a great degree of investment there in the next few years.

So those are areas that we've been exploring with CMS, in particular. I will admit that we're still skimpy on child care and WIC and early intervention. Like, I would like to, you know, to think about those other systems as well, as well as home visiting. We're meeting with the

home visiting research network next week, and so we'll have explicit recommendations probably related to the implementation of MIECHV coming off that meeting.

Three, ensure access to high quality -- high quality prevention and intervention services. And in this case, this gets to the development of that sort of framework for those plans. How are we going to fund the substance abuse treatment programs, the domestic violence services, et cetera, that really get around family risk? And are not -- and how -- what is that going to look like in the future?

I mentioned an innovation fund as a way for tests to -- states to test some of the strategies they're working on. But ultimately, you know, I was thinking about this in the interim between the last meeting, that wouldn't it be great if we had a step sequence. If some states can show that the investment in some of these services actually really reduced mortality, and particularly, child abuse neglect fatalities, you're making a very cogent argument for whether these should be EPSDT services.

And so, for example, I've always believed that home visiting services that I understood the political expediency to have a separate funding stream that was capped as a block grant, if you will.

But if home visiting services truly can reduce preventable early childhood mortality and we can demonstrate that through our state investments, why aren't those billable Medicaid reimbursable services? And so, I do think we could think about that in two steps.

And then, finally, enable more flexible funding in play space strategies to better integrate and align cross system efforts. And this was a placeholder for thinking about that innovation fund, for thinking about to the degree to which, you know, finance reform, however that's defined, whether it's just IV-E or whether that's permissible rules around targeted case management and Medicaid, that we need to really understand where our -- the levers there that we have potential opportunities to create flexibility for states to reposition their funds.

So those are the areas that when we got down to the details we were focusing on, but I'll open up to discussion. And Commissioner Dreyfus, you can expand, too, if you'd like.

**COMMISSIONER DREYFUS:** Yeah. So I was just kind of looking through my notes today just ask our fellow Commissioners if there's a couple of other areas they'd like to see us stress more. And I'm -- just very quickly here, a couple of things.

One is this whole -- we were -- we had a number of recommendations given us today around substance abuse. And I'm wondering if we shouldn't do a little deeper dive in our recommendations specific to substance abuse, with more specificity of our recommendations.

Now, I know people say, well, then you should add domestic violence, too. Fine. But I'm just wondering if our committee should go a little bit more deeply into more specificity on those things.

The other thing was this whole issue of unplanned births and whether or not we don't want to be calling that out a little bit more in our recommendations than we are right now. But I don't

know if it fits, it's just things that came up today. So I'd love to hear Commission thoughts on that.

And then, the other thing that I know it's kind of an over arching umbrella, I'm sure, but we need more research funding. We need more research funding. We need -- we need to have a clarity of a research agenda and more federal dollars.

I mean, we were told one time, I think, for every dollar being spent on child welfare research, we're spending almost $4,000 on fibromyalgia research. I was like, really? So those would be the things I would just add and ask, I guess, fellow Commissioners, are those things that you think we ought to --

**COMMISSIONER RUBIN:** I just want to add some context there. I did receive an e-mail before this meeting. Apparently, as NICHD and NIH disbanded the National Children's Study, they've reorganized the funding around different priority areas, and child abuse and neglect was not one of those areas.

And so I received an e-mail that I'll forward to Commissioner Sanders about a hearing that folks wanted to have next month on the Hill to talk about the investments in child abuse research. So that's a good area.

I think also we need to call out -- it's reminding me for the staff that we need to call out some of the -- some of the -- you know, I guess the question is, what do we want to do with current requests that the White House has made that have not seemed to pick up the kind of traction that they probably should, the investment in trauma informed programs, in capacity building for trauma informed programs within child welfare systems across the country.

That was a significant step when the White House made an appropriation request, I think, of about $750 million over several years to increase access to trauma informed programs, recognizing that many children were at, A, at risk; and B, often succumbing to the lack of tools by being placed on powerful sedatives and antipsychotics.

There's value in calling out some of those investments in this -- in that context here. And there are some -- and there are other ones as well, too, because they mention their request as well to try to reposition IV-E resources as part of preplacement services. And so the question is, do we want to mention some of those specific requests that were made in the White House budget?

Commissioner Covington, you're the other part of this trifecta. Any thoughts?

**COMMISSIONER COVINGTON:** I think with the other Commissioners -- I just think, you know, we have general themes, but I'm hoping that we're going to come up with some much more -- many more specific sort of subrecommendations under these bigger categories for people. Because I'm all about specificity when it comes to being able to address some of this.

And we're still meeting with -- we still have more to go with CMS, so we had a pretty productive meeting with CMS. And I guess -- are we still negotiating two or four with them? But they've been working with us in trying to think through some -- some possible approaches that might work with some Medicaid thinking.

**CHAIRMAN SANDERS:** Susan, you mentioned a couple of things. What was the first one that you mentioned? I didn't get that.

**COMMISSIONER DREYFUS:** Substance abuse, should we go into greater specificity? Actually, it's on section within our recommendations with the area of substance abuse, specifically.

**COMMISSIONER COVINGTON:** I think it goes under three. And then, we can -- I think we think about how we want to --

**COMMISSIONER DREYFUS:** Sure. Sure. That's fine. But we call it out, right?

**COMMISSIONER MARTIN:** You have it under two already.

**COMMISSIONER COVINGTON:** Uh-huh.

**COMMISSIONER DREYFUS:** But I think three, though, is about ensuring access to high quality prevention and intervention services, right?

**COMMISSIONER COVINGTON:** Uh-huh.

**COMMISSIONER RUBIN:** I would have the staff make a note of the testimony received today, which was very, very specific in terms of that area, which -- particularly around expecting mothers, right?

**COMMISSIONER MARTIN:** So -- and I'm not trying to be objectionable or -- but why would we pull out substance abuse and not domestic violence? Or why would we pull out --

**COMMISSIONER RUBIN:** I'm not saying that at all. We do both. I think we need our staff to go deeper. I sort of can see we have not gone deep enough yet into what would be facilitators to improve the inclusion of domestic violence services as part of a comprehensive state plan.

I mean, I think of these as catalysts. Like how can we use our recommendations as catalysts so that when states develop their plans, they have the -- some of those levers that Commissioner Dreyfus was -- so domestic violence, child care, right? And I think we want to make sure we have all the areas that -- home visiting, right? The other points of contact for children in early childhood.

**COMMISSIONER DREYFUS:** And I was more focusing on those things that we have heard are the highest correlates to fatalities. So I know there's a whole range of them, but we have heard overwhelmingly substance abuse and domestic violence and mental health.

**CHAIRMAN SANDERS:** So when I read these recommendations, and I think they're really strong, it seems like the first one is directed at states and the remainder are as much federal.

Under the first one, is there -- what is the -- is the federal role here oversight or is there some something addition that they -- in addition that they would have a federal role if states are now developing plans?

So, for example, if every plan says, we need to integrate these services, is there something specific that we're asking the federal government to do or is it purely the oversight?

**COMMISSIONER RUBIN:** Oversight, innovation fund in terms of access to grants to test promising strategies, and evaluation and measurement.

**COMMISSIONER PETIT:** Is funding this research --

**COMMISSIONER COVINGTON:** Incentivizing.

**COMMISSIONER RUBIN:** Incentivizing.

**COMMISSIONER PETIT:** There's a number of things that this whole --

**COMMISSIONER COVINGTON:** Wade's not here, I can use that word.

**COMMISSIONER PETIT:** -- this whole report is meant to inform what the federal strategy should be. So I do think that you can't go directly to the states and bypass the federal.

**COMMISSIONER RUBIN:** Oh, no. I think this will be organized -- this would be organized at the federal level. And so I'm thinking of it much like, you know, sort of, you know, within that -- that HRSA group felt like the right group when we met with them, and having someone who this is a, you know, a part of HRSA, the state -- the state response to child abuse and neglect fatalities or preventable early childhood mortality, whatever you want to call it, and they would have a sequence of things that they were doing from the oversight over those state plans, the articulation of what the common elements needed to be on all those plans, how that related to payment incentives, et cetera, all the way down to grants, and then, evaluation.

**CHAIRMAN SANDERS:** But -- so -- not a but, because I think it's a great recommendation. I guess I'm thinking then maybe there needs to be something just slightly separate that isn't in place right now for the federal responsibility to actually -- beyond the funding assistance and so forth, I think that, for example, the strengthen their role in spreading practice in this area or development of policy or supporting policy at a state level.

It seems like there is a role that the federal government has beyond just the oversight in facilitating practice.

**COMMISSIONER RUBIN:** Well, the other stuff -- I don't know how you feel about this, Commissioner Covington, in terms of -- in terms of standardization of definitions and where -- we talked about early on getting the count out of NCANDS, right?

**COMMISSIONER COVINGTON:** Yeah.

**COMMISSIONER RUBIN:** And so this provides a potential landing spot for all those activities, including a more organized and comprehensive count and standardization.

**COMMISSIONER MARTIN:** So, explain to me. Are you talking about another cabinet position -- I mean, where is this --

**COMMISSIONER COVINGTON:** No.

**COMMISSIONER MARTIN:** I mean, where is all this housed?

**COMMISSIONER COVINGTON:** We haven't really gone there yet. But I think, for me, one piece and it would go under this in a sense -- you're thinking of it being separate -- would be how does this get operationalized at the federal level?

Because part of this is the federal level having to let -- to me, it's almost like the federal government is going to have to model what we're asking the states to do because they're not currently modeling good cross coordination in these areas between CDC, HRSA --

**COMMISSIONER MARTIN:** That's what I'm saying --

**COMMISSIONER PETIT:** They have a federal interagency committee right now that --

**COMMISSIONER COVINGTON:** Pardon?

**COMMISSIONER PETIT:** -- that exists. They draw from all the departments. I think it's a weak process.

**COMMISSIONER MARTIN:** Right.

**COMMISSIONER PETIT:** The Children's Bureau is who takes the lead within HHS. This small. They are way undersized in terms of the magnitude of this problem.

So -- but at some point, the administration and the congress would be in the best position to say, here's what the organizational chart should look like. What needs to happen is somebody needs to be tasked with this responsibility. And there is now no one now at a high level within the federal government.

**COMMISSIONER MARTIN:** So this is my question. If we made this recommendation as drafted right here, is it okay for us to make this recommendation and say, feds, you figure out where it sits or should --

**COMMISSIONER COVINGTON:** No.

**COMMISSIONER MARTIN:** -- because I think our recommendation is a lot stronger if we say it sits with X, Y, Z, you know, department or --

**COMMISSIONER COVINGTON:** But that was kind of my comment earlier --

**COMMISSIONER DREYFUS:** At the federal level, Commissioner Martin?

**COMMISSIONER COVINGTON:** -- is I see under each one of these broad themes that we're going to have to hash out more specific thinking in terms of what specifically we want to have happen. And I think one of those would be, how you make this operationalized at the federal level.

**(Speaking over one another.)**

**COMMISSIONER RUBIN:** And I would add, where I gave the states flexibility for their plans, I want -- I would like to be more explicit about what this looked like at the federal level. So I'm voting on more specificity at the federal level.

**COMMISSIONER PETIT:** So we're going to add stuff as we're doing right now, and we're going to have a chance later to look at all this, of course, and we'll go over it and decide that we reject this after all or we accept this after all. So with what's right in front of me, if I can just give a couple of comments.

**COMMISSIONER DREYFUS:** It would be great.

**CHAIRMAN SANDERS:** The one you -- a couple of comments before that, you said?

**COMMISSIONER PETIT:** I was saying whatever is being written is it's the first of a series of documents that we're going to continue to modify and shape and seek more information on that.

**CHAIRMAN SANDERS:** That's correct, yes.

**COMMISSIONER PETIT:** But just with respect to this, if I may. And again, I don't think we need to decide on these right now or we can and we can see what people say.

One is, I question whether or not -- and it appears that it's the public health unit that you are suggesting pull together a comprehensive state plan. I would say they should pull together a comprehensive state plan for preventing child fatalities, not child maltreatment fatalities.

And that the knowledge, the most knowledge, the highest concentration and the legal responsibility as it stands right now is CPS. So, that's one thing I would note.

The other thing that I would just state is that I do not believe that we are in agreement on who CPS knows before they die and who health knows before they die. So where it's written here the majority of children who die --

**COMMISSIONER MARTIN:** You might tell us where you are reading.

**COMMISSIONER PETIT:** Two. Two, the first sentence, the majority of children who die due to abuse and neglect may not be known to Child Protective Services before they die, but likely they are. And I think there's more evidence on the table that says they do know them than don't know them.

With the second piece, David, what I would say is an important qualifier is while it's true that health knows these kids -- first of all, to say health system, you'd probably agree, is a stretch.

And secondly, it's unlikely that they know them as victims of abuse and neglect. Virtually all the ones that DHS has, whatever, HHS, they know that they're abused and neglected. That's how come they know them. And right now, people call that, you know, 9-1-1, you know, CPS number.

So NCANDS -- and we've gone over this before, that annual report keeps saying that 70 percent, you know, were not known or whatever the number is. But if you recall, there's about 10 things that they exclude. A referral doesn't count. A substantiation, but no services, doesn't count. I mean, there's a whole bunch of things that they exclude on it. So I just think that --

**COMMISSIONER COVINGTON:** Michael, though, when you don't look at NCANDS, but you look at the state child death review reports where they've gone and really pulled CPS records to see if there were any reports or any referrals or what have you, when you look at those reports across the country, it tends to average out to be about 30 percent of the kids were known to the system. So I think it's probably kind of fair to say we didn't know most of these kids.

**COMMISSIONER DREYFUS:** But let's clarify just because I want to make sure we're all saying the same thing. When we say "known" to other systems, particularly healthcare, we're not saying known to have been abused and neglected. We're saying some -- there are professionals with their eyes on these kids and their training and they're level of awareness needs to improve --

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER DREYFUS:** -- to identify risks than relying on somebody to call in to a hot line.

**COMMISSIONER PETIT:** Right. But to your point -- what? Teri -- Teri -- it's that haircut. I didn't recognize you. It's such a nice haircut. What? Teri --

**COMMISSIONER COVINGTON:** Off the record.

**COMMISSIONER PETIT:** Yeah. Off the record.

Teri, if you were to do what we're talking about before, David, which is slicing the deaths and categorizing them differently, if you left out, for example, the sleep safe -- safe sleep type issues and you get down to the dismemberment, the throwing over bridges, the putting in freezers, et cetera, those are known.

**COMMISSIONER COVINGTON:** I'll tell you what I'll do a run of that data because we can do that.

**COMMISSIONER PETIT:** I wish you would. I wish you would because right now all we have is what federal piece says, and that is completely discredited. That is not close.

The other thing that I would just mention --

**CHAIRMAN SANDERS:** Michael, just a question. So is it that the bold language under Number 2, you're not disagreeing with that, it is --

**COMMISSIONER PETIT:** No.

**CHAIRMAN SANDERS:** It's the language that's supported because that may be --

**COMMISSIONER PETIT:** Yeah.

**CHAIRMAN SANDERS:** So --

**COMMISSIONER RUBIN:** I just want to note also that in anticipation -- because I knew you had raised that objection before. The prior document said between one-half and two-thirds, and I probably still haven't gotten it right. I wanted to acknowledge that may -- you know, that may -- they may not be known. I think because we have no idea.

**COMMISSIONER PETIT:** No. No. It was close, David. I saw that and I said, I see what he's trying to do here, but it's not going to work.

**COMMISSIONER RUBIN:** I tried. And I was thinking about you.

**COMMISSIONER PETIT:** So -- so, no, I got that.

**COMMISSIONER COVINGTON:** I'm going to do a run of the data and bring it to our next meeting.

**COMMISSIONER PETIT:** All right. So something else, David, on this one that I think is important and that I know you believe. But in terms of recommendations, one is this business about prenatal care, the universality of it, and I think we need to say that it currently exists, the money necessary to underwrite the costs that is basically available. It's not being taken advantage of by some states.

I think we need to show that some of the most critical things that we are recommending are already funded, but the states are not exercising their option to participate. That's one.

The second piece on the teen pregnancy issue. And what was it called from this morning? What did he classify it as?

**COMMISSIONER RUBIN:** Long-acting reproductive --

**COMMISSIONER PETIT:** What?

**COMMISSIONER RUBIN:** You're talking about unplanned pregnancies and birth spacing --

**COMMISSIONER PETIT:** Again, you know, I can't emphasize enough that in the end, notwithstanding all the difficulties with all the departments and agencies and researchers and judges and everything else, what we're really looking at is poor parenting. I mean, in the end, the reason why we are all involved with this is -- it's not to say that parenting can't be improved, et cetera. But in the end, in the first instance, what we're talking about is there are families that are simply having difficulty in managing the well-being of their children safely.

And that teen pregnancy thing, I think, is critical. That early -- so I don't know where that is in there, but in terms of the funding, I'm saying that that is -- it's been dropping, but it's nowhere near where it is in other countries.

**COMMISSIONER DREYFUS:** You know who's sitting on really good research is Emily on parenting teens in child welfare.

**COMMISSIONER RUBIN:** We're also doing a study on -- you know, we noticed that in -- you know, for young moms, I think, under the age of 21 or 24 in Philadelphia, half of those moms had active histories with child welfare. So the overlap is pretty significant.

**COMMISSIONER PETIT:** So the last thing I would just note is what Judge raised and what you've raised as well, which is the obstetrical care process during a pregnancy and into the delivery, that whole process ought to be informed by child welfare and child protection as well so that there would be no one leaving the hospital that at least there wasn't some kind of

a scan that was done of that family's situation. And that during the pregnancy while someone's receiving obstetrical care, this issue be raised at that point and not postponed until after the child is born and we find out six months later that there's a problem.

**COMMISSIONER RUBIN:** Yeah. I do think we have an opportunity to do that. There are ways of doing family risk assessment, and it all comes down to whether they're incentivized through the contracts. And that starts with quality measurement program in CMS.

**COMMISSIONER PETIT:** And there are examples of it in other -- I know there are examples of it where this has actually been done.

**(Speaking over one another.)**

**COMMISSIONER COVINGTON:** You're talking like the birth match project where after the baby is born, they match them up with --

**COMMISSIONER PETIT:** No. I'm saying during the pregnancy, there's some an alertness by the obstetrician and the obstetrician's nurse, et cetera, about is there a problem here in this pregnancy? Is there going to be adequate support? Is there, you know, are certain people in their lives? Is the substance abuse being taken care of? Is there violence, et cetera? So that doctors participate more in that process.

And then, the issue is when the baby is being delivered, prior to the baby going home, there's somebody that's looking at it and just determining whether this is -- can be done straightforward or whether there's some help that's needed.

**COMMISSIONER MARTIN:** As a practical suggestion -- as a practical matter, a lot of my parents, pregnant women don't get prenatal care.

**COMMISSIONER PETIT:** I know.

**COMMISSIONER MARTIN:** So, you know, just to --

**COMMISSIONER PETIT:** I am well aware of it. And what I also know is that prenatal care money is available through federal law, through Medicaid expansion, through ACA, through a number of things. And in many cases, the states are simply not exercising spending that money, Judge. So it's not -- it's not for lack of resources for the most part.

**COMMISSIONER RUBIN:** I want to make clear -- I just want to make clear that prenatal care that most -- that pregnant women are mandatory -- yeah, they're a mandatory populations in Medicaid, so that's about engagement more, per se. I worry more about, you know, a mom's Medicaid funding going away right at the time of birth, right? So some of our prenatal care issues, they're not about the Medicaid expansion, per se. They're more about the fact that at a time when that young baby with colic is coming into that family, we suddenly don't have access to any services.

**COMMISSIONER PETIT:** There's large numbers of young women and men that are not covered by Medicaid, and if you expand Medicaid, they would be covered. So I'm saying, if there's an issue of just expanding the payment process, which Medicaid has -- is ready to do. There's just obviously a political conflict here. The question is: Do we come down on one side of it or not?

Do we say the state should exercise the expansion of healthcare that's already been paid for? So those are my comments on this.

**COMMISSIONER RUBIN:** And I agree. I think Number 2 should actually just be -- we should probably just reword it to kind of be a little more -- it's a little bit healthcare centric because that's where we spent some of our time now, but we're really talking about a number of points of contact with kids early in childhood and the response of those public systems.

**CHAIRMAN SANDERS:** So it seems like at least to begin to put a much more solid outline to something that includes some writing behind it that we have accomplished quite a bit.

**COMMISSIONER RUBIN:** I will add that HRSA -- the reason I keep talking about HRSA is because that's where MCHVIE is. When you actually go there and you realize a lot of programs we've been talking about, home visiting, emergency care services, a lot of the response that -- you know, a lot of the federal organization for that is kind of being put into the Children's Bureau and that group over at, you know, at HRSA.

So -- and so that's why it seems like the right place to go because they're sitting next to each other.

**COMMISSIONER COVINGTON:** I think we have to be careful, too, though, because as wonderful as MCHVIE is -- and I'm a total fan of it -- it doesn't reach everybody. And in some states, it's only in selected communities. So it's not universal by any stretch of the imagination.

**COMMISSIONER MARTIN:** So I just wanted to ask in Number 2, leveraging opportunities, have you included, and I just don't see it, like, you know, law enforcement?

**COMMISSIONER RUBIN:** I would agree law enforcement would be one of those areas as well, too.

**COMMISSIONER MARTIN:** I would suggest to you it's one of the bigger areas. I mean, we've heard communities that rely very heavily on law enforcement to bring that information to the attention of --

**COMMISSIONER RUBIN:** Yeah. I heard an interesting comment today actually. I don't know if you guys registered it, I did. When someone made the connection of looking at folks who committed homicides and whether they had children in their household and they decided to make that linkage, right? Those intuitive linkages that people take for granted and that actually can inform safety and risk assessments for kids.

**COMMISSIONER MARTIN:** And also the meth labs. They mentioned that today.

**CHAIRMAN SANDERS:** Susan.

**COMMISSIONER DREYFUS:** So one thing, David, you said earlier -- and I can't repeat exactly how you said it -- but it was this issue of -- of when we're talking about accountability, right, and I think the one piece we're probably missing here that we need to think about -- and Judge Martin, I think you were kind of getting to this a little bit, too -- is I looked at these state plans to -- that were specifically to prevent maltreatment fatalities. I looked at that as

being at the level of the governor in terms of them tasking as the governor sees fit the right state agencies that he or she is going to task with that responsibility.

But that being said, it's got to be hard wired into that process, the identification of federal barriers. There's got to be something that closes the loop here between what states are doing and learning about what works and how they're identifying things -- things at the federal level on a regulatory or fiscal standpoint, policy standpoint that are standing in the way of progress, whether they've had to work around or get waivers for or what have you.

Something that creates a continuous loop here of the feds getting -- what I loved about this recommendation is we're basically creating what it will be like 50 innovation labs across the country dedicated to the task of this Commission, eliminate fatalities from abuse and neglect. And there's going to be a learning loop in there, and it's got to be a federal learning loop as well. I just think we need to say that.

**COMMISSIONER PETIT:** Yeah. The feds are able to collect and distribute information in a way that no state can. And that's one of the things that they're able to do in numerous areas. They should be able to do it in this area. They think they are, but they're not doing it on a scale that's needed.

**CHAIRMAN SANDERS:** So I think we can probably adjourn for now. We have the child protection subcommittee.

I should mention that the -- I think it was the last meeting I mentioned that we had applied for an extension, and we did just have that granted, so our --

**COMMISSIONER PETIT:** Until when?

**CHAIRMAN SANDERS:** March 18th, 2016.

**COMMISSIONER PETIT:** Can I -- David, at some point -- and I think this exercise is exactly what we need to go through, but I do think we have to have a meeting in terms of how we're going to stage this issue in terms of --

**CHAIRMAN SANDERS:** Say that again.

**COMMISSIONER PETIT:** How we're going to stage the release of a report, whether it's -- I mean, I don't know if the feds have a particular protocol. I don't believe there was in the legislation, was there, that just said basically prepare something and turn it over.

Is that right, Liz?

**LIZ OPPENHEIM:** I'm sorry?

**COMMISSIONER PETIT:** It's nothing -- or David, you may know. There's nothing that says in the statute here, prepare it and distribute it this way. It just basically says, prepare recommendations for the White House and for the congress, right? So the way that we release that, how that happens, the events leading up to it, who does it, when, where, et cetera, to me is an important conversation.

I mean, as strong as the content is going to be, it won't mean anything if it doesn't receive the attention and review that it deserves. So I'm simply suggesting that it's something we have a conversation about.

**COMMISSIONER COVINGTON:** I'm wondering if tomorrow if we could spend a little bit of time having a conversation about areas where we feel we haven't touched base yet. I mean, there's a couple that I have sort of in the back of my mind that I'd still like to figure out where we can fit them in. Because I know the meetings are getting full already.

**CHAIRMAN SANDERS:** We can probably start tomorrow with that.

**COMMISSIONER COVINGTON:** Okay.

**CHAIRMAN SANDERS:** Do you know when Jennifer's joining us? Anyone know when Jennifer is joining us? She is going to do it by phone. So maybe we start with that.

**COMMISSIONER COVINGTON:** Okay. All right. Good.

**COMMISSIONER PETIT:** Just before adjourning, I mean, we had talked before about this US Shame report. And when we were in Oregon, there was -- there was going to be some kind of a side by side, some piece, somebody was going to do some vetting of it.

So now here we are in April going into May and the report, as you know, got a lot of attention. And I don't know that we've actually gone through it as a group or in a summary fashion even as to what it says. Does it simply reinforce? Is there anything new in there for us?

**LIZ OPPENHEIM:** We've shared the executive summary and the full report with all the Commissioners, but that you all haven't discussed it collectively.

**CHAIRMAN SANDERS:** Yeah. So if -- it falls under the question of accountability. To me, it's another report in the history of reports. I don't know that there's more that we will do beyond that, but we can -- if we want to have something specific on accountability and what are accountability recommendations that others have made --

**COMMISSIONER PETIT:** Well, for example, I thought it was a pretty strong charge, Judge, that the report really was very critical of federal courts in terms of allowing these cases to come forward. I don't know.

**COMMISSIONER COVINGTON:** Maybe tomorrow morning that might be a topic then to add to the list of what --

**COMMISSIONER PETIT:** At the end of the discussion on the --

**COMMISSIONER COVINGTON:** Or no. In terms of topic you don't feel we've covered yet.

**COMMISSIONER PETIT:** Yeah. Yeah.

**CHAIRMAN SANDERS:** Anything else then for today?

Well, thanks, everybody. We'll start at 8:00? We start at 8:00.

**(WHEREUPON, THE HEARING WAS RECESSED UNTIL APRIL 29, 2015 AT 8:00 A.M.)**

**DAY TWO—APRIL 29, 2015**

**CHAIRMAN SANDERS:** So most of our agenda today is going to be deliberations of the Commission on the report from the child protection subcommittee. We have Jennifer Rodriguez, who's joined us on the phone. And we, hopefully, will have good reception. Jennifer, are you there?

**UNIDENTIFIED SPEAKER:** She's not here yet. She's is calling in.

**CHAIRMAN SANDERS:** She is calling in. She's not on yet.

**UNIDENTIFIED SPEAKER:** She's not on yet. Sorry about that.

**CHAIRMAN SANDERS:** That's okay. Michael, we have the child protection subcommittee. You want to -- since you're the sole member here right now.

**COMMISSIONER PETIT:** You know, this document, the one that reads Child Protection System Subcommittee, does everybody have that? Do you need a minute to just review it? You know, just take another second to reread this thing, and then, begin, David?

David, can we do that? Just take two minutes?

**CHAIRMAN SANDERS:** Sure. That sounds fine.

**COMMISSIONER PETIT:** And then, we'll go back through them.

**CHAIRMAN SANDERS:** Well, let's take a minute. At the end of yesterday, we had talked about the overall recommendations, and then, there was some -- we wanted to have some opportunity to identify areas that we might need to explore further today. And I think, Commissioner Covington, you had a couple of things.

**COMMISSIONER COVINGTON:** Yeah. I just - - there were a couple -- and I -- you know, I realize time is starting to not be our friend anymore in terms of getting all of this work done.

So I started to think that there were a couple areas that I don't think we've really covered, but I know they're sort of -- I don't know if they're elephants in the room, but they've kind of just sort of been a layer on top of everything.

And one is the issue of transparency and confidentiality. And I really think we need to put some dedicated time in a meeting to hear from people who feel strongly either way about that and how it affects fatalities and our understanding of fatalities.

And then, the other one is this whole issue -- I think we need to give a little bit of due time at least to consider -- and I'm not saying I support it or don't support it -- but the Shame On Us report, which came out in the middle of our deliberations. I think we should probably maybe at least give them an opportunity to present to us on some of their findings.

And I think what a lot of them relate to is not meeting -- not -- what's the word I want to use -- not enforcing some of the federal mandates and what that means for fatalities. And I just -- I think those are two areas for me that I'd like a little of attention to paid through either public hearings or through deliberations and how they affect our recommendations.

**COMMISSIONER MARTIN:** So I thought that confidentiality and the whole sunshine issue was really contained within -- on that outline when it said something about sharing of information. So that's why I assumed we were going to have further conversation about it. But maybe I was wrong, but that's how I read that.

But I do agree with you on the report. We should have some mention of it in the record and some conversation about it.

**COMMISSIONER COVINGTON:** Yeah. I just think we should spend some good time talking about it.

**CHAIRMAN SANDERS:** Say the last thing you said. I missed it.

**COMMISSIONER MARTIN:** The report that she's talking about, I think that we should at least have some conversation and some mention of it in the record, and kind of some -- whether or not we agree with it or disagree with it, but at least discuss some of the major components of it, the Shame On Us report.

**CHAIRMAN SANDERS:** And I think that I would view it in the broader context of accountability. And I'm not sure -- it seems like there are a number of documents that have been provided over time on accountability, and I would see this as one of a series versus it's a separate document that we would undertake additional review on.

But -- and so, in some ways, the whole issue of how we pursue accountability and think about getting information about what have recommendations been for greater accountability. I'd prefer that than just to focus on the one report.

**COMMISSIONER COVINGTON:** That's kind of -- I agree. I just -- I use that as an example that I think we do need to spend some time talking about accountability.

**CHAIRMAN SANDERS:** I think that makes sense. And we have --

**COMMISSIONER COVINGTON:** And that's one of the pieces that are out there that explicitly addresses it.

**COMMISSIONER PETIT:** David, are we going to wait for Jennifer to get on the phone? Is she on the phone?

**UNIDENTIFIED SPEAKER:** No, not yet.

**COMMISSIONER PETIT:** You want to start without her?

**CHAIRMAN SANDERS:** We'll try and reach her because she had said that she would try and call in first thing here, so...

**COMMISSIONER PETIT:** Yeah.

**CHAIRMAN SANDERS:** Any other areas that we need to spend time on in addition to the accountability? And to the point that you raised, Commissioner Martin, the sharing of information, at least in the document that I prepared, was not confidentiality, it was a sharing across systems. So I think that is an area that we want to spend some time on.

**COMMISSIONER PETIT:** David, you guys may have mentioned it, but we say confidentiality, I may have missed it, but where is that sitting right now?

**COMMISSIONER MARTIN:** That's what Teri was raising, that we need to look at that. And I wonder -- I don't want to put Commissioner Horn on the spot, but having been responsible for the agency that was given the charge of doing some interpretation of sharing of confidentiality and so forth, is that something that you could provide us some guidance on to lead a discussion here?

**COMMISSIONER HORN:** So as I think y'all know, ACF recently, within the last year, released a confidentiality tool kit. And the purpose of that was to try to clarify what could and could not be shared, with the understanding that -- that there are a lot of things that are true about confidentiality and some things that are not so true, but people believe.

So if we -- I do think we should focus on confidentiality, but I'm wondering if maybe what we do is invite someone to one of the meetings that was really -- someone from ACF that was, perhaps, you know, integral in the development of the confidentiality tool kit that could share the specifics of it, and also the reaction that states are having.

**COMMISSIONER COVINGTON:** And I think beyond ACF, I think we should invite folks in the field who feel strongly one way or another. I mean, there's organizations out there who really oppose the limits that they feel ACF puts on them, and then, I think there's others who would take the other direction. I think we should hear from both sides and not be afraid of it.

**COMMISSIONER DREYFUS:** Because also I think you have got examples in local communities and states where they have figured out the way to do memorandums of understanding, opt in/opt out provisions that allow for consumer choice, but at the same time, don't thwart the ability to share information between agencies. So I just think we also have to look at some of the ways that folks have figured out how to do this.

**COMMISSIONER PETIT:** But there's the related issue beyond cases of public scrutiny of these records and being made available after a death or a serious incident has occurred. So did the tool kit speak to that as well?

**COMMISSIONER HORN:** Uh-huh. And somebody who might be able to provide us with an interesting perspective on both sides, federal and state, is George Sheldon who was the secretary for the Department of Child and Family Services down in Florida, then was the acting assistant secretary at ACF who actually developed -- he was very involved in the development of confidentiality tool kit. And now he is the director of the Department of Child Family Services in Illinois. So he might have a really interesting perspective.

**COMMISSIONER DREYFUS:** George is great.

**COMMISSIONER HORN:** So...

**CHAIRMAN SANDERS:** So what if we -- I think, Commissioner Covington, I agree about the broader invitation. I'm wondering, though, if we want to first hear about the tool kit and hear, potentially, from George Sheldon, and then, do a subsequent meeting where we hear from people on different sides of the issue. Because I just want to be clear about what the interpretation is of federal law that ACF is now --

**COMMISSIONER HORN:** Yeah. And ACF did not intend with the tool kit to proactively challenge the law, but simply to clarify. And so now that he's no longer sitting in the chair, he may also have some interesting perspectives on whether there are things in the law and current regulations that he actually might think deserve to be at least looked at a second time, and have the freedom to be able to make -- express those opinions that, when he was sitting in the ACF chair, he was not.

**COMMISSIONER DREYFUS:** David, is there any way -- because I think this issue is really important. And I look at our schedule and I think there's a lot in this that could inform an awful lot of these emerging recommendations we're all working on.

Is there any way that some of this might be done with people with an open conference call line that I know would be publicly accessible, where we could engage like with the Shame report authors?

Does it all have to be waiting for in- person meetings for us to have the ability to engage with some of these authors or to get deep into, like, the confidentiality, although, that probably needs to be in person, but --

**CHAIRMAN SANDERS:** Yeah. I would say a couple of things. We'll work on proposing some times, I think, for some options. But we also, with the extension granted, I think we'll want to look at some dates after the last meeting, which we have scheduled in August.

So -- because I think there will be some -- we'll need some additional time, particularly, if we're going to spend some time in the next few meetings on accountability and on confidentiality.

**COMMISSIONER PETIT:** And the extension is to February 28th?

**CHAIRMAN SANDERS:** March --

**COMMISSIONER PETIT:** March 31st? March 18th?

So one of the things that we probably should do, whether it's today or at the next meeting, is identify what that agenda would look like in the fall. I mean, we're pretty far into this right now. Next March is almost a year away. It's 10, 11 months away, right?

So what is -- what does that allow us to do that we wouldn't have otherwise done had this been hashed out in the fall?

**CHAIRMAN SANDERS:** There's also, we've put together -- staff has put together some ideas about the beginning to what we might think of with the release of the reports. I'll share this at the end of the meeting, and then, we'll have a chance for everybody to read that and have some conversation in the next meeting, too.

**COMMISSIONER PETIT:** So David, one of the concerns that I have, and it's a concern of all the material that's been presented so far, including what I'm going to present with Jennifer in a few minutes.

What I'm concerned about so far is that we have not amassed or put in a place what the numbers are, what the stories are, what the facts are, that are drawing us to a particular conclusion. So, for example, that first chapter needs to be one that describes what's happening. I mean, what's the problem?

So I think each chapter needs to be buttressed with not just we heard, but here's what the numbers are that document what we're taking about.

**CHAIRMAN SANDERS:** Yeah. And I think that part of the idea of going through what we did yesterday was to give enough guidance to staff to begin to do that. And then, I think we'll get something in front of us and we can decide, is that adequate, is it not adequate?

**COMMISSIONER PETIT:** And it also means that with the extended time that we now have, we can do that more thoroughly.

**CHAIRMAN SANDERS:** Yes.

**COMMISSIONER COVINGTON:** Is it also possible, since we know we have three meetings coming up, to let us know what the focus of those meetings are? I mean, I heard the other day that the meeting in -- I don't know where it is -- maybe New York was already completely filled for the -- for disparities in terms of the agenda. I didn't know what --

**COMMISSIONER MARTIN:** I don't know if it's filled with the agenda.

**CHAIRMAN SANDERS:** Yeah.

**COMMISSIONER COVINGTON:** Yeah, that's what we were told.

**UNIDENTIFIED SPEAKER:** It's six hours.

**COMMISSIONER COVINGTON:** I was told it was filled, completely filled. So -- but I didn't realize that we were -- we filled our agenda with themes.

**CHAIRMAN SANDERS:** Well, we can always change the agenda.

**COMMISSIONER COVINGTON:** I'm just curious what they are. I mean, we haven't even been told what the different meetings are.

**UNIDENTIFIED SPEAKER:** Amy's going to put together everything that everybody's requested for each meeting and send it out to everybody.

**COMMISSIONER COVINGTON:** Because, I mean, there's a couple things I'd like to request, but then I find that everything's pretty packed. So I'm worried we're -- I'd just like to know where we're going in the next few months so we have a sense of it.

**CHAIRMAN SANDERS:** Yeah, that makes sense.

**COMMISSIONER PETIT:** Well, we can define where we're going.

**CHAIRMAN SANDERS:** And we can -- it really is our choice what we put on the agenda, so we can change.

**COMMISSIONER PETIT:** So, for example, one of the things that I've raised regularly and will continue to raise is being able to display visually the vast differences in outcomes and processes among the states in terms of every statistic that I've seen, removal of children from their families, substantiation rates, child fatalities, the difference between the top state and the bottom state is always multiples of a hundred percent, 100 percent, 200 percent, 300 percent.

It visually conveys how uneven the situation is. So I'm hoping that we can get into what it is that we want now that we have more breathing room, it sounds like.

**CHAIRMAN SANDERS:** And, again, that's the purpose of the conversation we had yesterday and --

**COMMISSIONER PETIT:** Yeah.

**CHAIRMAN SANDERS:** -- to begin to put something together so we can begin to decide, is this meeting the needs and what we've heard or not, so...

**COMMISSIONER DREYFUS:** Well, I think that fits to what Wade was talking about yesterday, which I thought was great when he talked about what we know, and in terms of what we know isn't just all the positive things.

What we know is we've got this wide variation. What we know is that this doesn't -- when this happens, this doesn't work, right. So I think it was a different take on how people would think about defining what we know.

And I'd hope that what you're talking about would be part of that. And one of the things we know is that we've got wide variation right now occurring, to your point.

**COMMISSIONER PETIT:** Yeah. So for me, in the beginning drafts of documents that we're going to see, there ought to be a placeholder on each page for a child -- a summary or bullet points or a graphic will go here so that we just start right from the beginning saying, how do these visuals inform the text or vice versa.

**COMMISSIONER MARTIN:** Using data.

**COMMISSIONER PETIT:** Yeah, using data. Okay.

**CHAIRMAN SANDERS:** All right. So we will lay out the next few meetings and also attend to the issues that we've talked about. We will look to schedule at least one or two meetings after August, and they may be phone conferences, as well as in between if we need to.

I believe Jennifer has joined us. Jennifer?

**COMMISSIONER PETIT:** Jennifer?

**COMMISSIONER RODRIGUEZ:** Yes. This is Jennifer.

**CHAIRMAN SANDERS:** That came across a little loud, so I think they're making some adjustments. Can you say something, Jennifer?

**COMMISSIONER RODRIGUEZ:** Yes. Good morning, everyone.

**COMMISSIONER MARTIN:** Excellent.

**CHAIRMAN SANDERS:** Great. We can hear you.

So I'll turn it over to the child protection subcommittee.

**COMMISSIONER PETIT:** So Jennifer, this is Michael. Do you have the child protection system subcommittee findings and recommendations?

**COMMISSIONER RODRIGUEZ:** I do.

**COMMISSIONER PETIT:** Okay. So we're adjusting microphones, Jennifer.

Okay. So the purpose of this subcommittee is to make, I think, recommendations that are -- would alter practice or would alter policy, but would be very specific to the kinds of short-term things that can be done to protect children from dying.

So they might have a long-term effect, but they are meant in the aggregate to launch something as quickly as the process allows to be responsive to kids who are in a particularly dangerous situations.

So why don't I kind of touch on each of these, and then, Jennifer, with each one, do you want to just jump in or any ones that you want to take the lead on in speaking to, just do that, all right?

**COMMISSIONER RODRIGUEZ:** Okay.

**COMMISSIONER PETIT:** Okay. So -- and the language on all of this is, you know, some of it would hold, some of it not.

Everybody set? Everybody have the paper?

Okay. The first piece is the leadership vacuum. And this isn't -- leadership vacuum federal level regarding investment in addressing fatalities. At this point, while there is some federal activity in this area and while there is some federal spending, it hasn't been elevated to a position of urgency or high visibility that the administration or congress is addressing.

And that's really what we're saying there is that our government, which is all of us collectively, haven't elevated this issue to one that must do, urgent response, to help protect these kids the way that we do in some other areas.

So there's different ways of expressing this. But first and foremost is, we didn't find in the course of our activities that this was given a high priority. And unless it is given a high priority, all the things that follow aren't going to be adopted, the legal changes, the protocols, the spending, et cetera.

So first and foremost, there needs to be some leadership at a federal level on this, which then extends its tentacles into all levels of state, local, private, public, nonprofit, et cetera.

Jennifer, do you want to add to that?

**COMMISSIONER RODRIGUEZ:** Well, what I think I want to add is, actually, I think everybody knows I have said (inaudible) that call the yesterday, but I was trying to jump in to say on the public health question that I actually really do support the public health approach.

I know when I exited the call, there was some controversy about --

**COMMISSIONER PETIT:** It's too loud. It's too loud.

**COMMISSIONER RODRIGUEZ:** -- whether that was the right approach or the wrong approach. And part of the reason that it resonates with me is that I think, to this point, where people had to look for leadership has been within the child welfare system.

And when I think about an approach -- and this, to me, points to who's responsible. But I just know that this issue (inaudible) presented in entirely or it's inconveniently tied up in child abuse and neglect or preventing child abuse and neglect, how (inaudible) we'll never have the capacity to actually deal with the issue.

It actually doesn't matter how much we bolster the system. It will always be a last resort to go to child welfare. Because the only intervention child welfare really has to offer is to remove children, which doesn't get us where we need to go.

So I just want to say globally that what -- while I really do appreciate the approach of saying this is not child welfare's issue. However, it's a part of the system that needs to respond to it.

But whether there is a leadership vacuum is actually not just in child welfare, but it's in all of the agencies that should be responsible for making this group of children and these (inaudible) a priority. So I think that -- this is a comment, but an overall comment.

**CHAIRMAN SANDERS:** Jennifer, we're having trouble understanding you. They're trying to make some adjustments to the speaker. I think I was able to get the gist of it, but we'll -- we'll continue to try and make modifications here.

**COMMISSIONER DREYFUS:** Jennifer, a follow-up question to that. So are you envisioning that there needs to be some -- one agency identified as a point person with some ultimate accountability and responsibility here, but also something that congress needs to do to make sure that the crosscutting federal agencies are demonstrating accountability as well to congress on this issue?

**COMMISSIONER RODRIGUEZ:** Absolutely.

**COMMISSIONER DREYFUS:** I think it's really an important distinction.

**COMMISSIONER RODRIGUEZ:** I think that part of the problem is that when you say this is - - this is a child welfare issue as opposed to whatever language we use to make it clear that child welfare is actually only one piece of this, that none of the other agencies that we actually need will ever prioritize this group and claim them as their own.

It means that every time there's a death, people will only look at child welfare as the failure instead of looking at health, at substance abuse, at mental health, at housing, at any of the other agencies that actually probably were equally responsible.

**COMMISSIONER PETIT:** So I'm not sure, Jennifer -- this is Michael -- that I got all of that, but I know what Susan asked about. Susan, I think in terms of where it goes administratively and within the federal government is the DHHS. I mean, they encompass probably 98 percent of all the federal money that's spent on child welfare, child protection.

Then, after that, there are all these committees that are comprised of the other departments, right. But I don't think it stops with where you assign it. I mean, there's a domestic policy council that needs to address this that hasn't addressed this. There's Congress, and what we've talked about.

It's not here in our recommendations, but we've discussed it and I think we need to move it into this status, Tom, was the business of an annual report and an annual hearing before the congress. There is not now an annual hearing before the Congress on how we're doing in this particular area. So no place where the citizenry can testify, no place where the department is pulled before two congressional committees and asked to explain why child abuse deaths are going up, going down or not changing at all.

**COMMISSIONER RUBIN:** Can I say something, Commissioner Petit? You know, this section of the report is probably the most provocative. I mean, sort of articulating at the federal level lack of leadership is important, and I think will be an important part of it.

But I'm wondering as we think about going down into the fall here whether there might -- we never actually received testimony -- I know we -- we spoke to the Commissioner at ACF -- about why haven't the CAPTA provisions, you know, been enforced in terms of plan of safety?

We've received a lot of testimony now from the states. I'm wondering if it might be worthwhile at some point in the fall after we finish the New York meeting to return to Washington, actually identify folks within the administration or in congress and actually call them to testify and prepare for that meeting to really probe why it is we've gotten to this place, so that it can reinforce some of the recommendations you make as part of this subcommittee. It might help strengthen them. You know, just a suggestion.

**COMMISSIONER PETIT:** Yeah. I think there is some -- I think there's some utility to that. I would say, first and foremost, this is not a political priority. And I don't mean political in a partisan way. I mean in a nonpartisan way.

And until the electeds actually think this is something that needs to be dealt with by them, all the machinations and work by mid level bureaucrats in a single state agency -- a federal agency, in my mind, is not going to move this enough.

**COMMISSIONER HORN:** So a 30-second history lesson that I think gets straight to the point. When President Taft created the Children's Bureau back in the early part of the 20th century and appointed Julia Lathrop as the head of the Children's Bureau, she had a direct reporting relationship to the president of the United States.

Today, the Children's Bureau head reports to the Commissioner for the Administration on Children, Youth and Families, who reports to the assistant secretary of the Administration on Children and Families, who reports to the secretary of HHS, who reports to the president.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER HORN:** It just illustrates how less of a priority this issue has become in a hundred years. We are not making progress on this. We are going backward.

**COMMISSIONER PETIT:** Yeah. So I've mentioned -- we all are familiar with the fact that on the 50th anniversary of the Children's Bureau's founding, the speaker was John F. Kennedy. And 50 years later, the speaker was an administrator within the Department of Health and Human Services.

So it's an issue that deserves higher attention. And I think our speaking to it in an urgent kind of manner, how urgent this is to these children and elevating this, will serve well.

The other piece related to this, Tom, that we talked about yesterday that I think needs to be added on here is the DOJ type like intervention by the federal government if a state is really performing poorly, children are dying, and there are not serious efforts being made locally at a state level to do this.

So we have a situation like Ferguson which we all understand DOJ comes in and says, hey, there's federal law, you guys aren't in compliance with it, we need for you to do better. There's the same thing that we have going now with all the standards within HHS. There are a bunch of standards and criteria that the states are supposed to meet. And the vehicle is clearly not working at this point.

So one of the things that we're talking about is this business of compliance with national standards, that this is a national issue with the states playing a critical operational role, but there's a critical national role on this as well. So beneath --

**CHAIRMAN SANDERS:** Is that -- is that actually one of the recommendations or is that --

**COMMISSIONER PETIT:** I think Jennifer and I and Bud Cramer talked about it. I think we drew a conclusion on it. We've talked about it here, but Jennifer, weigh in on this, this notion of the ability of the federal government to come into a state and determine whether or not --

**CHAIRMAN SANDERS:** Well, I'm just thinking procedurally, it would be helpful to have it written down as one of the recommendations.

**COMMISSIONER PETIT:** No, no, I agree. And that's why you heard me say to Tom to add it to the list. We've talked about it, it just didn't -- it's not in here. It should be in here, just as the other issue is about congressional hearings and annual reports by DHHS on this thing.

There's a blank on the next page. Item F says, you know, write it out, but that was kind of like the placeholder for it.

And then, there are -- Jennifer, did you want to add to that?

**COMMISSIONER RODRIGUEZ:** No.

**COMMISSIONER PETIT:** Okay. Then --

**COMMISSIONER RODRIGUEZ:** I'm going to try to add as little as possible because I know you all are having trouble hearing me.

**COMMISSIONER HORN:** David, are you planning on --

**COMMISSIONER PETIT:** It's Michael.

**COMMISSIONER HORN:** Michael. Sorry. Michael.

**COMMISSIONER PETIT:** David, Michael, it's all the same.

**COMMISSIONER HORN:** You know, I forget my kids' names, too. So are you planning on -- are you going through these eight, and then, going in more detail? Because I actually have a comment.

**COMMISSIONER PETIT:** Yeah. I think this is the time and place. I mean, let's comment on each of the ones that fall. I don't need to necessarily introduce them if you've already got comments on them. Is that what you're saying?

**COMMISSIONER HORN:** Yes, I've got comments on --

**COMMISSIONER PETIT:** No, no. Let's do that right now.

**COMMISSIONER HORN:** So on Number 1, I completely agree with you about NCANDS needing more information. One of the things that's frustrating is that NCANDS should be the repository of a lot of this information, and yet, a lot of information is missing.

And so I completely agree with you, we need more information about the children who die from abuse and neglect. I also think we need more information about the perpetrators.

**COMMISSIONER PETIT:** Okay. So -- but let me just say something on that. If you have not all seen it, it is extremely noteworthy to see what the responses are that we got from health and human services in response to a number of questions.

And what we got back with questions like, who, how, what, where, when, is, we don't know, we haven't researched it, we haven't spent money on it. Very fundamental basic questions as far as I'm concerned. If you were running the operation, you'd say, I need to know these things.

They are saying they don't have the information, they don't collect the information, they haven't funded research in it, period. And then, it just goes on. Not we'll look at it, we'll get into it, but we don't do it. So I think -- so I think your point is well taken and we're very mindful of it.

But, David, if everybody hasn't received it -- Liz, has that been distributed to everybody?

**LIZ OPPENHEIM:** It has been.

**COMMISSIONER PETIT:** Yeah. I mean, I think it's worthy of an actual read through if you want to elevate your blood pressure for a few points so...

**CHAIRMAN SANDERS:** I know there's a couple of questions. I just want to make sure.

Jennifer, we can at least make out the gist of what you're saying, so if you have input, it's important for you to weigh in. I think David and --

**COMMISSIONER RUBIN:** Yeah. I was just going to say, I think this is an important -- the issue of NCANDS is an important branch point --

**COMMISSIONER PETIT:** What Wade was -- were you done?

**COMMISSIONER HORN:** So I just would like to recommend that you incorporate information about perpetrators with the same sort of level of detail of the --

**COMMISSIONER PETIT:** Right. Tom, you have that?

**TOM MORTON:** I'm sorry?

**COMMISSIONER PETIT:** The perpetrators, incorporate?

**TOM MORTON:** Yes, I do.

**COMMISSIONER PETIT:** Yeah. Okay.

**COMMISSIONER RUBIN:** I was just going to say, I think the issue of NCANDS is an important branch point. I just want to make sure we have time to discuss that. Because earlier on in our hearings, there was a decision of, are we doubling down on NCANDS as the repository of this information or are we saying that NCANDS is inherently flawed as a collection system for deaths on child abuse neglect fatalities, that this needs to be organized closer to vital statistics?

And I don't remember us fully vetting that out to decide where does this belong, ultimately, in terms of measurement.

**COMMISSIONER COVINGTON:** Well, we have recommendations in the measurement committee that address that. But, you know, the NCANDS was a piece of it, but we were using another system. Really, we were proposing another system that would collect more comprehensive information on it.

For me, as I look at this one, I'm just wondering since we all complain about NCANDS all the time if we even want a stronger recommendation about NCANDS generally in terms of the priority that gets placed on it and, you know, the whole piece about it being voluntary and states can choose to use it or not use it.

**COMMISSIONER PETIT:** Right. So we should --

**COMMISSIONER MARTIN:** I mean, I think that's the first thing.

**COMMISSIONER PETIT:** Yeah. So we should speak to that being voluntary -- I mean, involuntary. It should be a requirement of receiving federal money. It's not voluntary.

**COMMISSIONER COVINGTON:** I mean, even if they expand the data that they want to try to collect, we're still left with the same mess we have now, which is states can just not collect it.

**CHAIRMAN SANDERS:** But we already incorporated that into the measurement recommendation. I mean, that would be included. So --

**COMMISSIONER PETIT:** Yes.

**COMMISSIONER DREYFUS:** So what about differing definitions by states? You know, we have talked about, is it time for there to be more --

**COMMISSIONER PETIT:** Standardize it.

**CHAIRMAN SANDERS:** In the measurement committee, we recommend one, that there is a federal definition.

**COMMISSIONER COVINGTON:** What we could do is move -- take this and play with it in the measurement committee and add some weight to it for you., add a perpetrator piece and the --

**COMMISSIONER PETIT:** But I would just say, as a general rule, I wouldn't take the position of throw the bums out. I think that what we need to do is make it work. And what incrementally can we add to something that makes it work without somebody saying, we need to do reorganization charts all over again, we need to have hearings on that, we need to write statutes, rules, regulations. And five years from now, they'll be up and ready and ready to go.

I mean, there are some things we know we want NCANDS to do. It's not funded adequately. It's not involuntary. I mean, there's some specifics that we know already that either the people that are there now change them or they just add new people who know that they're supposed to change them. So I think this one is more -- it's less legal and more administrative.

**CHAIRMAN SANDERS:** And I think this is one of the areas where, as the draft is being done, we can look at where --

**COMMISSIONER PETIT:** Yeah. Yeah.

**CHAIRMAN SANDERS:** -- this best fits, and then, incorporate those recommendations, and then, decide --

**COMMISSIONER PETIT:** Yeah.

**CHAIRMAN SANDERS:** -- where we want to go.

**COMMISSIONER PETIT:** You got another one, Wade?

**COMMISSIONER HORN:** And so also, under federal accountability, so this is something that the public policy subcommittee is also looking at, but I just want to sort of as a place holder --

**COMMISSIONER PETIT:** Is this E you're looking at?

**COMMISSIONER HORN:** E, yeah.

**COMMISSIONER PETIT:** The second page for everybody else, E.

**COMMISSIONER COVINGTON:** Where is there an E?

**COMMISSIONER PETIT:** E on the second page.

**COMMISSIONER HORN:** I thought they were about to go on to Number 2, so I was just --

**COMMISSIONER PETIT:** Item 1, item E sub E.

**COMMISSIONER HORN:** So I think that -- I think to David's point -- I got the name right this time -- David, I think we do need to have a better understanding about why the provisions -- the enforcement provisions within CAPTA have not been enforced, and maybe some state perspective.

I'm not sure we need, you know, 16 state representatives here. But would they even be effective given how little money there is in CAPTA? But I do think there is a very legitimate federal responsibility to enforce the law, and that I don't think at the moment that the law's being enforced.

**COMMISSIONER DREYFUS:** Other than litigation.

**COMMISSIONER HORN:** Right. And so what we -- that's a great point. So what we have done is advocated the enforcement of the law to advocates and to the courts. And I think that we should make a very strong statement that it's the responsibility of the executive branch, whoever holds it, whoever is in charge of the executive branch, to enforce the laws and the requirements under the statute. So I think we need a very strong recommendation there.

**COMMISSIONER DREYFUS:** And when you say that, you're talking beyond CAPTA, you're talking about the protections and the Social Security Act title IV and --

**COMMISSIONER HORN:** Yes.

**COMMISSIONER DREYFUS:** Okay.

**COMMISSIONER PETIT:** So, Tom, you got that on this piece? Yeah. No, I can't tell sometimes. He's scribbling and some of it's in here, some of it's not.

**CHAIRMAN SANDERS:** And, Michael, I have a couple of other things in this area. It seems, I think, the finding of the lack of leadership is really a critical one. There are a couple of pieces that I think potentially fall under this, although it may fall under someplace else.

One is I think that there -- we talked about the aviation industry yesterday. And I think some responsibility for understanding this issue beyond what's reported to states. And I think one opportunity is for the federal government to be more directly involved in some of the actual investigations or reviews of what happened.

**COMMISSIONER PETIT:** Yes.

**CHAIRMAN SANDERS:** And then, secondly, some responsibility to spread practices and not just to gather the information, but to assure that -- that the -- the variation that we see from state to state is minimized --

**COMMISSIONER PETIT:** Absolutely.

**CHAIRMAN SANDERS:** -- because there's practices that are spread.

**COMMISSIONER PETIT:** Yeah. You know, look, there will never be, you know, federal employees running child welfare locally. You know, that's -- no one is ever going to want to do that. That's going to be a state function.

But there are things that we do know that, by virtue of these children's birthright, being American first, Mississippi second, Texas second, Maine second, the first is that the FAA, there isn't -- there aren't 50 state FAAs that look into these things. It's a federal because they amass more knowledge.

So I think that's the principle that we're talking about here in terms of that. Also, the DOJ parallel, that if there's a need to go in, which, you know, the feds are always slow to act on those things as they should, they should act with restraint, but if they need to go in, they go in. If some state is really ignoring its responsibilities in this area and they have consistently bad outcomes --

**CHAIRMAN SANDERS:** But I'm actually suggesting something different. That they have a responsibility to actually be part of investigating some kinds of -- there are some situations that it would be helpful to have a national perspective on why did this happen in Arkansas and Kansas and Texas versus what's happening now state by state. So it's not necessarily just stepping in when there's a crisis, but a responsibility --

**COMMISSIONER PETIT:** Right, right, right.

**COMMISSIONER DREYFUS:** But then turning those -- but then turning that into knowledge that creates a continuous quality improvement loop that the federal government's involved in. I think one thing that's really important here is we've got to be careful that people read things like this and they go on the pendulum swings, widely left, widely right, state's rights, federal take over. We're talking about the effectuation of what is the federal/state partnership?

**COMMISSIONER PETIT:** Balance.

**COMMISSIONER DREYFUS:** And I think we've got to be really clear about that or people will swing.

**COMMISSIONER PETIT:** Yeah. Yeah.

**COMMISSIONER COVINGTON:** Or turn off completely to what we're saying.

**COMMISSIONER PETIT:** Yeah. But I do think we have these other parallels, the way the other systems work to protect people, whether it's the fire department going out on an all-calls, whether it's the FAA doing these reviews, whether it's DOJ coming in, there is a vehicle in many other areas where the federal government can assert itself.

And we're saying in this case, both in terms of spreading knowledge and evaluating and discovering something in Idaho that, if any of you have this provision of the law, get rid of it

because it's guaranteed to kill a kid, then that would be a useful role for the federal government to play, right?

And there are -- there are some things that are like that. You know, Idaho is a long way from here. Actually, I like Idaho. It has great fishing.

**COMMISSIONER HORN:** Just one last thing, and then, I'll be quiet. I also -- and I know we're now wordsmithing the actual text, but I just want to point out that phrases like there's a leadership vacuum at the federal level is unlikely to win friends and influence people.

**COMMISSIONER PETIT:** Right. I agree.

**COMMISSIONER HORN:** And so I think that we should think as we write this that more -- you know, there's a need for enhanced federal leadership.

**COMMISSIONER DREYFUS:** The federal/state partnership.

**COMMISSIONER HORN:** Yes. Exactly.

**COMMISSIONER DREYFUS:** And the role that the federal government in this, as well as the role of the states. I think it's in that frame.

**COMMISSIONER PETIT:** Wade, given the time frame, I went -- and maybe Jennifer and Bud feel the same way, I think they probably do, but we went with just kind of what was here for the moment, knowing that, for example, we're not going to lead with a negative, we'll lead with a positive on it.

So there is a role -- there is a critical role that the federal government needs to take on this thing, so we'll start out positive and, you know, modify accordingly.

**COMMISSIONER COVINGTON:** In the --

**COMMISSIONER PETIT:** No. But, I mean, it will be crystal clear, I think, what we're saying. But it can be, I think, presented in a way that's not -- that doesn't immediately put them on the defensive.

**COMMISSIONER RUBIN:** Yeah. If we're coalescing around state plans and state flexibility as well, too, you have this enhanced enforcement at the federal level, but you also have a lot that's going to be in our plan that's around states determining how they're going to position their resources. And so, I think that -- I think it works nicely, honestly.

**COMMISSIONER PETIT:** Right. So does anybody --

**COMMISSIONER RODRIGUEZ:** And I think it's also consistent with what we've heard from the public hearings in states, which is that there's really a knowledge vacuum in the states about what safety critical practice looks like, what interventions are effective, what the research says or doesn't say.

And so that those -- this is an area where it's important enough for the federal government to step up and be more prescriptive and set more parameters and actually try to get services

and policies and programs more consistent across the states, based on the little that we do know.

**COMMISSIONER DREYFUS:** She just said something that I think is really important that is, I think, is an additive to this. And that is something that I've really been struck with during our time together.

And that is, as a child welfare administrator, I think about how hard it is to really be using evidence-based policy, evidence- based practice, from the standpoint of what the research is telling us, and how do you dissect that research and look at it through the lens of, okay, what do I do with it?

I mean, we do it all the time in medicine, right? It's how medicine rolls. But we don't do it in the, quote, unquote, social service world as readily. And I'm just wondering if there's not something here as it relates to the role of the federal government. And I don't know if it belongs here or someplace else. I just hope it gets parking lot somewhere.

**COMMISSIONER PETIT:** Can you state what it is?

**COMMISSIONER DREYFUS:** I think it's more than just about do more in research. I think it's more about this role of the evaluation of research to practice, research to policy, right? And a larger role that the federal government plays in that. Because I do think that is a vacuum.

I've been struck with all the research that our great staff have been giving us to read, and it's like, why didn't I know that? Why didn't I know that? Why -- you know, and I think it could be really helpful. But it's got to be able to be applied. Not just don't just send me the link to a research article, help me with the application.

**COMMISSIONER PETIT:** So the letter that we received from HHS would confirm what you just said in terms of there does exist certain knowledge or the knowledge hasn't been collected when people say they need it and want it. And, I mean, it was a very disappointing response because it failed to address just these kinds of questions that you're raising and how to implement them. So we'll so note.

Jennifer, anyone here have anything more on this first item?

Tom, was there any more that you wanted to add here? No.

Go on to item -- oh, well, let me just say, the piece in D, 1D, the absence of a national registry, et cetera, more information sharing, is that being dealt with by another committee? That came up again yesterday, sharing of information. Didn't you bring that up?

**COMMISSIONER DREYFUS:** That came up yesterday about the ability to share across states.

**COMMISSIONER PETIT:** Yeah. But the business to -- when one government agency is conducting an investigation of somebody and they need help from another government agency, the default position should be it can be shared. And then, where can it be shared? I mean, when do you depart from that? So I just --

**COMMISSIONER DREYFUS:** That has been an issue here.

**COMMISSIONER PETIT:** Yeah. I just didn't know if that was being dealt with by another committee. But we've raised this issue, this is this business about confidential case practice level information.

**COMMISSIONER RUBIN:** Just a small point. Just so I know that some of this will go back to measuring. If we're going to look to reinforce NCANDS, this is an area that I think we should be -- I agree with you, Commissioner Covington, we should be more explicit about exact -- you know, what I learned from the testimony speaking about evidence-based policy, particularly the articles you guys did up in Michigan, I think we should define the data sources that actually have to be linked in order to classify child abuse -- like that it surprised me just how variable it is across the states.

Some states are doing very little; some states are linking four or five different data sets. The data is clear. The more you link, the more you classify, right?

And I think we should be very explicit and we should, again, get rid of the optional requirements for -- if we're basing this on NCANDS, we need to be extremely detailed in what we're asking for in legislation.

**COMMISSIONER DREYFUS:** On this interstate issue and what APHSA think has just done a wonderful job with NESE. I don't know how many of you are aware of this, but the federal government funded it. Wade, are you aware of it?

The federal government did fund it. And it, basically, I think, has created a wonderful way of making sure that home studies are being done, you know, quickly in receiving states to really expedite the move of children between states when they're being placed elsewhere or permanency is elsewhere.

And I'm wondering if there is not a connection here to that system on this issue of data sharing across states. I don't think the issue is just county by county. I think we've got to also look at this state to state.

**COMMISSIONER COVINGTON:** I don't know if it's something you'd want to address, but I know one of the issues that I've heard from states is, it's not just a matter of being able to call a state and say, did you have Johnny in your state, but it's being able to go to a source that would do that. Because states have to shop around and figure out where Johnny went sometimes.

And there isn't a way in a unified -- and I don't know if that's what you're getting at here, Michael, or not. But there isn't a way, uniformly, for a state to very much more simply without a whole lot of labor, go and find where Johnny and his family moved to without going, you know -- going state by state. And then, every once in a while, you'll hit a state that you don't have an interstate compact with and then --

**COMMISSIONER PETIT:** We're working backwards from the objective. I mean, the objective is to not lose the trail of children that are in households where something could happen. So how do you assure that when you cross a state boundary, you're not leaving a trail behind you or you are leaving a trail behind you?

**COMMISSIONER COVINGTON:** But is the recommendation saying to establish a national registry or to just allow data sharing among the states? Because those are very different.

**COMMISSIONER PETIT:** I think it's more of the latter. I don't think our committee, Jennifer, discussed a national registry, and I don't know if we have as a group here. I haven't heard the case for it or against it. I mean I would know what some of that is. But is it something that's worth looking at, David?

Is Cassie on the line?

**LIZ OPPENHEIM:** There was a study done on the feasibility of a national child abuse registry done by ASPE was a couple years ago. It was sent to Congress and it was --

**COMMISSIONER PETIT:** Could we get a summary of it? Could we get a summary of it, and then, maybe put it on the agenda?

**LIZ OPPENHEIM:** It was. There's too many due process issues. At least, too many protection issues --

**COMMISSIONER COVINGTON:** They vary by state.

**COMMISSIONER PETIT:** That's in terms of registry. But if you end up with just voluntary exchange of information between states without beefing up their capacity, you'll have some states that will do it and some states that won't.

Do we have records of children killed under those circumstances? I mean, when I guess they talked about using a specific case to inform each of our major conclusions of findings, this could be one where we showed that when the kid went from Minnesota to Wisconsin, they lost the protective mantel of the state.

**COMMISSIONER MARTIN:** I think that that's a great thing to do because it's very difficult in a court building when you are losing kids across Indiana's line or Iowa's line, Wisconsin's line.

But I was just going to say, do we have any indication the number of children that we think have died due to moving from Illinois to Indiana and Indiana not knowing and no follow up?

**COMMISSIONER PETIT:** I don't --

**COMMISSIONER MARTIN:** I mean, because I think -- and I don't mean to be too critical, but I think our recommendations have to go to where the biggest problems are that we find.

And so as much as I appreciate something like this, because I can't tell you how often I'm calling and begging CASA to go do, you know, a quasi home study to find out, you know, where people are, but I just need to make certain that it's well grounded in what we're supposed to be doing.

**COMMISSIONER PETIT:** Yeah. I agree. And I don't know if, Teri, when you talked before about describing what the cause of deaths and what the circumstances were, if we could do a run on this particular question.

But, Judge, I don't think it matters too much whether there's 1 or 50. I mean, I think that in the end, we want a capacity to protect every child, right? But we don't know what it is in this case. So, I mean, it would be helpful.

My guess, Tom, is if you ran through all those stories that you've given to us in the last year, which have been hundreds and hundreds, if not a thousand, somewhere in there there's a case or cases where they were crossing lines and nobody was tracking them.

But has there been a report on that? Anybody got any numbers on it?

**CHAIRMAN SANDERS:** I think we just -- we'll need to look to see, because I think it's -- I'm not aware of anything. That doesn't mean it hasn't happened.

**COMMISSIONER COVINGTON:** I mean, anecdotally, I know through child death review you hear about it -- not rarely, often enough, certainly, but I don't know that it's something that is such a huge issue. But it is an issue.

**COMMISSIONER PETIT:** Yeah. If you're a kid being dragged from state to state and you're in trouble, you want somebody to be looking out for you. All right. So --

**COMMISSIONER DREYFUS:** But I do think to Judge's point, I always envision -- and you can correct me if I'm wrong here -- I always envision, there are going to be some really core recommendations that are just a straight shot to what it's going to take to eliminate fatalities from abuse and neglect in our nation.

But then, I'm going to envision -- I'm going to use the wrong term here -- but I envision another set that are almost like these protective factors that we talk about, that these things that start to form an inoculation, right, to kids falling in -- it's like Wade's funnel, right, those protective things that are going to keep kids from falling further in.

And I would liken this to that point. But I think Judge Martin makes a really good point, but let's be really clear that to stop this, right, there is some really core critical things. And it should not be a laundry list. It should be really core and a few and actionable.

But I don't think we should stop at not being clear what we've learned to be some of these protective factors that stop the flow of kids into that funnel.

**COMMISSIONER RUBIN:** Yeah. I'm going to follow that reasoning there. You know, I think this is like for the early chapter. Because I think we should start out -- the recommendations that we start out with here, what will it look like if we -- what is the vision of what we're trying to accomplish? And then, the recommendations that get very specific are intended -- because we defined -- we diagnosed, and then, defined sort of the recommendations that get us to that vision.

So we have this vision, and we'll see it carried down here, of all the states having a high level of effective coordination across their different public systems. We have a vision that when folks invest -- when folks are providing services for high risk families, that there's a tight level of communication and coordination and integration into -- into -- so we should define all those things.

We have visions around ensuring that disproportionality does not increase, rather to some degree that maybe we improve the issue of disproportionality.

And so we should list all those -- that's chapter one for me, because those are the - - that's what we're -- that's what we're trying to get to. And there is law enforcement stuff as well, too.

So figuring out what that is, that will then sort of lead into the next chapters, because the next chapters are really saying, how are we going to get there?

**COMMISSIONER PETIT:** Right.

**TOM MORTON:** Commissioners, this is somewhat anecdotal. But I am aware of cases that are somewhat related to this, and that is cases where in divorce and child custody, a child is moved from the custody of a parent in one state to the custody of a parent in another state and is killed by the parent in the other state. And that happens with some degree of frequency.

So as you're thinking about upstream the whole issue of evaluating the safety of children in child custody decisions, and divorce kind of comes into play here.

Obviously, we don't have hundreds of deaths in those circumstances, but I hear more about that incident and I've seen it up close and personal as a director of a child welfare agency. For example, a death of RJ Arrington in Las Vegas where the child moved from the father's home in Chicago to Las Vegas and subsequently was killed.

**COMMISSIONER PETIT:** But I think all that we're saying with this is that wherever children are, they should receive protection. And how do you assure that information is transferred from one jurisdiction to the other in a timely manner?

So move on to the second item?

This is the focus on the quality of safety critical practices and current quality assurance efforts at the state and local level is limited, if not mostly nonexistent.

Jennifer, did you want to speak to this or, Tom, do you want to speak to this? In terms quality. We don't have much under here, but it's --

**COMMISSIONER RODRIGUEZ:** I think that the presentation yesterday was a really good sort of example of the way that other industries have actually thought about quality assurance and sort of carefully dissect the way that they structure both their policy and practice to ensure that safety is paramount.

And so, I mean, I think all that we're saying here is that when it comes to dealing with children and safety, we have not done anything close to that. We typically jump to sort of when there's a failure, to the same set of solutions, without identifying if those are really what were responsible for causing the issue.

And so, I mean, I thought, you know, the example that -- at the end of the presentation around, you know, and has -- it's the presenter's specific system where he said, you know, we

could have a caseload set at a certain level, however, the issue that we're really experiencing is this turn over within that, is a really good example of, you know, if you don't have some sort of quality assurance mechanism, you never get to figure out what is actually at the root of whatever is happening.

**TOM MORTON:** Commissioners, when Chairman Sanders first brought me on the Commission staff, he asked me to actually look into how different systems define critical safety practices or safety critical practices. And I did a small sample of interviews with judges and law enforcement, but a larger sample with child welfare administrators.

What I found was there was no consistency in the answers that I got from child welfare administrators as to what they considered safety critical practices. And in many cases, I would say having spent a lot of time on safety as an artifact of child welfare, many safety critical practices were not identified by the interviewees.

The only example that I found in the history of the Commission so far of specific QA of safety critical practices was in Oregon. And as a result of their critical incident review team process, they identified deficiencies in how staff were performing a number of safety critical practices, and began a process of quality assurance of those practices.

I think what you'll find -- and the reason it's worded the way it is now -- is that most quality assurance is compliance driven and measures did something occur. For example, was a safety assessment completed within the policy required time frame, rather than what was the quality of the safety assessment? Or were child contacts made every 30 days as opposed to what was the quality of the contact and what was discussed?

**COMMISSIONER PETIT:** Tom, in terms of the writing of this thing -- and I think we should apply this across it -- if the average person reading a topic can't figure out what is implied by it, then I think we should prepare something else. I have trouble myself with this language. I mean, I don't really know what it means. There's no nouns. There's no -- you know, it's not concrete enough. So that's a separate thing. We'll talk about assembling that. Okay.

Is there anything more on this particular piece?

**COMMISSIONER DREYFUS:** Just to follow up with Tom.

So Tom, is that -- getting to the specificity of recommendations, do you believe today in the current CFSR when the feds pull the cases that they're going to review, do you review the quality of those critical safety practices is being reviewed in those cases, or just their compliance with a visit every 30 days with the example you gave?

**TOM MORTON:** I think there is an attention to some practices, and it is qualitatively focused. But the CSFR case review at the federal level happens once every four years in contrast to what we saw in Hillsborough County where they're reviewing high profile cases regularly and providing realtime feedback within 24 hours of observing a deficiency.

So whatever is done in the CFSR is not realtime in terms of feedback and identification of problems. And I think if you were to look into healthcare settings, for example -- I think Dr.

Rubin might verify this -- that many of the safety critical practice review processes that are in place in hospitals provide much more timely feedback.

**COMMISSIONER DREYFUS:** I just want to really say, I think it's important that when we talk about the compliance, the accountability and the compliance with federal law, the issue of compliance and quality, right?

I can't tell you how many child deaths I have reviewed where we did everything, quote, unquote, right. We were in the home; the problem was the caseworker, best of intentions, didn't see each child or the child was sleeping underneath the covers and didn't pull the covers back to look at the child or didn't interview the children separate from the caregivers. You know what I'm saying? So this quality issue, I think, is really important, and maybe it comes under this issue of accountability, but --

**COMMISSIONER RUBIN:** My reaction to the testimony yesterday on safety -- you know, first of all, you have folks who are making a lot of nice comments about my colleagues. I think it's - - some of it's more myth than reality in terms of how much we base on evidence or how truly strong a lot of our safety cultures are in the hospital. I think we're improving, but I wouldn't say we're there yet.

But I will say, you know, I was struck by the thought when we -- there were some really important elements that were discussed in that safety lecture yesterday about the confidential reporting system to allow people to really improve and do it in a non-punitive sort of way, how you - -

**COMMISSIONER DREYFUS:** Debriefings.

**COMMISSIONER RUBIN:** Yeah, the debriefings. And I sort of think the quality service reviews, which we may hear about in Utah, kind of do a similar type of thing. It's constructive. The same time I found myself wondering, with hospitals, there -- you know, that are governed by HIPAA and everything else, there is a strong protection there to -- and a sense that that's not going to end up in the media.

And I wonder about the perception that if we instill this, how that -- you know, there is such a galvanizing of the media any time a child dies in the child welfare system that the idea that we're enforcing practices that actually have very pragmatic -- that are very pragmatic and important could also be perceived by others as trying to hide information about what's happening to children.

**COMMISSIONER DREYFUS:** Isn't that what the legislation did on the culture of safety that they passed here? Isn't that what that legislation did is it gave that protection?

**COMMISSIONER COVINGTON:** Well, I asked that question, you remember, at the very end, and they said it was -- that they can disclose, and they fully disclose, they just take away -- they take identifiers off. They sort of felt that they had done both.

**CHAIRMAN SANDERS:** Michael and Jennifer, I do wonder -- when I read this, I'm not -- I think what Tom described is helpful. When I read this, I wonder, well, there are CSFRs. A lot of

states would say that's what they -- so I think we might want to think about either incorporating this some place else or --

**COMMISSIONER PETIT:** Yes. Yes. We will. We will. We will.

All right. Ready to go to Number 3?

I mean, this -- we have several recommendations that are very -- will be very concretely spelled out. This is one of them in which we're talking about a multi team approach being brought to certain cases early on right up front so that the department, CPS, is not by itself defining what the treatment or intervention strategy should be, but if it meets certain criteria, other parties are brought in, whether it's medical or mental health, substance abuse, law enforcement, whatever it happens to be. There's a team of people that look at these cases more comprehensively right from the beginning.

**COMMISSIONER DREYFUS:** Define "right from the beginning".

**COMMISSIONER PETIT:** The department gets a call. They send out a CPS worker, which is what they would do today. Today, they wouldn't be doing it jointly with law enforcement or public health nurse, but they could in the future. And that's one of the recommendations that we've got coming up.

But in this particular case, the 25-year old worker goes out, they do a look of what -- like you just described, it says, cursory or it says shortcoming in it -- shortfall as you just described the case that you had, and that case would then be presented to a multidisciplinary team at a CAC.

CAC might convene a group, but they would say, what is the full range of responses that we should be giving to this case? So that there would be an activated process in a jurisdiction, once CPS says something is going on, where we've substantiated something, we now want to meet with a group of people to put together what the case plan should be.

**COMMISSIONER DREYFUS:** Well, the reason I asked that is when I read this, what my head went to, and it was something validated here yesterday, this whole issue of the checks and balance issue. And I think it's not -- it's not a one size fits all.

I think there are a range of ways in which checks and balances need to occur. We heard here how they have a hundred percent redundancy on all intakes, screen out decisions, right.

**COMMISSIONER COVINGTON:** I love that.

**COMMISSIONER DREYFUS:** A supervisor reviews it, and then, the supervisor's supervisor reviews it, right? That is a really great practice. I mean, if I were sitting in a child welfare agency today, I'd be implementing that tomorrow.

So I'm wondering here on this issue of checks and balance, check on the system, this is important where you're really identifying a really high risk, but are there -- is there a range of --

**COMMISSIONER PETIT:** Well, yeah, I mean, it would be. Yeah, depending on what the finding was, whether it was one pertaining to sexual abuse or whatever it happened to be, you'd bring together the right team that would take a look at it and create whatever the intervention strategy was on it. So --

**COMMISSIONER DREYFUS:** But I'm just saying, not everything requires a team.

**COMMISSIONER PETIT:** No. I'm saying the ones that do require a team. And then, the ones that don't require a team, sure, we're -- again, you're talking about case practice and how you manage something that might be in a different category than this one.

This one is one that's meant to address, bring in a squadron of people because you don't have it all figured out by yourself. This piece that you're describing, is there a point, you know, where the supervisor reviews and the supervisor's supervisor reviews, where does that end? Does it end with a multidisciplinary team or does the department just deal with it on its own?

In some cases, the department is going to know they've got it under control. In other cases, they know that they need other people in. In other cases, they don't know they need other people in, but they do need other people in.

**COMMISSIONER DREYFUS:** So while it's my opinion -- I just don't want to say it's everybody else's opinion here in the room -- I'm just saying, is there a finding of the Commission that there is a -- that there's -- there is a lack of the necessary checks and balance throughout the system?

There's examples of it today, courts, right, are definitely part of that. So we have to talk about where it exists today, but also where it's not and how we have seen examples of the improvement of that from, like, the redundancy issue that I just brought up, up to and including these multidisciplinary reviews on these cases that are identified at this higher level of risk.

**COMMISSIONER COVINGTON:** And I --

**COMMISSIONER MARTIN:** So this is my issue that I was trying to articulate yesterday. And that is, when do we know that we have this situation? Because if we're relying on the agency to voluntarily say this case is too much for me, I don't see that happening very often. I just don't see the -- you know, and maybe they will. I've never been a director of an agency, although, I've worked closely with social workers for years.

But I just can't imagine the agency voluntarily saying, the circumstances of this case are so dire that I don't think we have the resources in which to evaluate and assess the risk for these children and this families.

**COMMISSIONER COVINGTON:** Can I give an example? Like Michigan, there is a -- I don't know if some of you know, Steve Yeager presented to us. He now is deputy director, I think, at the department, but he started out as a lowly CPS worker when I first met him.

And they were looking at child fatalities that had just been under the purview of CPS. And he said, you know, this is kind of crazy. I could really use some help when a hard case comes to my table, you know.

And all they did was they started creating a team of people who volunteered and said, I'm willing to be a second voice for you or second eye -- set of eyes. And when a case came in to a worker that seemed complicated or complex or they weren't sure what to do with it, they just had a phone call case conference where they involved law enforcement, they involved mental health, they might have involved substance abuse, depending on what was going on in that family.

And it changed everything. It wasn't like there was -- they had to worry about where the line was, but they just kind of knew this family had complex issues, perhaps, or it was a substance using mom so they knew to bring in the substance abuse agency to kind of create a more -- a more team involved case conversation. It just seemed to work better.

It's not like they had this formal team that met on every single case, but they --

**COMMISSIONER PETIT:** Isn't that what the CACs are doing?

**COMMISSIONER COVINGTON:** Yes.

**COMMISSIONER PETIT:** I mean, largely, that's just what they're doing. So they must have a process where, if they think something's low grade, it doesn't come into the full group.

**COMMISSIONER MARTIN:** But we heard them. In Arizona, we heard that they look at every case. They look at every case and they make a determination. They start talking about the kids that were on the street for truancy. They start looking at those families.

And then, the CAC that we went to yesterday, which is, I think, a more -- more universal way that they work, they depend on referrals from the pros- -- from the law enforcement or child welfare. I mean, that's how they get their cases.

So I'm just concerned that we're putting -- we're saying that there's a problem that the child protection agency is not the sole source of the governance of these cases, but then we're going right back and putting it back in their lap again.

**COMMISSIONER DREYFUS:** But, Judge, let me ask you this. So in Wisconsin, I hope we're going to hear from the child protection center and the great work they've done over many, many years in advancing something called cart teams. They've identified -- and I think it's five or six -- predictive factors as they reviewed past cases, right, that when present, needed cart review.

So instead of leaving it to the whim of that caseworker, his or her supervisor just say, here's a case we should take to multidisciplinary review, the system triggers those cases that must be reviewed.

Now, you can always bring other cases to cart, right, but you don't have an option not to bring those cases to cart. And that's the memorandum of understanding that exists between healthcare, law enforcement, education, who all then get together and review those cases. Is that really what you're kind of getting at?

**COMMISSIONER MARTIN:** I don't know if that's the process we should recommend. All I'm saying is that we have to be very clear about when it's triggered that this MDT program kicks in.

I don't know -- I mean, to my own liking -- excuse me, I'm sorry -- I would almost prefer that there's an initial assessment done by a multidisciplinary team. I know that's expensive. I know, you know, it's almost unheard of to think that we would do something like that, because there are a lot of cases that won't need it, and I appreciate that. But I don't know if you're going to know what case needs it until you start assessing the family.

And so -- and so, rather than, you know, allowing for holes and getting -- not getting all the cases we need to see, I'm almost to the point that if there is a hot line call and there's a substantiation and there needs to be some intervention for the family, then that's time to bring in the people who are expert in mental health, the people who are expert in pediatrics, the people who are expert in whatever the issues may be -- substance abuse, and then, let's do a real in-depth assessment of what the needs are of that family based on not only the risk factors, but the protective factors of that family.

And then, from that step, somehow determine whether it's -- it goes into the slot of, you know, public information, you know, what we call voluntary case management, or whether it goes deeper into the system.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER MARTIN:** But I don't know if -- I'm just having a hard time -- Pat is having a hard time visualizing when we kick in MTD if we don't kick it in in the beginning to make an assessment to determine what the source of the --

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER RUBIN:** Can I -- yeah, I'm actually going to -- I support you on this one, because I think there's a standardization there. I think the outcome we're trying to achieve is some level of a standardized, collaborative assessment, right?

And we want to support the initiation of that because, otherwise, it could be haphazardly enforced and stuff like that. I think there are issues of disproportionality that can be raised. But I think we've seen systems that are actually doing that. I mean, Vermont's sending out a domestic violence counselor to every one of their -- we're going to be in Utah next month --

**COMMISSIONER DREYFUS:** I think (inaudible) sending out a nurse.

**COMMISSIONER RUBIN:** We're going to be in Utah next month and find out that they have a ratio of public health nurses within each of their child welfare agencies that are helping to coordinate the medical care and doing the assessments on that.

And so I do think that's the vision. Where I -- so I totally agree with you. I think that that's sort of in that large -- that's what we'd like to see.

Now, the question is, how do you achieve that? You suggest it in Number 3 here that we do this, but we do this through grants. I'm going to suggest that's not --

**COMMISSIONER PETIT:** We do it through what?

**COMMISSIONER RUBIN:** You suggest here in terms of congress should authorize funding support multidisciplinary teams. I'm going to get a little bit more specific around 3B, in particular.

Now, first of all, I'll say, in order to get to that vision, the question is, how do they fund these programs like in Vermont? And how -- you know, so what are the triggers that are more sustainable, those levers that you that you talked about, Commissioner Dreyfus, yesterday, like, for example, defining the permissible uses of targeted case management in Medicaid to support that collaborative assessment from health, defining -- you know, where do each of their funding streams?

And so how can we reposition existing funding streams and clarify the intent of their use so that when we ask states to submit their plans and we actually say, define for us how you're standardizing collaborative assessment at the point of intake, right, as part of their plans, that we've also given them some guidance about how -- how they can use existing funding streams to do it. And then, you should get the desired outcome that you --

**COMMISSIONER PETIT:** But the basic principle that we're talking about is that every kid should be looked at, if there's any question at all. So if there's substantiation, you would just trigger process. That's it. And the only issue is going to be whether or not people are willing to pay for it.

You could do it on a demonstration basis, show that it works, show that it actually has an impact, and then, you could broadcast it across every single case. But I think we've been talking from the beginning on a full response to everything that comes in, like using that fire department metaphor type thing.

**CHAIRMAN SANDERS:** But I think this doesn't -- I mean, this -- yeah, that's not what this seems to say. So it does seem that the -- I agree, I don't think this can just be a social worker bringing the case to a team. I think we have to conceptualize it differently from the beginning. I do think we can define who should be part of that --

**COMMISSIONER DREYFUS:** Right.

**CHAIRMAN SANDERS:** -- to be much broader so that there's not the decision --

**COMMISSIONER DREYFUS:** I'm hearing two very specific things here that I just want to state. So we have talked over months about do we not need a new version of child protective services?

And, Judge, I would say to you, as a former child welfare director, we can't afford as a nation not to do what you're saying. We -- we can't afford not to say that when there is a substantiation of abuse and neglect that has been validated through supervisory approval, which I love, when there has been a substantiated abuse and neglect of a child in this nation, it is a sentinel event in our country.

It is not something where you just use this age-old approach where you send out the single caseworker, hoping he or she has had the necessary training and skill and life experience and

everything else that goes into what we know are not just single issues within households, but a multiplicity of issues within households.

So I just first want to say that this multidisciplinary team, we started talking about it as it related to high risk identified cases, sexual abuse of kids, right, kind of that once they're in. I think what the judge is talking about is this -- this multidisciplinary approach to child protective services at the front end, not just when we've got the bad case. So that's Point 1.

Point 2, we have all seen examples, I have lived them in my life -- and I'm going to use family search and engagement as the example. Family search and engagement should not be a program that you do if you happen to be funded or not.

To your point, Doctor, it should be integrated into how we roll as child welfare. We should -- from the point of child involvement with our system, we should be identifying relatives all the time and reaching out and engaging them. But because it got grant funded, right, states took that and interpreted that to, we do it if it's funded. We don't have the funding.

What we're saying is, no, we've got to re envision, right, the system and the levers that get pulled to make it an integrated part of every CPS system, not just if it happens to have congressional funding, grant funding or not. And I think that's really important.

**COMMISSIONER PETIT:** Let's just -- I think we're all on the same page, actually. Just take a look at what the language is. Demonstrate multidisciplinary case review of cases in which serious harm or endangerment has occurred.

Pat, you had said earlier that the worker goes out and substantiates. Once they substantiate, it gets flipped into this process. This is the multidisciplinary team review process. I mean, that's what it states. So we'll state it a little differently, but we're saying all cases in which serious harm or endangerment has occurred, those would be flipped to a multidisciplinary team.

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER DREYFUS:** I think that's it right there. Where serious harm --

**CHAIRMAN SANDERS:** I think that's too late.

**COMMISSIONER MARTIN:** That's what I'm saying, that's too late.

**COMMISSIONER PETIT:** Well, no, no. You said once it's substantiated.

**COMMISSIONER MARTIN:** But if you look at B, you're already saying it in B --

**COMMISSIONER RODRIGUEZ:** I think what people are saying is that, by that point, you've already relied too much on one person to make a determination. That's there's a good amount of cases where that person who is out there, the child protection worker, will never have the skills or the experience or the background to be able to accurately substantiate.

And that -- and this is part of the reason that I like the frame around public health is that it takes -- it actually makes it clear that, unless we build -- rebuild the child welfare system to have all of those other sort of perspectives and skill sets in it, law enforcement, health,

substance abuse, mental illness, that they actually are not -- they're not capable of making that sort of determination about how much risk the child is actually facing.

**COMMISSIONER RUBIN:** I want to suggest that -- I think we're focusing too much on substantiation, because that assessment should be happening at the point of the investigation. We may not substantiate, but we may actually refer a family for home visiting services, right..

**COMMISSIONER PETIT:** Right. So the investigation --

**COMMISSIONER DREYFUS:** It's a screen in.

**COMMISSIONER RUBIN:** It's a screen in, yeah.

**COMMISSIONER PETIT:** In the second recommendation, there's where we talk about two people going out, so a public health nurse and a social worker, or a social worker and a law enforcement officer, depending when it's made. But one and two here really go -- 2A and B really go with each other.

**(SPEAKING OVER ONE ANOTHER.)**

**CHAIRMAN SANDERS:** (Inaudible). It wasn't as clear. So they are actually --

**COMMISSIONER RUBIN:** The last thought I would say is, is I don't want to be too prescriptive here. I mean, that's the outcome we're trying to achieve. The way you achieve that outcome is by emphasizing that's the one of the criteria we're looking for in states developing their plan.

And I would give them flexibility to find what their MDTs look like, based on the resources they have in their community, but we -- there are certain things we want to see that they're standard -- there's a level of standardization, that they have a plan for a collaborative assessment across different systems.

And so I think, to me, I would engineer that through the way -- through the expectations that you're placing on states to develop plans for a more integrated delivery response.

**COMMISSIONER DREYFUS:** I do think we have an opportunity here -- if the Commission is in agreement, this is simply the way I talk -- is that as a nation, we have lost our sense of outrage at a child being at risk for their -- for their physical and emotional safety in their families.

It's a sentinel event. It's a sentinel event in a community. And I think for us to -- and the economic cost of it, the -- as we were hearing yesterday from the Commissioner, are just staggering. So this gets back to kind of the bigger themes of what we've learned and how does it -- how does it back up our ultimate recommendations.

I do think we need to call congress's attention to -- we can't just normalize this, right. We've got to understand, this is a big, darn deal in our country. When a child gets called in to a child protection agency and gets screened in and is substantiated for abuse and neglect, you know, it is an all-hands-on-deck moment.

And what happens now is, is in order to get the intensity of services and all eyes on a child and stuff, you got to fail into it. And so I just think what the judge is talking about is consistent with what we've talked about as Commission, and that is a re-examination of what is child protective services and -- because it is lacking.

**COMMISSIONER PETIT:** Right. And in the recommendations that are going to be made clearer are two people go out on these cases instead of one, and there's a multidisciplinary team review every time the team, those two people, bring it to their attention or however -- whatever that vehicle is going to be to bring it to their attention.

I don't know if you're planning on having six or seven people on every single case that's referred to the department. There has to be some screening process. That's why two people would be going out on this thing, right?

**COMMISSIONER RUBIN:** See, I think that's too prescriptive. I -- see, that's where I think we're getting too prescriptive because we're saying that we know there has to be two or three people. That's where I think that -- look, that's the vision, but I don't think I'm prepared to say, you must have at least X or Y every place in the country.

What I want to do is give the states flexibility to engineer collaborative assessment based on the resources they have, facilitate that through funding -- through some levers of funding streams that would actually explicitly say you could like, use these funding streams to support these types of activities, and then, evaluate and incentivize that kind of behavior so that you get some really good -- some real investment.

But if we start getting too prescriptive, then I think we're being too heavy- handed as to what exactly is going to work.

**CHAIRMAN SANDERS:** I think, though, what we heard about the issue of redundancy is not unimportant in thinking about how we structure this. That I think we're -- that if we believe that that issue of redundancy is important in the assessment and screening, I think we have to define that, then, as part of what we're expecting to see.

So I don't -- I'm not sure we can get around saying that one person is going to miss things because, again, airline industry has said have two pilots in the plane to make sure there is that redundancy. So I think we need to think about that part of the prescriptiveness.

**COMMISSIONER MARTIN:** But let me ask you this. I mean, I don't think it's -- I don't think we need a multidisciplinary team because workers, you know, are sloppy or whatever. I think it's because workers aren't pediatricians. I think it's because workers aren't mental health providers. And so, to me, putting two social workers to go out and investigate --

**COMMISSIONER PETIT:** Not two social workers. A public health nurse or a law enforcement officer, depending. But the whole -- for me, it's crystal clear that we are all committed to this multidisciplinary team approach, and we've got some specific recommendations.

**COMMISSIONER MARTIN:** I guess we're just trying to figure out when it's triggered.

**COMMISSIONER PETIT:** Well, that's one of the -- I'm not sure that sitting here we can actually calculate that. I mean, there's a lot that goes into it. But we can say that any time they

substantiate or when they find enough concern, somebody has to go out the first time, and then, it needs to be referred to somebody.

And, David, you're right that it can't be too heavy-handed. And on the other hand, it can't be too light-handed either. You were either saying you're going to go before a multiple disciplinary team process --

**COMMISSIONER MARTIN:** Well, what's the multidisciplinary -- what's the purpose, in our mind, for the multidisciplinary team? Because I thought it was to do an adequate assessment of a family so that we can provide the services that they actually need in order to heal, right?

**COMMISSIONER DREYFUS:** And assess safety and --

**COMMISSIONER MARTIN:** Right. Right.

**COMMISSIONER PETIT:** Yes. Yes. It's that.

**COMMISSIONER MARTIN:** So if it's at the assessment time, when is that done for social workers? Is that done in the home when you go to investigate or is that done --

**COMMISSIONER DREYFUS:** Well, so to David's points here, what I'm hearing building -- and I think this is a great conversation. I think what's building is maybe for the Commission, it's our articulation of the what, not the how, and the need for there to be some examination of getting to what are those best practices and strategies.

The what is the redundancy. The what is the multidisciplinary -- what we have learned here, right --

**COMMISSIONER MARTIN:** But that's what I'm trying --

**COMMISSIONER DREYFUS:** -- is that this reliance on one person and one supervisor isn't enough. Whether it's in the screening in or screening out decisions, whether it's in the assessment leading to substantiation, whether it is in the case management and the -- you know, ongoing throughout the duration of the case.

We've learned that this is an important component, but maybe we don't get into the -- and we give examples without getting specific about exactly how it should be done.

**COMMISSIONER MARTIN:** So what I'm trying to crystallize is what specifically have we learned about MTD? Because what I thought I learned about MTD was the value of really getting a good assessment of the circumstances of that family and what their needs were.

And if we're doing it to get an assessment, if that's our purpose, then we put it in at the assessment time. If the purpose is to have an MS -- MDT -- MDT team just to provide the services --

**COMMISSIONER PETIT:** No.

**COMMISSIONER MARTIN:** -- then we can do that later in the --

**COMMISSIONER PETIT:** Both. Both.

**COMMISSIONER MARTIN:** So what I'm saying is if the purpose of the multidisciplinary -- if the value of that team is for the assessment, then, by gosh, why aren't we putting it in at the time we do the assessment of what the needs are in the home?

**COMMISSIONER PETIT:** You mean going to the home? You're not going to send seven people into the home.

**COMMISSIONER MARTIN:** I surely would like to. They do it in MST all the time.

**COMMISSIONER RUBIN:** I am totally agreeing with Judge Martin here.

**COMMISSIONER MARTIN:** I don't see why you wouldn't.

**COMMISSIONER RUBIN:** I think this is a - - I call it multidisciplinary collaborative assessment. That means as that family comes into the system, it trigger a cascade of assessment of what the response is and that there's some degree of integration --

**COMMISSIONER PETIT:** Sure. So you would physically send seven people --

**COMMISSIONER MARTIN:** Michael, they do it on juvenile justice cases. They call it MST, multi discipline -- what is it? Multisystemic treatment something, something. And they do it on juvenile justice cases.

And the whole idea is, when a kid gets into criminal behavior or like criminal behavior, the idea is to evaluate the family to see what the issues are within the family that drives that kid to go out and do, you know, gang bang and stuff, or whatever he's doing. And so the point is, they bring in a substance abuse counselor -- so why would we not --

**COMMISSIONER PETIT:** No. But, well, the CACs do it in their offices. They have a house. They bring people together. They have the team. They meet with the family. We have seven people who would go to someone's home and --

**COMMISSIONER MARTIN:** Yes, Michael. And let me explain why. Because the home is where the child lives. That's what you're trying to assess. That's like doing parenting classes without the kid. Why wouldn't you go to the place that the kid's being hurt?

**COMMISSIONER HORN:** Can I just ask, are we talking about at the point that a call comes into CPS?

**COMMISSIONER PETIT:** That's what -- apparently.

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER DREYFUS:** Once it's been screened in, Wade.

**COMMISSIONER HORN:** So I agree with what you're saying. I agree with what everybody's saying. But I just -- the -- so -- but if a juvenile was committing crime, was doing something really bad right now, you wouldn't send seven people in, you'd send the police in.

And so when a call comes in to CPS, the first question that CPS is charged with answering, is the child in danger right now? And that's the first -- being a former front-line CPS guy, I know

that's the question. It's not, what does the family need? The first question, is the kid going to die or be harmed right now?

Now, I like the idea of more than one eye being laid on them at that time, but I think what you're asking for, just pragmatically, happens a little bit later.

You know, you're in the battlefield and you've got wounded coming in, you don't send a dentist to see whether he needs, you know, some dental work, too. Somebody's triaging that case. So just pragmatically, I think a little bit farther down the road is when seven people go to the house.

I'm -- I almost don't even understand how it would work that you get -- what would happen to coordinate seven people's schedules?

**COMMISSIONER RUBIN:** I don't think we're -- I don't think you guys are saying different things. I think, in some ways, the CPS worker's responsibility is to assure exactly what you said, right.

But what we're saying is that -- that we're actually asking states to initiate a collaborative assessment. It may not have to be on Day One, but it should be during that -- before they kind of close out a case, whether they substantiate it not, they do that assessment.

**COMMISSIONER HORN:** Absolutely.

**COMMISSIONER RUBIN:** Then they send the public health nurse in at some point. That actually helps the CPS worker because then, the CPS worker is not doing 20 things. They're focusing on safety, right. And they know there's going to be a collaborative assessment about, is the kid's health needs being met? Are there mental health or substance abuse issues that are involved here?

Now, whether it's seven or two or three, I think that's where I want -- I agreed with what Commissioner Dreyfus said, the what is the collaborative assessment that happens. The how is what you're incentivizing states to articulate.

Now, I hear what you're saying, you want to see at least two. But, you know -- you know, if you start to put a number out there, then people will default to the mean. In some ways, I'd like to see what states come up with in engineering collaborative assessment and how we can facilitate that through funding streams.

**CHAIRMAN SANDERS:** Let me actually -- because I think that -- I think it's really not dramatically different things being said. And I think there is a pragmatic way to do this, which is after that first question, there are questions then about, you know, what did you observe and so forth.

And if it's substance abuse, then send in a substance abuse counselor, along with the CPS worker. I mean, but having the option of having a variety of professionals who might go in in the front door based on what the hot line call reveals -- and I think you're right, it should be at least two, it shouldn't be defined beyond that -- but we can talk about the circumstances of who should be available, potentially, as part of the plan, given what we've seen.

And I think the issue of it happening at the screening is based on the research that we've heard. That substantiation isn't the factor that places children at higher risk for later fatality, it is a call into the hot line. And that it's at that point that we want to offer a different kind of intervention.

So I think -- I think we have enough here to talk about. There should be at least two, we want to have a variety of people who might be available to accompany the worker, depending on the circumstances presented in the hot line call.

**COMMISSIONER HORN:** In other words, what you're saying is that CPS should not be in isolation when calls come in, and that there should be a wide range of disciplines that are available to the team.

But on the initial call, depending on what the initial call is -- I mean, you know, when I was down in Florida I asked them, could you respond to a hundred percent of the cases? They said, well, we basically already.

I said, really, a hundred percent? He goes, well, it's like 76 percent. And he goes, you know what the other 24 percent is? They're calling it, this is where I apply for food stamps, okay.

And we're not sending seven multidisciplinary people in or even CPS to go into a home because you simply say, no, that's -- this is the wrong number, let me give you the right number. But they said, no, we -- and then what they do, as I think you know and we heard, is after the initial assessment about whether the child is in immediate, imminent harm -- risk of harm, then the multidisciplinary team goes around it and comes up with, what are we going to do with this family, you know?

So I think if that's what -- that's what I hear everybody saying. So I'm trying -- I think we're in violent agreement.

**COMMISSIONER DREYFUS:** But I hope it includes this larger issue of redundancy, not --

**COMMISSIONER PETIT:** Yeah. I think --

**COMMISSIONER MARTIN:** But I still say that multidisciplinary team needs to go in the home. I don't think it's adequate enough to bring them to a sterile environment to make a determination about their risk.

**COMMISSIONER PETIT:** So whether that is where we end up or not, but --

**CHAIRMAN SANDERS:** I think -- I think there are two steps to this, and we're combining the two. I think for the actual going out and screening, we want to make some decision about who should go out based on what we heard on the hot line call. But it should be this issue of redundancy.

But then, we also want to make sure that others are available based on the information that comes in on that, and that others may then come out. I don't know that we design it so that seven people go out on every case, because some may not need to do that. But they are available as part of a team to hear the presentation from the two who've gone out.

**COMMISSIONER PETIT:** Tom, B should be become A and A should become B. Reverse that order.

**COMMISSIONER DREYFUS:** One thing I just want to be really careful about -- it sounds all well and good. But one of the things in my experience is that you've got to be careful, too, that you don't end up overwhelming a family where what you get is a real fight or flight response from them, of feeling that it's very adversarial.

And so, you know, let's just be careful here of our sensitivity to our understanding of what that feels like on the parent's side, right? And the kind of reaction that that kind of over reach, you know, can create. So it's just a sensitivity to that.

**COMMISSIONER RUBIN:** Yeah. I think the other way to say this instead of a number is to say that you would hope that under -- every time a family is referred to the system, that it would generate at least a collaborative assessment that included both the traditional child protective services and a public health response.

And then, let the states define what public health response means, whether that means substance abuse, mental health, domestic violence counseling. You know, that's the flexibility. But that's the duality that you're looking for right there.

**COMMISSIONER PETIT:** In another time when I was doing this, when -- if a case is opened, if the government declares that a case is open and is questioning your parenting and whether or not you should keep your child, that could be a triggering event to release money that would pay for intervention with services and whatever else.

So right now, if you take legal custody of a child in foster care, it triggers money. There's an entitlement there. The question is, could you do the same thing at the front end on the CPS side, is that once you say we're opening something, then those services are eligible for reimbursement from the government?

Right now, what you have is a huge, huge shortfall of people who think they know what needs to happen and there aren't the treatment services that are available -- the intervention services aren't there.

**COMMISSIONER DREYFUS:** But in the short time, to the Commissioner's point yesterday when he's talking about how excited he is about his waiver -- and again, I just say, we can't waiver our way through child welfare for the rest of our lives, right. There's got to be some point where we're learning from these waivers, and then, changing the financing mechanism accordingly.

But he talked about his eight counties where, the bottom line is, he is constrained to his waiver on what is IV-E eligible activity.

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER DREYFUS:** He can't -- he can't use his waiver to beef up his child protective services.

**COMMISSIONER PETIT:** Right. Right.

**COMMISSIONER DREYFUS:** Correct, Commissioner Horn?

**COMMISSIONER HORN:** (Inaudible) So on the concept of a waiver, there's no reason why, if he wanted to -- that's what they're doing in Florida, for example. I mean, they're providing a lot of services based upon a CPS call, and they're using their IV-E money now to actually provide the services as triggered by a CPS call.

**COMMISSIONER DREYFUS:** Provide the services. But I'm talking -- that are triggered. I'm talking about actually wanting to beef up the CPS function as we were just talking about.

**COMMISSIONER HORN:** I don't see any reason why, if you wanted to put that in your waiver, you couldn't.

**COMMISSIONER DREYFUS:** Well, then I think that needs to be clarified. Because I don't think that's universally understood.

**CHAIRMAN SANDERS:** I would say, too, is the concept of the component of the president's budget around candidates includes what you just described? I mean -- and we haven't weighed in one way or the other on that, but it is something that -- I mean, that is the concept is that once a determination is made that the child's at risk, not once the child enters out of home care, so.

**COMMISSIONER HORN:** But before -- we'd have to have a better understanding what the administration's proposal is because I think it's a little bit more restrictive than that. You're suggesting once a call is made and there's something substantiated -- there's lots of things that get -- neglect gets substantiated, no one ever thinks the kid needs to go to foster care. A candidate is different. A candidate is for -- pardon me?

**CHAIRMAN SANDERS:** I thought you said once a determination of services are needed.

**COMMISSIONER PETIT:** Once the government says we're here because we don't think that what's happening is right and we want to improve it, once they say, we're in your life, then they need to pay for services.

**COMMISSIONER RUBIN:** I'm going to actually balk against that one. There's an --

**COMMISSIONER HORN:** My only point is that the -- I think the administration's proposal is about candidates for foster care, not children who somebody made a referral to CPS and they said, this family needs services. You know, lots of families need services. So I just want to be clear that I don't think --

**COMMISSIONER RUBIN:** This is actually a false trap here because there's an unintended consequence, and we see this all the time, which is if you start to link services to a kid who has a contact with child protective services, that means we start -- because we can't get services without that, we start referring families to the system when kids have serious mental health issue or parents have substance abuse.

And so, the way to attack that issue is about the -- the availability for -- the availability of treatment services for parents that can improve the outcomes of children. This is about EPDST.

And so we talked about two strategies to make this more universal and less linked to CPS. One was dual-generation reimbursement, right, that there are certain types of services because the evidence is really clear. I mean, this is evidence-based policy. This is aligning, you know, policy with -- with science, that substance abuse treatment and mental health treatment of parents should -- should be reimbursable within a child's account because it improves the health of a child.

Now, in states that have expanded Medicaid, they may not need to do that because they can just pay for the treatment services through Medicaid. But this removes the decision of Medicaid expansion from whether or not you can provide substance abuse treatment or mental health treatment when there are young children in the home. And it shouldn't be linked to CPS service delivery.

**COMMISSIONER PETIT:** Okay. So what we've all just done with what we have is we say, first, we want to have beefed up capacity to go into a home in the first instance to just see what's going on. So it's not left to a 25-year- old social worker, it's a social worker and a cop, a social worker and a public health nurse, a social worker and somebody. That's one piece.

The second piece that we've just basically said is, we want all of these cases subject to a multidisciplinary review team process in order to assure the best assessment of what's needed, et cetera, et cetera.

This next one that we're talking about is probably the most immediate, and it's the one that I've been calling the surge one. So if you take a look at Page 3 -- Page 3 where it says that first sentence, funding -- forget congress, forget authorizing funding.

What we're talking about that would be of benefit to children right now is a multidisciplinary retro review of cases in which children have been seriously harmed, that is cases that are now open, children are at home.

And what we've seen in a number of jurisdictions is those cases have been unattended to for a long time and no one has been really tracking them closely. And in some cases, because of the unending crush of cases being brought to the attention of the department, in some states, they have literally shelved cases that have come in and not even gone out or even decided on an intake basis.

So what we're talking about here would be similar to the Bush/Iraq, similar to the Obama/Afghanistan, which is throw a very large force to look at these cases with retired judges or retired social workers or pediatricians or whatever, that would go in a place like Texas and say, we want to look at 1,000 cases that you've got, and we think that from those ranks is where a kid's going to die and we want to see what's happening on all 1,000 of those cases.

That's what they did in Hillsborough County. They went back and looked at every single case that was outstanding. They brought a team of people to it.

In this case, just to give an example in how this could work, forget for a moment demonstration, forget experiment, forget implement nationwide, just in terms of what we might learn.

If you took a look at Dallas and Houston -- and they're about the same size. They're different, every place is different, but they have striking similarities and they both lose a lot of kids every year.

So it gets difficult when you're looking at Vermont, Maine, Idaho and some of these other smaller states to say that two deaths one year and four the next, a hundred percent increase, means anything. They're too small.

But in a place like Texas, you could say, we do what we've always done in Dallas, we look back -- and Houston -- and we see whether or not the outcomes are different. If they both had 50 deaths a year and one goes from 50 to 25 as a result of what we're talking about, it suggests that something is happening.

So in terms of the immediate question of, how do you protect children now, which is one of our first charges, it's this notion of a look back at these cases that are now open, kids are at home, and make a determination as to whether it's appropriate.

When you first sent the kids home -- and a lot of the kids stayed home -- there wasn't a guy who had a record of pedophilia in different states. Now, he's living in that home. We didn't know that. The worker didn't pick up on it. The mother didn't call and say, oh, by the way, somebody's living in the house. This would be designed to address that.

**COMMISSIONER MARTIN:** So, Mike, let me make certain I understand this. Because my understanding of that situation where the kid is at home and mom's brother comes to live there and he's a pedophile or he's got a long record, is that the worker doesn't typically know that the brother lives there, right?

**COMMISSIONER PETIT:** Right.

**COMMISSIONER MARTIN:** So how is a group of retired judges, pediatricians and social workers looking at the file in a social worker's office going to get us to find out that the brother's living in the home? That's my problem.

**COMMISSIONER PETIT:** Well, the problem is one to be solved, right? And so we don't think it's -- you're not saying it's not a good idea. You're saying you don't see how it would work.

**COMMISSIONER MARTIN:** Yeah. I just don't understand --

**COMMISSIONER PETIT:** Well, I'm not sure that it would work in a hundred percent of the cases. What I do know is that Hillsborough, which is about the only place that actually brought to our attention the fact that they had this many deaths, and a few years later doing what I've just described, they had substantially -- they had no deaths over a long period of time.

So in this particular case, you might or might not find that. You might decide, looking at your desk with all these cases, that we need to send somebody out and maybe that's what you would do is send somebody out in every case.

But you would have a thousand cases. Some of them you'd flag. You'd say, these 900 seem to be okay. These 100 are what beg questions for us.

What we know is from that AP report that was done last October, and what we know from talking with these states, is just a lot of the kids that are killed are going to come out of the ranks of kids that we already know.

So we already know that these kids are in risk situations. We've decided to leave them at home. We think it's a manageable risk. And the question is, has the risk escalated? Has the risk factor changed on this thing? And you'd get that by looking back at them.

The problem that we have right now in too many jurisdictions is the workers have too high a caseload. Instead of going in every day or every other day or once a week or once a month, they may be going in every three months and they may be going every three months for 45 minutes.

This would be a longer, deeper look at that. From the very place where the majority of children are going to be killed are all -- and not sleep -- safe sleep, I'm talking about, you know, murdered, killed, dismembered, thrown off bridges, we know largely where that group of kids is going to come from. They're going to come from the families that we're already working with, not brand-new stuff.

**COMMISSIONER MARTIN:** Okay. I don't have an objection, and I think it's actually a good idea for near fatality cases to have a subsequent review or a duplication of -- of assess -- of review.

So, in other words, a near death, I don't think it's a problem like we talked about yesterday on just assessing whether a case should come in, whether or not we should have a supervisor review it. So on a near death case, I think we could have like a staffing on that case. I call them staffings. I don't know if that's a right word or not.

But I still don't understand why we would take that out of the realm of the people who are actually working on the case --

**COMMISSIONER PETIT:** Because --

**COMMISSIONER MARTIN:** Let me just finish my question. Giving it to a retired judge and a retire social worker, I don't have access to that family, nor can I go into their home.

**COMMISSIONER PETIT:** Well, you do a desktop review, first of all, and see if there's anything that you think that the worker missed based on the material that was contained in the case record.

You'd say, look at all this. And you could talk to the worker, you could talk with the supervisor. You'd say, you know what, you guys aren't visiting this family often enough. There's been a history here of this and that. We're sending somebody back in to take a closer look at it.

So the issue of death, near death -- I mean, I don't know how many near death cases there are, but that would be too narrow a focus. There are children who are harmed, who will get killed and there was never a near death experience. It went from no death to death, not near death.

So I wouldn't try and define exactly what those were, but there are some criteria that we could apply to it. That Hillsborough model, I think, is a good one. They've already provided some of the framework and protocol and documents and procedures on how they did it.

But in thinking about the universe of children that are out there right now that are going to be killed in the next year, upwards in my view of 2,500 maybe 3,000 or more, this, I think, is an important hands-on, take a look at, bring another set of eyes.

And, again, the question is, why couldn't the existing people? Because they've got 40 cases, because they're in court all the time, because they're not trained, because whatever it is. And you bring it to a group of people with expertise and say, this raises these red lights, go out there and take a look at this case.

And again, of the thousand, they'd screen out 950, they'd go out on 50 or they'd go out on two. But it would be as a result of a second look by a group of people who were not involved the first time.

There may have been no MDT -- and it's likely that there wasn't an MDT in these earlier cases, right. This would be going back and bringing an MDT perspective to those cases, by you'd have a law enforcement officer, a mental health person, substance abuse person, whatever it is.

**COMMISSIONER MARTIN:** I guess my difficulty is I don't know what cases we're talking about that we would have this heightened review for. And if we can tell -- if you can tell me what cases and identify what cases we'd have this heightened review, I still am not -- and it's just because I can't see it -- have people who don't have authority to make decisions about the case. Because you're asking for me to do this on a voluntary basis.

**COMMISSIONER PETIT:** No. No. No. I think what you do is you take Houston and say, we're going to look at 5,000 cases. And take Dallas and say, we're not going to look at 5,000 cases. We're going to do what we've always done in Dallas. In Houston, we're going to look at 5,000 cases. And as it turns out, there's 250 of them that we think warrant another look.

And at that point, you'd have committed the resource necessary from someplace, either the Texas legislature or a foundation or the federal government or somebody, that said, we want you to go back and look at those 250 cases. You're the - - you're the experienced worker, you're the experienced cop, you're the experienced public health person, go back and take a look at them. As opposed to cases now, which can just sit in limbo, sometimes for years, before anybody goes out, right. So, this would be different.

And what we know, in all of these reports and recommendations and analyses that we get that Tom keeps sending us from what's going on in the states, is time after time after time, there was an open case and nobody was going back to look at those cases.

And in this case, we're saying we're going back and giving them another look. That's why I'm calling it this surge kind of thing. Is that throw more force at it.

**COMMISSIONER COVINGTON:** My only concern about this recommendation is, for one, I think it's already being done in a lot of places where people are already doing it.

**COMMISSIONER PETIT:** Good. Maybe we need -- what have they found? Have they found anything?

**COMMISSIONER COVINGTON:** Well, yeah, they find a lot of things. I mean --

**COMMISSIONER PETIT:** Did it reduce deaths?

**COMMISSIONER COVINGTON:** I don't know. I don't have that data. But -- and I don't know that this recommendation as written is going to reduce deaths either. I just think the way I see it is, I -- I guess -- so to me, it's -- I'm trying to get my head around this.

It seems like in these recommendations, we're offering a web of different kinds of MDT responses, so to speak, or multidisciplinary responses. And this is one of them.

**COMMISSIONER PETIT:** Right. Complex area, complex solutions.

**COMMISSIONER COVINGTON:** But I think there's a lot of these reviews already going on. And I'm not sure a surge review will get to it either, rather than a sustained, comprehensive review process in place that's not just a surge review, but that exists as we have today.

And, if anything, what we need to do is buttress those up and standardize them and include not just the fatalities, but kids that are seriously harmed. I mean, there is a piece in CAPTA already that says you're supposed to, you know, do reviews of children near -- quote, unquote, near fatalities. Well, most states are not doing the near fatalities. There's only three that are.

But let me -- so I'm concerned that this is too prescriptive maybe and that what we want is a recommendation that just really talks about improving and buttressing up the review processes that are already in place in states.

**COMMISSIONER PETIT:** Texas can't get below 250 deaths or so a year. They have 250, 300 all the time. And when we read about the children that are killed, overwhelmingly, they are -- the ones that I'm talking about, the murder kids, not the safe sleep kids, not left in the car, I'm talking about the other cases, they are overwhelmingly known to the department.

**COMMISSIONER COVINGTON:** Yes.

**COMMISSIONER PETIT:** Most of these departments do not have the wherewithal to go back and track those because they've got this steady group of new cases that are coming in. It would be great if they could do a comprehensive review of everything they've got in place now. A handful of states might do that, most states don't do it.

So I'm saying, in the states right now that are showing the worst conditions like Texas - - and there's a bunch of other ones --

**COMMISSIONER COVINGTON:** But that's not what this recommendation says. It's not saying, go to the states with the worst cases. It's not doing --

**COMMISSIONER PETIT:** Well, I didn't write this. The way it is now, it's a summary piece. But that's what I'm talking about, is to go into those places right now that have got to worst results -- and there's number of them that show significantly worse conditions than the

national average -- and either offer to them the opportunity to participate in this funded or go in and say, we really want to be able to do this.

The legislature could force this to happen. If the Department of Texas said, we don't want to do it, the Texas legislature could say, well, you know, we think this is a good idea. We want you to do it.

**COMMISSIONER COVINGTON:** Texas has legislation in place to allow it to happen and Texas does do it --

**COMMISSIONER PETIT:** What's that?

**COMMISSIONER COVINGTON:** Texas does do their reviews in places like Dallas and Houston. I mean, they are doing these.

**COMMISSIONER PETIT:** Well, I don't think they're doing what I'm talking about. And the 250 to 300 deaths a year is all the evidence I need to say that whatever it is that they're doing isn't working. So, I mean, we need to take a look at it. I mean, you're saying that they're doing it. I'd want to take a look and see what means.

But the question is, how can we have a hands-on presence right now with a group of kids that we know 12 months from now are going to be dead? There is a group of kids -- we just don't know which ones within --

**COMMISSIONER COVINGTON:** So you're not talking about fatalities. You're talking about identifying kids that are seriously harmed right now?

**COMMISSIONER PETIT:** I'm talking about kids that there's an open protective case, we've left the kid at home. And the AP report, their whole -- their whole report was all the kids that were left at home that were killed, how could they have died when we knew who they are?

Fine, go back and do a deep look at the them again, all of the cases. Pick some number, a thousand, 2,000, 5,000, to see if it makes any difference.

But where is the point of immediate intervention with anything it is that we're doing? If you said tomorrow, the money's here to do this, and you could get a state to do it tomorrow, you'd be able to put on a fast track a review of cases and see if there's anything in there that you're saying we should go back out on them.

**COMMISSIONER RUBIN:** Yeah. I see this as sort of the vision of being that this is the red flag case, right? So the only jurisdiction that I -- or area that I saw where they were making progress on this issue was Tampa, right?

They had done those really nice predictive analytics where they were -- where they were piggybacking a more senior supervisor on cases, had rich data about when kids weren't showing up for school, when case notes were being absent --

**COMMISSIONER PETIT:** Correct.

**COMMISSIONER RUBIN:** -- but it's really underdeveloped. And so that makes it very difficult to be prescriptive of what exactly this should look like. Other than saying that this is an

expectation we're trying to achieve, how are states going to elevate cases that potentially are at risk for falling through the cracks, which could involve the following criteria -- you know, following kind of examples: Kids in which visits are not occurring, kids in which -- you know, who are not showing up to school, kids -- you know, kids in which there is -- you know, there is someone who's been convicted of homicide in the house and the kid's remaining at home.

But I'm worried that in trying to achieve that outcome, we're over articulating that we know exactly what that red flag system looks like.

**COMMISSIONER PETIT:** No, we don't know at all. We don't know that at all. What we're saying is, what happens -- as we've all been talking about for months and weeks and days and hours in the last two days -- is bring a lot of different sets of eyes to a problem and see if they have a different interpretation.

**COMMISSIONER COVINGTON:** Can I -- when I read this, I can't -- I'm having a hard time figuring out what the difference is between 4A and 3A.

**COMMISSIONER PETIT:** This is not written the way that I think it needs to be written. It's not clear. So I'm not going to try and defend the language as it's written here.

The point that I'm making is, there's a large universe of children that are in state custody right now that are going to be dead in the course of next year. They are. They will be gone. That's where a lot of these kids are going to be drawn from.

And what I'm saying is, design whatever vehicle you want, but say, we're going to sit down and look at these things and we're going to go back into those households that raise a red flag for us.

**COMMISSIONER HORN:** So I'll put aside the fact that any time Michael quotes a Bush policy, positively, I'm inclined to support it. The -- I like this recommendation.

**COMMISSIONER DREYFUS:** I already tweeted it out.

**COMMISSIONER HORN:** I like this recommendation a lot. Because if you were -- if I were brought into to a child welfare agency as a consultant and they were to ask me, what do we do about this, this is exactly the first thing I would do.

And I don't think we should get hung up on the precise language of this, but rather, I think what he's presenting is the idea. And the idea that there is a lot that we can learn, both nationally and in states and local jurisdictions, from this surge identification of kids who are currently in the process, which is much more, as I see it, the difference -- this is a prospective, current analysis, not a, the kid's dead, what went wrong?

**COMMISSIONER COVINGTON:** It's not a (inaudible).

**COMMISSIONER HORN:** Yeah. Which I think is really important. And so I think -- I like this.

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER DREYFUS:** So I want to ask -- wait, I'm going to follow up with Commissioner Horn. Let me just follow up with Commissioner Horn with what he just said.

So I'm thinking about this from a funding mechanism, right. Okay. So I agree with you, it's an opportunity, let's save some kids right now, and in the process we're going to learn from it, which feeds into a lot of our other recommendations.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER DREYFUS:** But so then I think about the 90/10 funding, right. I think about the feds for a period of time giving an enhanced federal match for something to happen for a duration of time.

Is there a way to look at this from the standpoint of enhanced federal match, right, that we would recommend for states to have the ability to do this?

**COMMISSIONER HORN:** Yeah. And as with the surge in the military terms, there's -- it has an endpoint.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER HORN:** So this is -- this is one where we're not creating a new entitlement forever, but rather what we're doing is we're saying there's a certain period of time in which there's a finite amount of money that has a very specific purpose, at the end of which, we'll have learned something or achieved an objective.

And I think it's very doable, reasonable. And I think we're going to get support among -- a wide support among the congress for something that is time limited, that the amount of money is definable, and would serve, I think, a really, really very legitimate purpose.

**COMMISSIONER RUBIN:** And I like that, Commissioner Horn.

**CHAIRMAN SANDERS:** And before anybody else -- before anybody else jumps in, we're going to need to take a short break -- sorry -- in the middle of this conversation. But we'll come back and David --

**COMMISSIONER PETIT:** Hey, here's a new term for you, surge urgent, call it surgent. That's what's missing right now is the sense of urgency to talk about --

**CHAIRMAN SANDERS:** All right. We've got to take a break.

**COMMISSIONER PETIT:** Surgent. Surgent. Remember that. Write that down, a surgent situation.

**(WHEREUPON, A RECESS WAS TAKEN FROM 10:16 A.M. UNTIL 10:49 A.M., AT WHICH TIME THE HEARING CONTINUED AS FOLLOWS:)**

**CHAIRMAN SANDERS:** All right. I think we're ready to get started. We have our child protective committee here.

Dr. Rubin, would you like to comment on what you were going to say before?

**COMMISSIONER RUBIN:** Yeah. I actually thought that, Commissioner Horn, the idea of this surge strategy, a part of that is the alignment of the recommendations. Yeah, I think part of

it is the alignment of a number of different recommendations that all coalesce with what you were talking about, Commissioner Petit.

So Number 1, on the research side, we heard in Philadelphia the need for better models of risk stratification, how do we define -- instead of defining type of abuse, that we -- there was a great need to do more research into how we stratify risk at the point of intake in terms of imminent risk. And so you can imagine time limited funding to support research in the best development of risk stratification systems.

The second item is the issue of data systems and team development around this sort of surge -- this sort of -- this secondary review of high risk cases. That sort of feels to be part of that innovation fund. That if we develop this around this new federal focus, that that time limited investment to develop, you know, predictive analytics models, this is where -- you know, to develop sort of how these reviews would be done and allow -- and really start to test and experiment, there would be an evaluation in outcomes component to this about sort of we heard in Tampa that they had reduced deaths through the use of secondary review. Let's test and evaluate if this risk stratification actually works.

And then, finally, I think there's -- there's the great need for federal legislation around data sharing. I think that -- on data sharing. In order to accomplish what you're talking about, too often do cities and states fall back on, we just can't share the data.

I can't tell you how many times that impedes us. And I really think that needs to be done federally. That once a child is referred to the child welfare system, we need strong federal guidance about the permissibility of using data across a variety of systems.

**COMMISSIONER DREYFUS:** So without -- this needs more analysis. And to Commissioner Horn, I pull him in on this. I think we -- we shouldn't just go to the idea of an innovation fund. I really think we should go to a time limited, enhanced funding opportunity for states, right.

**COMMISSIONER RUBIN:** That's fine. Whatever you want to call it.

**COMMISSIONER DREYFUS:** But, in general, if we're looking at anything about states wanting to do, you know, innovation in this area, you know, not just what we're talking about here, but could we lump it into a time limited enhanced match funding opportunity? I think that's far better than --

**COMMISSIONER RUBIN:** Yeah. That's fine. But I also want to say, when I say "data systems", you know, I think about meaningful use in healthcare. I mean, the types of -- how antiquated a lot of these data systems are, these old SACWIS systems to be able to do this.

I mean, we think about the -- we would like every state, if they want, to potentially to have a prism system like we have in Washington where they're really richly sharing data across systems.

And so, I think that's part of this investment is ensuring that they have the technical capability to kind of do this kind of risk stratification or predictive analytics.

**COMMISSIONER DREYFUS:** I just think it shows the urgency issue more if the feds say, we're going to do 90/10 funding for three years, right, on these things.

**COMMISSIONER PETIT:** David, I think that the innovation fund that you've been talking about from the beginning works. But, honestly, I think it's -- just from a political point of view, instead of an innovation fund, I'd call it emergency fund, an emergency fund to protect children.

And at that point, states could come in with what their best thinking is, what our advice would be on what they should approach. We've described one approach, which would be the surge - - the surgent issue, but there would be other things as well.

But I had a question for the judge. When agencies invoke the fact that they're operating under a closed rule in terms of sharing information, which each of these parties can do, whether it's healthcare or child welfare or something, is there any latitude by a judge or jurisdiction or authority by a judge that says, this is -- that is trumped by this, by our need to know that? Are you able to cancel any of those things?

**COMMISSIONER MARTIN:** Well, federal law is federal law. So I have to abide by HIPAA and all the other federal laws. But, certainly, I have the authority to invite for an in camera inspection.

So like if someone argues that mother's mental health reports are none of Dad's business and they're not discoverable by Dad for some reason, I would have the right to bring them into my chambers, review them myself, and determine if they're pertinent enough or relevant enough that Father's attorney should get them, too. But I don't have the authority to trump federal law.

Now, what I do have the authority to do is tell someone their interpretation of HIPAA's wrong, right? I can certainly tell someone that I don't think that HIPAA provides for what they're offering it for or the confidentiality that they're offering it for.

And then, I certainly have the authority to say, Mom, you know, technically speaking, your mental health records are personal, but if you want to participate in these services, you can sign a consent. And I can explain what that consent is and she can then give authority to waiver confidentiality. But I'm restricted by federal law, too.

**COMMISSIONER PETIT:** Okay. All right. Good.

**CHAIRMAN SANDERS:** We should probably move on.

**COMMISSIONER PETIT:** Want to resume?

**CHAIRMAN SANDERS:** Yes.

**COMMISSIONER PETIT:** I won't repeat where we were. I'll just move on to Number 5, I guess. Well, A, B and C are all related, right? Well, B maybe deserves some time. States should adopt a broader statute protocol on threat of harm when establishing a threshold. That is a lower standard than what exists at present. Threat of harm as opposed to actual harm.

I think, Tom, you've talked about this. Some states do invoke threat of harm, they have the ability, others cannot. Do you want to speak to this?

**TOM MORTON:** Commissioners, I believe in the material that Kathleen Noonan prepared to you -- for you for her presentation at a prior meeting, she identified that there were 39 states that included threat of harm language in their statutory provisions for child abuse and neglect.

The issue may well be that, generally, to be an allegation of abuse or neglect, the threat of harm has to be active and immediately endanger the child. And if you think about a parallel, I suppose, to mental health, the statutory language of threat or harm to self or others, the threat of harm has to exist, but the individual doesn't have to be harming himself at the time in order to commit the person for evaluation.

So I guess this sort of came out of recognition of the Florida case where the father's behavior arguably constituted a threat of harm. Conceivably, the father would have had access to the child later and did, and subsequently, killed the child.

Florida, subsequently, changed their policy to include a caregiver with active mental health issues as something they would accept and investigate. They did not change their statutory language.

But in my career, I've seen a number of instances in which you had parents acting dangerously, and sometimes it qualifies and sometimes it doesn't. An example of the former would be manufacturing meth in the home and the child was there. The child may not be harmed right now, but, nevertheless, there's a threat of harm, so...

**COMMISSIONER PETIT:** So is there any debate on this one, expanding it to recommend that all 50 states adopt a threat of harm or -- and you can do more than urge them, you can make it -- you can predicate it on receiving things.

**COMMISSIONER DREYFUS:** Is there anything that shows that in the 39 states that have it, it's making a difference?

**COMMISSIONER PETIT:** I don't know. Tom, has anything been written on this?

**COMMISSIONER DREYFUS:** Does Texas have it?

**COMMISSIONER PETIT:** I don't know.

**TOM MORTON:** I suppose it might mean what you mean by making a difference.

**COMMISSIONER DREYFUS:** In child fatalities. Does Texas have it?

**TOM MORTON:** I don't know if -- specifically, if Texas does or not. I don't know -- I'm not aware of anything that's been written linking threat of harm statutory language to prevention of fatalities. Obviously, a number of states think it important enough in terms of protecting children to have it in their statutory language. I mean --

**COMMISSIONER MARTIN:** I don't know if I agree with this. I mean, I think I understand, and I certainly appreciate the idea of what we're trying to get to. But I'm not really sure that reducing or lessening the threshold is necessarily our answer.

It doesn't seem to me -- and I don't -- I can't make the tie to reduction of fatalities. Now, if we do have something to support that in jurisdictions where we are utilizing this as a policy and there are -- there has been a reduction or there are few deaths, then maybe we can revisit it. But I'm not sure that we should start recommending things because -- I mean, it sounds great, but we're not sure if it's going to help.

**COMMISSIONER PETIT:** I agree. I don't know, Tom, if we've got enough material that --

**CHAIRMAN SANDERS:** I think, though, there is a piece that may -- we may not have the material on I think we need to consider, and that is, we heard testimony from workers saying there were children in high risk situations that they couldn't serve because they could not prove that an incident occurred.

And so I think -- and I think the research that we saw from Emily Putnam Hornstein about who's at risk, the substantiation in and of itself is not the determinant. It really is the call into the agency.

So I think the way decisions are made now is not -- means that children who are at risk from research and clinical judgment are not going to be served. And so -- now, this may not be the right solution, but I think we do need to think of how to -- how to address that.

**COMMISSIONER PETIT:** Well, how about if we leave it on the table until we do a little bit more exploring as to whether there's anything formally written on this, Tom, whether there's any research on it or not. And then, if not, put it back of the table as, does it still rise to the level of consideration.

Then anything else on that one?

Jennifer, are you back with us?

Okay. Jennifer, did you want to comment on this?

**COMMISSIONER RODRIGUEZ:** Yes. Can you hear me?

**CHAIRMAN SANDERS:** Yes.

**COMMISSIONER RODRIGUEZ:** Okay.

**COMMISSIONER PETIT:** Did you want to comment on this, on 4-B? Threat of harm? No.

All right. So 4-C. You know, a question that I have -- I mean, we all know -- I saw yesterday the numbers for Tennessee, it was 97 percent of the kids -- 98 percent of the kids were five and younger, and I think 50 percent were one or younger. But the concern that I have on this one -- and Tom or Jennifer, jump in if you want to add to this.

The concern I have is, I'm not sure what prioritize responses children -- response to children aged zero to five means. When you prioritize services do you say, how old is the kid? If somebody calls you and says, this is terrible, it's going on, and I say, how old is the kid? And they say, well, the kid is six. And what's being reported is more riskful than the call that just came in on a four year old.

So do they say, well, we're going to -- you know, the age trumps everything? I mean, I don't think so. So what does prioritize mean?

**COMMISSIONER RODRIGUEZ:** So, to me, this belongs actually under Number 5. Because I think that what this is recognizing is that we do have some information about what some of the most serious risk factors are in making children vulnerable to being very hurt or killed.

And so age is one of those risk factors, as is we have other risk factors as well that we know. And that this is, I think, sort of back to the earlier discussion about getting more precise about the work that we do and using the evidence base that we have to be able to -- in the course of our decision making.

I mean, it is just a fact. We know that for young children, they are more at risk. And so calls that come into agencies should be handled in a different way for that population.

So I don't think we -- I don't think we would want to prescribe what it is that agencies might do differently, because it goes back to what I think -- I think it was -- David was saying earlier about letting folks come up with sort of their multidisciplinary approach and their team and what that looks like.

But you might have a different level of assessment and convening and folks that are brought in for an infant than you might for a 10 year old. And you might have a different level of response and services that get provided in.

**TOM MORTON:** I would say this is kind of a placeholder statement. It was meant to create an opportunity for Commission discussion about this population, given the prevalence of fatalities among this population.

I can give you a couple of examples. I don't think you want to be that prescriptive. But in Clark County, Nevada, we had two specialized units to investigate all cases involving children five and under.

And they were more specifically trained about, you know, issues with younger kids and investigation with younger kids. They handle all of our fatality investigations, for example.

Commissioner Dreyfus was telling me about what Denise Revels Robinson did in Washington in which the state responded to all calls regarding children age two and under, regardless of what was being reported.

**COMMISSIONER DREYFUS:** And all pediatrician calls.

**TOM MORTON:** So, you know, again, it's kind of a placeholder for you to refine. But here you have 80 percent of the kids who are dying are under the age of five. What does that imply in terms of the response and prioritization? And that's up for you to decide.

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER COVINGTON:** Yeah. I was going to give another example where Michigan decided that any child with -- any child under age four, I think, with more than three calls

reports in, regardless of the, you know, the perceived egregiousness of those reports, received an investigation. It required an open investigation after three calls.

**COMMISSIONER DREYFUS:** I would just like to recommend. I think this is really important that we respond to this young age group. But I agree with Tom and Teri, I think we just got to expand what we're talking about, right, to Teri's point.

**COMMISSIONER PETIT:** Which is what?

**COMMISSIONER DREYFUS:** Which is that there's a range of things that need to be looked at for this group than just, you know, prioritize responses. I think --

**COMMISSIONER PETIT:** Right. Based on age.

**COMMISSIONER DREYFUS:** Yeah. I think it's just deeper than that. I know for our work, it -- we were really focusing in on looking differently at mandatory reporters. I know in Oklahoma -- I think it was Oklahoma, David, Oklahoma or Nebraska -- where the -- any call from a doctor or educator that is not -- does not rise to the level of being screened in, right, they are going out.

The CAC is actually -- they're contracted to go out and just do a warm touch with the family, what's going on, what do you need? So I think it just gets into more issues.

**COMMISSIONER PETIT:** I think, for me, the potential problem is that we know that the same amount of applied force to a two year old versus a five year old is going to do more damage to the two year old than the five year old.

On the other hand, because I think it's simply a matter of resources -- in other words, if we had enough money, we'd say, go out on every kid, go out on the 2, go out on the 5, go on the 10. They're all vulnerable on this thing, right?

I don't think it should come out that we're saying don't -- or minimize five year olds in order to benefit two year olds. I mean, I think they're all important. So I'm trying to think of how to do it in a manner that doesn't detract from the culture's responsibility for protecting a five year old as well.

**COMMISSIONER MARTIN:** So what about what Teri just recommend -- or just enunciated? You know, if there are three calls on a child under the age of three and there's no case or no investigation warranted, they automatically have an investigation at that time?

**COMMISSIONER PETIT:** What if there's three calls on a five year old or five calls on a five year old?

**COMMISSIONER MARTIN:** So the point is to look at where we have the most kids, the most vulnerable kids, and make that the brink.

**COMMISSIONER PETIT:** Yeah. I'm just raising it's more a function of resource than it is a clinical issue of whether the five year old is going to be harmed or not. And so I'm just saying, do you -- I'm just trying to think of how you end up presenting it so that we're not saying five year olds are on their own.

I mean, I've been in jurisdictions where they don't do 10 -- they don't do 10 and older because the attitude was 10 year olds can walk away or run away from the situation. It's just a point -- just maybe a framing of how we do it. We want to help every kid, right? We're not excluding.

**CHAIRMAN SANDERS:** But I think it is more than that. If we know that birth to five is more vulnerable, it seems that we have to attend to it. And maybe it's more articulating a developmentally appropriate approach or an approach based on data, but that we know that they're far more vulnerable. So it seems like we have to capture that.

**COMMISSIONER PETIT:** Correct. And if you had enough resource, you'd do everybody, but we're presuming that you don't.

**COMMISSIONER MARTIN:** But I love the idea that -- because I can't tell you how many cases I will have, well, this is the twelfth sequence, but they didn't -- you know. And so it makes sense that if there -- if we take the most vulnerable children, the children where we find the most fatalities, and look at those and say -- and give, you know, if it's two or three, you know, then automatically at that trigger, then they have an investigation.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER MARTIN:** I mean, it's similar to our mothers with substance abuse kids. So now we have -- if you have a certain number of substance abuse kids, your next one automatically comes in, right? So I don't have a problem with something like that.

**COMMISSIONER DREYFUS:** But I also just think with these younger ones, from our perspective when we looked at it, it was also through the lens that this is a population of kids that, more times than not, don't have other eyes on them.

So, you know, age five, you're going into kindergarten, you know, the education system. Again, I'm not trying to be absolute here. I know that there's always variation. But that was our rationale in doing more with the younger kids just because they were at higher risk with fewer eyes on them on a regular basis.

**COMMISSIONER PETIT:** We'll flesh this out a little bit more.

Jennifer, anything else on --

**COMMISSIONER RODRIGUEZ:** (Inaudible) developmentally informed approach. I think it's important because, you know, I mean, in talking with child welfare agency leaders, it's been really clear to me that there's not a lot of information that's out there commonly sort of about what -- what makes babies, infants, young children different from older children.

And if the leaders don't have it, I'm not even going to presume that the investigators have it. And so, I mean, I think that there is behavior that might not warrant an immediate behavior -- or immediate removal of a seven year old, but that would absolutely warrant an immediate behavior if you have a three month old.

The child is -- so it kind of ties back also to the earlier discussion about the threat of harm as well. But it's just folks that are doing the investigations, they have to understand babies are different.

**COMMISSIONER PETIT:** All right. Anyone want to respond to that or do we need to? Do we want to go to 5-A, which I think is the child welfare and juvenile justice for kids.

Young parents who live in the child welfare and juvenile justice, so they're being specifically identified as needing prevention and support services. Any issues there?

**COMMISSIONER RODRIGUEZ:** Yeah. And again, also I think it is critical that we call out this population because -- for a couple of reasons. Because we know so much about the reason that they're involved in our systems at all is because they've had so many of the risk factors. And, you know, we have full control over them at a certain part -- point in time.

And also because it's just been my experience that actually these two populations of young parents, they don't actually get equal services when they is concerns about their parenting. I think they get less services because people figure they're already in the system, so they don't need the same type of referrals to other services.

Like in California, we have, you know, a pretty extensive array of what we call differential response services. And young people -- young parents who are in foster care never get referred to those services because they're already in foster care and people feel like that is enough, that's the intervention.

So I think that is one reason why we want to focus in on this population. But I'll just repeat what I just said, which is that this section needs some expansion. Because I don't think that this is the only group of children that we know is highly vulnerable that we're aware of that we're currently not serving.

**COMMISSIONER RUBIN:** Right. This is Commissioner Rubin. I see this as one of the visions, like you'd like to know that youth who are at higher risk who are having children, this intergenerational child abuse and neglect, that they're going to be prioritized and receiving more services like child care, receiving more services like home visiting, et cetera, at some level of response.

But I just don't know how to operationalize that because I don't think you can -- because knowing how it works even locally where I'm from, you know, people treat -- they are triaging different types of home visiting programs, et cetera.

And so I'd like to kind of think about beyond the vision, which is what I see here, how do you really operational -- is that our job to operationalize that or is that more guidance that we're providing to states?

**COMMISSIONER DREYFUS:** So I would have probably agreed with you two weeks ago until I saw Emily Putnam Hornstein's research on this population, her data on this population in California. It's compelling and it does give you the crosswalk to what you need to operationalize. So when we're -- I think just in looking at this, I think she ought to be brought in to help us think about it.

But her data really does -- when I sat and watched her present it, I was thinking as a child welfare director, you got to do this, we got to do this, we got to do this. So I think that

operational path is sitting in that data. And when we're looking at the data we want to put in the report, talking specifically about this population, that is pretty darn good stuff.

**COMMISSIONER PETIT:** Anything else on this?

So six, child abuse and neglect, not homogenous in their nature imply different prevention. We -- how do we flesh this out? I mean, we all --

**CHAIRMAN SANDERS:** I think we -- I think we agreed that we would -- this would be part of our opening statement of defining the problem and that we would talk about the idea that we do need different strategies, so.

**COMMISSIONER PETIT:** Yeah.

**COMMISSIONER RUBIN:** This is where I actually -- I thought what you were trying to get -- this is where I put the risk stratification work and the research that's needed to better identify at the point of intake imminent risk.

And so that was a unanimous recommendation from the research forum in Philadelphia. And so that's where I -- rather than the measurement issue of neglect -- child abuse and neglect classification on fatalities, this really is -- is for Commissioner Covington's group, but I thought I would actually just reword this to talk about that need for better identification and stratification around risk.

**COMMISSIONER DREYFUS:** So quick question. Are we starting to build -- I'll just use the term "bucket" -- are we starting to build that bucket of eligible things that states can do with a time limited enhanced match opportunity? Are we starting to crystallize the five things that would be eligible for enhanced match?

I don't like calling it emergency fund because I think that immediately takes it away from what we really want it to be in terms of learning and identifying what works and blah, blah, blah, blah, blah.

**COMMISSIONER PETIT:** I'm thinking of getting it adopted, but yes.

**COMMISSIONER DREYFUS:** But is there a way -- okay. I get how you describe it. But are we starting to identify those things? We don't know the answers to them, but we know that they're real issues, like the zero to five group, this topic here. So I guess I'm just putting on the table --

**COMMISSIONER RUBIN:** Well, that's what I wanted to also expand on because I realized I mentioned a word "meaningful use", which in my -- my terrain, everyone kind of understands, and even I don't understand all the time.

So meaningful use has been part -- it wasn't so much part of ACA, but, you know, was around in improving electronic health records to coordinate the care of patients in healthcare systems.

And the way the -- I think there's analogies here because they've structured meaningful use payments first on having electronic health records, but then, what are the capabilities that

those records need to have in order for you to get enhanced payments for demonstrating that you're actually doing these?

So there is the need to update systems, but then there is you want some sort of a stratification of risk system, and to what degree does your system do that? To what degree does your system pull in data from this variety -- and if you can accomplish those things, we will enhance some level of payment.

And so I think -- I would guide the staff to look at how meaningful useful structured because we're trying to get to that vision of pretty good data capability and team structure around sort of the secondary review that you talked about. And I think we can structure that in the way we think about this surge in funding or these enhanced payments that states receive to do this.

**COMMISSIONER PETIT:** All right. Seven? Law enforcement must be involved in all reports of child abuse and neglect that also qualify under criminal statutes.

And then, this is all related to the MDT stuff and the protocols and memorandum of understanding and all of that. And we're talking about a very small percentage of all cases, but a quite large percentage of the cases where children are going to be killed.

**COMMISSIONER DREYFUS:** So we know this is -- Mike, I know when I did a sit down with Milwaukee staff, a very confidential sit down with a group of front-line folks before -- as I was preparing to come on this Commission, this was one thing that they brought up, that they call law enforcement, but they don't come. It's not a priority. And I'm sure that's not an issue of not caring. It's an issue of resources, right.

So it's a great -- I agree with the recommendation that it should happen, but I just think as a Commission, we've got to also identify where we know we've got resource issues. And this is not necessarily a resource issue as it relates to CPS. This is a resource issue in a related system.

**COMMISSIONER PETIT:** Right. But they have -- they have a responsibility to protect children as well. And I've been in jurisdictions where there were 2,000 police officers, there were four that were assigned to children, and they had backlog of a thousand cases that they hadn't looked into that CPS was calling them to look into.

I mean, I don't know whether they need more resources or not, but they need to make the protection of children a priority, that's -- right.

**COMMISSIONER DREYFUS:** I agree.

**COMMISSIONER PETIT:** So we've heard from some CACs where they've had terrific police and prosecutorial cooperation, no additional money. They're locating them at the CAC, that kind of thing. In other cases, they've beefed up their capabilities, but we've heard them say they've developed protocols for investigating, for prosecuting, and all that kind of stuff.

All I'm saying on this one is I don't know that we need to introduce the resource question on this. I think what we're saying is that police and prosecutors are critical to the protection of children, and preventing them from being killed.

How they that should work, we've got a model in the CACs or MDTs, but I'm reluctant to get into advocating more spending by law enforcement. They may need to do that.

**COMMISSIONER MARTIN:** So if I take this in conjunction with the prior recommendation, then we now have people three people going out on investigations, right?

**COMMISSIONER PETIT:** Well, not necessarily. I mean, if it's a -- you know, the mother keeps putting the boy baby in pink clothes, I don't know if you'd bring the police out on that. I mean, there would need to be, I think, something that prompts a police officer.

**COMMISSIONER MARTIN:** Right. So what I'm saying is, if I take this in conjunction with one of the prior recommendations on some -- at least some investigations, we're sending three people out for the initial investigation? I'm just asking a question. I'm not putting a value on it.

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER PETIT:** No. No. No. All right. I'm just saying, it might be three, it might be two. I mean, they might say, look, we don't need the public health nurse on this, CPS needs to go out with a police officer because of this. It might be two. It might be three. I mean -- but I'm saying, a police officer is critical in some of the initial phases of this. Not all them, but --

**COMMISSIONER MARTIN:** Mike, what I'm trying to get at is, who makes those decisions? Because CPS is governed by some Person A and, in Chicago, the police department is governed by Someone B.

And so I need to know, when the hot line call comes in, who determines if it's a Chicago public -- Chicago Police Department and DCFS, or if it's DCFS and home nursing? That's where I'm kind of trying to help us, from my mind, crystallize to my mind kind of where we're going on that.

**COMMISSIONER PETIT:** You could have a three-person team located in an office that handles all calls that came in the night before that comes in the day. One of them would be a CPS worker, one could be a public health nurse, one could be a cop. And they --

**COMMISSIONER MARTIN:** So you're envisioning that --

**COMMISSIONER PETIT:** Well, no. I'm saying, that is a model that has been discussed and planned in some places, they're co-located and they say to each other, is this one that we all three of us go out on, is it two, is it one, whatever, and they decide jointly who's going to go out, right.

Or you have separate calls coming in, 9- 1-1, separate calls coming in CPS, and they just - - they talk to each other about who's going to go out, do they go out together or not on this thing. But I think at some point they need to ascertain what it requires on their own, that it's not going to be overly prescribed.

**COMMISSIONER MARTIN:** See, my problem is when we leave it to the individual agencies to decide, then that's when it slips through the hole, right. And so -- so that's why I'm asking us,

if we're making this recommendation, I'd like to have a clear understanding of what we're recommending.

Are we telling everybody that every time there's an alleged phys abuse situation from the hot line, that we need a Chicago police officer? And if that's the case, we need to make room to do that. We need to figure out how to do that, okay?

I mean, that's what we have to decide, in my opinion. We can't leave it up to the agencies to decide if the police go out this time or only CPS or only -- so that's my one issue.

My second issue is, when you send the police out, the police don't prosecute. The state's attorney in Cook County prosecutes. So the police can, in all -- have good intentions and bring a case to the state, and the state may decide to prosecute or not prosecute for a variety of reasons.

I may agree or disagree with that decision. But I think we have to be really careful about the purpose behind what we're trying to do and what we're trying to get out of it, okay?

So if the purpose is for more prosecutions, I'm not sure this is the way to get at it, is kind of where I'm talking about.

**COMMISSIONER PETIT:** Well, one big issue across the country with prosecutors is that they feel like they're not getting good work in many cases from the police. That is, they're not getting the information they need to successfully prosecute.

**COMMISSIONER MARTIN:** That's not what's wrong in Cook County. They just have an overload of criminal cases --

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER PETIT:** Yeah. No, I'm talking about --

**COMMISSIONER MARTIN:** -- and Cook County jail is crowded. That's why they don't do it.

**COMMISSIONER PETIT:** Yeah. No. That may be so in Cook County. I'm sure it is so in Cook County. But I'm saying in other places, DAs will say, the reason we're not prosecuting more cases is we're not being given stuff that's going to pass the straight test face, it's not going to be beyond a reasonable doubt.

And what I would argue is that there are jurisdictions that have prescribed what those protocols should be for investigating by the police that results in significantly higher successful prosecutions when there's criminal behavior.

**COMMISSIONER MARTIN:** Then if that's our goal, then I would suggest that the recommendation be that there be a protocol set and they sit down and decide how to do that. This would not be the recommendation I would make to get to that goal.

**COMMISSIONER PETIT:** Right. Well, no. But the real goal isn't successful prosecutions. The real goal is to protect children from harm. So I think there's two things there, there's two goals, right.

One of them is to protect the child by getting law enforcement. The 25-year-old social worker is not going to succeed in dealing with some thug where a cop might. So that's one thing is just providing safety.

But then there's this other question about providing the investigative results that cause the DA to say, I can go forward with this thing.

**COMMISSIONER MARTIN:** Then if we're protecting kids, the worst thing to do is supplement my child protection investigation for the criminal investigation. Because if it's a serious phys abuse and Cook County -- I'm just telling you in Cook County, it will take three years to get them to trial. And my kids should not have to wait three years for permanency in my courtroom for the criminal investigation.

So that's why I'm saying, tell me what your goal is, and then, I can tell you if I agree that this is the recommendation that gets to the goal. Because if it's protecting kids, I don't think this is the best recommendation.

**COMMISSIONER PETIT:** No. But police going out and looking at -- we've talked about this a lot, I thought. That the police going out on an initial report that a child has been harmed to the degree that it rises to a possible criminal act, the police would go out.

Or depending on where the investigation is supposed to take place, the police officer would accompany the CPS worker, right. In some cases, it's a safety issue for the worker, not just for the child on some of these things. So we're saying police should be more involved with these kinds of things.

Then there's the added question of, should somebody be -- you know, CPS is out to look for the best interest of the child. The criminal part is trying to figure out who's guilty. So at some point, do they present something strong enough to a DA that allows them to prosecute?

And so, I mean, that's been done in many jurisdictions in the country where MOUs have resulted in more criminal prosecutions. But it would -- I would think, you know, it would vary from jurisdiction to jurisdiction.

**COMMISSIONER MARTIN:** And I think -- and I'm not trying to be critical, Mike, but that's my problem. In different jurisdictions, personalities, we can sit across the table and make this a MOU and we work out great.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER MARTIN:** When we're talking about making it a national requirement, we have to be pretty prescriptive about what the goal is and what we're trying to do. Because it's going to work different in Illinois than it is in Seattle.

And so what I'm trying to tell you is, we need to think about, do we really want the criminal investigation to go before the child protection case? We really need to think about that. Because as a practical matter, that makes tremendous -- that puts ASFA out the window completely. We don't even need to think about ASFA because we're never going to get ASFA if we're going to do that.

Now, that's a violation of a federal law. That's what I'm asking us to think through. I'm not saying I agree or disagree. I'm just saying, if you help me understand what your purpose is, I can, in some way, try to help narrow down where we need to focus. Because right now, the way this is, I will never even come in compliance with ASFA.

**COMMISSIONER PETIT:** No, I -- so I'm not going to defend what's written there. The issue is, can the police intercede in situations that, without their presence, could result in a child being killed? Do the police have the ability to knock down a door if the person doesn't want to open it? Do the police have the ability to try and find people that social workers would never be able to do on their own? Do the police have the ability to seek a domestic order? Do they have the ability to bring something to the attention of the DA and get the guy off the streets? They have tools that social workers don't have, right?

And I thought what we talked about at the beginning is that both sets of skills would go out in these cases, along with a community person like a public health person nurse, right, and that they would assess what the degree of danger was, the degree of intervention was that was needed, and put it in front of the appropriate party. But the police always have the prerogative of acting as quickly as they need to act on a public safety thing.

I think you're right, there isn't a one size fits all on this thing because of the way the courts and the police and prosecutors are structured across the country. But there are models, and they can pick and choose from models in shaping what works for them.

When -- at one point, I was involved in a situation where we increased successful prosecution six-fold in a year, you know, over a period of time. We saw a definite reduction in the number of kids being reported as abused and neglected because these guys were off the street.

So I'm not sure where -- are you saying that one case compromises the other?

**COMMISSIONER MARTIN:** Yes. As a criminal defense lawyer, I don't want the child protection case going first more times than not, I mean, as a practical rule. And prosecuting in a criminal courtroom is not necessarily the best thing for my kids, not necessarily in all cases.

And so I think that's why I'm trying to push you -- and I'm trying to push you to tell me, if the goal is prosecution, this is -- this may or may not be the recommendation I make. But that also means that I personally don't think we're doing the best we can to protect kids if we're going to allow the criminal case to go forward.

Now, I think there's reasons why I might want it, but I will tell you, you'll get a big backlash from the defense bar, you'll get a big backlash from my prosecutors on this.

**COMMISSIONER PETIT:** Yeah, I know. I know. And this is an issue all across the country in which there are guys on the streets who we know have committed felonies against children who have not been prosecuted because somebody says, we don't have enough stuff or whatever it happens to be.

I would just mention one situation that -- in terms of what the prerogatives of the court are, if they choose. In our state, which is not Chicago, but our state, our chief criminal courts judge, after hearing what were the conversations we're doing right now, said that in the state

of Maine, all crimes involving children leap to the head of the criminal docket, except for homicide cases generally, that nothing trumps homicides. But it trumps rape. It trumps breaking and entering. It trumps burglary. It trumps driving while intoxicated. It trumps everything.

That shaved nine months off the time that a case went to court on this thing. Because you're right, because if you're a defense attorney, you're saying, whatever you do, don't go to parent counseling because it's an admission of guilt and -- well, so I just offered one thing, leapfrogging everything else and put it on a faster track.

But you're talking about constitutional law. You're talking about a bunch of things associated with this thing. And I think we just flag it that there aren't enough prosecutions. I mean, I've been in jurisdictions where the DA won't prosecute if the child is under five. They won't bring an action against somebody. Well, that's because they're uniformed or they don't know how to get good information out of their police officers.

**CHAIRMAN SANDERS:** It seems that we're not going to get resolution right now. It seems part of what we need is the identification of the goal, and then, we can talk through the best way to get there.

**COMMISSIONER PETIT:** So can I just suggest on this one? Because, look, I think I understand what it is you're saying, and I share the concern. What we need to do is flag the fact that it's an issue. And then, there are people who exist out there, whether they're university law professors or judiciary committees of legislatures or the Department of Justice, who should help in crafting a way to ensure that criminal prosecution does not interfere with the protection of a child, right?

So I think we can note that it's an issue, but I wouldn't pretend to have a national solution to it. There's something -- but the MOU thing starts to move in the right direction in terms of how to proceed.

**CHAIRMAN SANDERS:** And I do think, David Rubin, the concept of a state plan, that I assume something like this would be incorporated into that. I mean, so for the decision about who -- how -- who goes out would be part of that state plan.

And so, ultimately, the governor would need to decide for the law enforcement and child protection piece. I think the criminal justice piece, it seems like there's a lot more work that we need to do.

**COMMISSIONER DREYFUS:** So I just want to make one point. I remember back in conversations with folks in Wisconsin and Washington State, one of the things we had to bring ourselves around as the child welfare agency is that it is not our role as an agency to decide whether or not a crime has been committed against a child.

And what we're talking about here, just to be very candid, is crimes being committed against children. If these same things were being done to children by unrelated persons, we wouldn't bat an eye about law enforcement being there.

And I just -- I just had to check myself as a child welfare director that I wasn't starting to dumb down and normalize crimes committed against children.

So that's just where I kind of fall back to is when we're talking about crimes against children, what right do I have as the child protection agency to decide if it -- if a crime has been committed against a child or not?

And it always blew my mind when, like, sexual assault. And we would decide, well, there's enough strengths here in the home and we really think we can work with folks and so, you know, maybe we call, maybe we don't. And I'm like, what the hell, of course we call. So I just want to put that on the table from the --

**COMMISSIONER MARTIN:** That's not my issue. Just so everyone understands my issue. I'm not sure that Pat Martin would recommend that prosecution in cases where we know it's a crime, when it's statutory rape of a three year old, that prosecution should be our goal because sometimes that is not in the best interest of the child.

And all I'm saying is that let's figure out what our purpose is for this, and then, let's develop the recommendation that gets to the purpose the best, okay.

And if prosecution is the purpose, then I agree, there are people who are a lot smarter than I am that can help us figure out how to frame it. But I'm just suggesting that if it's the protection of the child, prosecution is not always the best thing.

**COMMISSIONER PETIT:** Yeah. It may not be. But on the other hand, you can't draw a pass by raping a three year old.

**(SPEAKING OVER ONE ANOTHER.)**

**CHAIRMAN SANDERS:** I think we're -- (inaudible) to do next. I mean, and that is really identify the goal. And why don't we take some time to do that, and then, bring it back.

And you're right, Michael, just flagging this as something there's concern about and we'll figure out the goal, and then --

**COMMISSIONER PETIT:** Yeah. Yeah. So Number 8 is a really big one. And let's just -- let me just frame it briefly for the moment.

There is a wide, wide variation among the states in their ability to respond and their ability to intervene and their ability to treat. There's a wide response. And so we keep talking about child protection system, but what we all know is that that's shorthand for child protective systems in all the states.

So, the question is, is there a way to eliminate some of the freelancing that takes place? Is there -- how do we close the gap on one state spending one-tenth what another state spends, in which it's a pretend situation that you're going to get protected in the first situation versus the second situation.

So this question of the federal -- this is really for me a question of the federal/state role in how you create the same likelihood of protection for children in any state as in every state.

That you shouldn't be more at risk in being in Nevada than in being in Texas. That all children in every place, this Commission says needs to be protected.

**COMMISSIONER DREYFUS:** So a Dr. Rubin question. You -- I want to carve out substance abuse and mental health for a minute.

**COMMISSIONER PETIT:** Wait. I'm sorry. I'm in -- I'm on eight and I think I -- oh, yeah. Eight A, okay.

**COMMISSIONER DREYFUS:** My question to Dr. Rubin is on mental health and substance abuse, and in this one. Isn't this more about not a carve out, but the full implementation of parity?

**COMMISSIONER RUBIN:** Well, I think there is -- this is going back to my comment before. I'm not sure there's a mechanism to quote, carve out, for states that don't expand Medicaid.

I think we're probably going to have more productive conversations around -- around, you know, I hope around some of the dual- generation reimbursement strategies, which is identified as substance abuse and mental health treatment for a parent can be covered under a child's EPSTD if a parent doesn't have insurance. And so that would create some capacity there.

And then, I think we heard yesterday the enforcement of mental health parity. The way the mental health parity act works is that if someone is provided insurance, right, and that insurance is going to offer a mental health component, you know, or mental health services, then the mental health -- that the mental health services they provide have to be in parity to the degree of services they provide in physical health.

So one of the ways -- you know, with the ACA plans, they required mental health as an essential benefit so, therefore, they have to have parity, right? But insurance companies, you know, can and -- can provide a plan without mental health benefits, and so there is no parity enforcement there.

So mental health parity is important and enforcement of it is important, but I actually think -- I think the way to get at this is to ensure that parents of children who are in the Medicaid program, that their parents have access to substance abuse and mental health treatment, regardless of whether they're insured.

**COMMISSIONER PETIT:** Yeah. But the substance abuse, the mental health treatment, the home visiting, are three of the four or five or six most compelling interventions, aid, support that need to be brought to families. In flagging -- so the real issue is that. Forget the funding mechanism, forget anything else.

We introduced -- I introduced the ACA carve out piece because it's already law, it already provides for these kinds of services. And if states had just said, we're going to expand Medicaid -- so without getting into the political debate about whether or not they should have expanded Medicaid or not, my guess is you could probably get most members of congress to say, yeah, we should protect these children from this kind of harm, and if there was a way to do it and contain it and keep it capped so that it's just that -- because without going into the whole thing.

But ACA is so controversial, et cetera, we may just skip that and say, do a direct appropriation. But then they'd be starting from scratch. And this is a very large budget item. There is rampant mental health, rampant substance abuse and a rampant need, if that's the right word, for home visiting.

**COMMISSIONER RUBIN:** Yeah. Yeah.

**COMMISSIONER PETIT:** This is a way for paying for it. That's all.

**COMMISSIONER COVINGTON:** I'm just personally -- I think it's a really political thing for the Commission to make a comment about without having to expand the entire Medicaid program.

**CHAIRMAN SANDERS:** Just specifically, are you speaking about A or more generally?

**COMMISSIONER COVINGTON:** A. So I guess I'm a little -- I'm a little tenuous about wanting to go that route in terms --

**COMMISSIONER PETIT:** About what?

**COMMISSIONER COVINGTON:** Wanting to go the route of having a formal recommendation.

**COMMISSIONER PETIT:** Well, because it's, right now, a hundred percent funded. The states would get money to be able to do this stuff and there'd be no cap on it. It's an open-ended kind of a thing.

So it is a funding vehicle there. And the issue is, is there enough concern for children? Forget the parents for a moment. Is there enough concern for children that you'd say, well, all right, we'll provide resources because of -- otherwise, you've got to find another mechanism.

If there was consensus or strong enough support among the group as a whole to say, look, guys, ease up on this ACA thing, do something, but it's probably very unlikely technically to open it without it cascading into the whole rest of the law and everything else. So they wouldn't confine it to just a debate on kids. They'd do everything else on it.

So it was just an -- so we could just leave out the ACA thing if we want to leave that out, and just say, do more on mental health, home visiting, et cetera. But that's just another --

**COMMISSIONER RUBIN:** No. I want specificity. I just don't think the carve out approach in the way that it was presented is the way to get to that vision. But I really want to push CMS around dual -- you know, creating an option for the states to use Medicaid funds for the child to pay for substance abuse and mental health treatment for a parent.

**COMMISSIONER PETIT:** So you know how complicated the federal law is on all this, subsections, pages, et cetera.

**(SPEAKING OVER ONE ANOTHER).**

**COMMISSIONER PETIT:** So I think without us trying to get into that, which is too sticky or wicked on this thing, we just say, feds -- and by the way, ACA could be a vehicle potentially. We could also identify something else on ACA, Medicaid.

**CHAIRMAN SANDERS:** So is B essentially what Dr. Rubin was just saying and so we're talking about not using A as a mechanism but --

**COMMISSIONER RUBIN:** No, it's not B. Because, remember, I am really worried about creating unintended consequences. So you don't want to link the provision of substance abuse and mental health services to being involved in the child welfare system.

You want it to be a matter of a Medicaid option that it's independent. So any family at risk, whether they're involved in the system or not in the system, that a Medicaid program can decide to provide mental health and substance abuse treatments if there's a public health response.

If this is someone in a home visiting program, a child who's in a home visiting program where substance abuse issues are identified in a state that doesn't have a Medicaid expansion, that there -- that if a state chooses to exercise that option, they can use Med- -- you know, Medicaid funds to support mental health and substance abuse treatment as part of a comprehensive care plan for the family. And it doesn't even involve the child welfare system.

**COMMISSIONER PETIT:** I think it leads -- it's too open-ended.

**COMMISSIONER RUBIN:** Why?

**COMMISSIONER PETIT:** The child protection piece, people -- in my experience, people say, we want the child protected. When you start leaving the protection of the children, you're getting into much more controversial --

**COMMISSIONER RUBIN:** But we have a long history -- and this is where disproportionality comes in. We have a long history of referring kids to the child welfare system because we thought that was where they could -- that's the only place they could get services.

That's the problem. It's not that the - - it's not -- I mean, it's well intended to try to link it to child protective services, but it's really problematic. And so that's my concern.

**COMMISSIONER DREYFUS:** My experience whenever the feds or even the legislature I'd be working for would use this prioritization, we want to prioritize these populations, with no thinking about capacity and access, right? I mean, yeah, it's nice to say, great.

But I think if you don't -- if you don't connect this to some kind of a mechanism for funding, like EPSDT, dual generation diagnosis and treatment -- I just found legislators and congress could prioritize all day long. If I didn't have the access and capacity in the mental health or substance abuse system -- it sounds nice. The thing that builds the access is when providers know you've got the funding to pay for it.

**COMMISSIONER RUBIN:** And I'm also giving a way out for those folks who don't want an open-ended expansion of Medicaid. It's -- I think there's a reasonable chance we're going to get them to agree that substance abuse and mental health treatment for a child at risk of their parent in terms of improving the outcomes for that child may be a nice compromise. I don't know.

**COMMISSIONER RODRIGUEZ:** I think that's really important. But like looking at this list here, one of the things that I think very concretely is, you know, we can try to do as much as possible up stream, but if it happens that there is a family that comes to CPS's attention where, say, for example, a child is unsupervised or there are concerns because the parent may or may not be using and that family doesn't have child care, I think there has to be the ability -- or like a more typical example would be, the mother is using, a boyfriend or somebody who we know from the risk factors really presents a concern to do child care.

I mean, I think there has to be an ability to get those families services immediately, to not have them go at the bottom of some wait list. But, you know -- and I understand the potential unintended consequences and the way that there are some perverse incentives.

But, I mean, in people's real lives, I do think there has to be a way that we get families who come to our attention who, for whatever reason, we've missed them at every other point, we've missed the ability to provide them services.

And, you know, the services don't have to be administered through the child welfare department. It could just be that other agencies commit to serving those families and to getting them -- getting them what they need so kids stay safe and the family can be stabilized. But that that's a better intervention than removing the child.

**COMMISSIONER HORN:** So a question for you. Can -- can we get CBO to score or someone to score how -- what -- what the price tag are on items on this?

**COMMISSIONER PETIT:** What was the last part you said, Wade? Can you get CBO to score? Yeah. No. I agree. That's where I was going to go next with this thing, 8A, B and C.

**COMMISSIONER HORN:** So, I mean, this is what CBO does for a living, right.

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER RUBIN:** Calculate the cost trade off of if we actually provided substance abuse and mental health treatment to kids --

**COMMISSIONER HORN:** So this way, I just want to know what it costs.

**COMMISSIONER RUBIN:** Yeah. That would be good.

**COMMISSIONER HORN:** And if it costs, you know, $500 million, that's one thing. If it's going to cost $500 billion, that's another.

**COMMISSIONER PETIT:** Right.

**COMMISSIONER HORN:** And that there are people --

**COMMISSIONER RUBIN:** There's good science about the impact on children. So if CBO scores it, they'll consider the cost of providing substance abuse and mental health treatment, but they'll also consider the potential impacts on children and their Medicaid use and downstream costs, right.

**CHAIRMAN SANDERS:** I think we need to be more precise in what the language is, what exactly we're asking.

**COMMISSIONER HORN:** Yes, we have to get it down. Because CBO is not going to go just score something. Well, geez, what if we covered everybody? So it would have to be very specific because, again, as I stated the last meeting, I'm not -- my instinct is not to create new entitlements, because we won't create new entitlements. We'll have a report that nobody pays any attention to.

So my concern is actually, one, to make the report that is actually actionable as opposed to pie in the sky and, gee, wouldn't it be great if everybody, you know -- if we could cure cancer, get world peace.

**COMMISSIONER RUBIN:** Would a state option -- that's not an entitlement, though, right?

**COMMISSIONER HORN:** Well, they have the option now.

**COMMISSIONER RUBIN:** They don't have the option to pay for child services -- they don't have the option to itemize substance abuse treatment and mental health treatment for a parent under a child's account.

If they're going to expand, they have to expand, you know -- you know, to the entire -- to the entire covered adult population, you know, for both physical and mental health services. This is actually creating that sort of carve out that Commissioner Petit was talking about.

**COMMISSIONER HORN:** I just want to know how much that costs. That's all.

**COMMISSIONER RUBIN:** Yeah, I know. I think we should know. I totally agree. I would love to have that scored. I think we also have to check with CMS about whether CMS Medicaid regulation would allow for that, and what it would take -- is it even possible.

**COMMISSIONER HORN:** It doesn't now.

**COMMISSIONER RUBIN:** I don't know enough about Medicaid law.

**COMMISSIONER HORN:** It doesn't now because it's all or nothing. I mean, that's the position CMS has taken.

**COMMISSIONER RUBIN:** Has taken. So I'm not -- yes. So that's what we -- so there's still more we need to explore under dual generation reimbursement. But they expressed --

**COMMISSIONER HORN:** I don't think we have to resolve the question about whether CMS would allow it because that's not the question.

The question is, let's just pretend that congress allows it and they pass a law, and then, CMS doesn't have a choice, what would it cost? Okay. And I just don't know. And we absolutely --

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER HORN:** This is what they do for a living.

**CHAIRMAN SANDERS:** I would actually think before then, we need -- because I've not yet heard evidence that either substance abuse treatment, supportive housing, mental health treatment, impact child fatalities.

I would like to see what that link is and what those services are. I think this sounds good, but I'm not sure we've heard that -- that we have enough of a case yet --

**COMMISSIONER PETIT:** David, but I think what we can do, really, is two or three or four of us should identify what the question is that we're asking somebody else to consider scoring. Because I do think we need to project what some of this stuff would cost.

But there's a number of items, B and C. B says basically services, and C says the structure that you would deliver it, right. C here is all about child welfare caseload, supervisors, blah, blah, blah. And B is really about the services that families need.

So could we reduce this to somebody saying, we're assuming 1,000 cases, 500 this, what would it cost to be able to do it?

**(SPEAKING OVER ONE ANOTHER.)**

**CHAIRMAN SANDERS:** Not unless that link is made --

**COMMISSIONER RUBIN:** I actually think the evidence is strong --

**COMMISSIONER HORN:** This is not the Commission on how to increase access to substance abuse and mental health treatment in America. That's a wonderful thing to do. We're also not the Commission to cure cancer. That's a wonderful thing to do. I'm glad people are doing that and thinking about it.

So I think David's point is important. It's kind of a two-pronged question, which, is there link? And also, we need to know how much it would cost. And if there's no link, then I don't care what it costs, we shouldn't -- this is not a Commission to recommend that.

**COMMISSIONER RUBIN:** I will go on record that the science -- this is where the science is really strong.

**(SPEAKING OVER EACH OTHER).**

**COMMISSIONER DREYFUS:** Yeah, to clarify. The link -- the link you're talking about --

**COMMISSIONER RUBIN:** None of what we're doing is -- but the link to impact on children's health --

**COMMISSIONER HORN:** This is not the Commission on children health --

**COMMISSIONER RUBIN:** So you're going to say, you don't believe we've heard testimony that says that treatment for mental health issues in parents, has -- that that hasn't been a strategy that states are employing to try to reduce imminent risk to children?

**COMMISSIONER HORN:** I'm going back to the charge of the Commission. The charge of the Commission is to eliminate child abuse fatalities. Is there a link? I don't know the answer to that.

**COMMISSIONER COVINGTON:** I think there is -- there is definitely a link with fatalities and parents' mental health or caregiver mental health and substance abuse.

**(SPEAKING OVER ONE ANOTHER.)**

**COMMISSIONER PETIT:** Right. That part --

**COMMISSIONER DREYFUS:** But I think the larger question, is there a link between treatment and --

**CHAIRMAN SANDERS:** Right. Right. Right.

**COMMISSIONER DREYFUS:** -- and reduction in fatalities?

**COMMISSIONER COVINGTON:** Well, if there's -- I mean, it seems to me, if there's a link that bad mental health and poor use of substances causes fatalities during caregivers -- that, obviously, treating them and making those problems go away has to be linked.

**CHAIRMAN SANDERS:** But you've added two things: Treating and making the problems go away.

**(SPEAKING OVER EACH OTHER).**

**COMMISSIONER RUBIN:** We have the testimony around cosleeping deaths. I mean, those -- I mean --

**CHAIRMAN SANDERS:** We haven't heard -- we haven't heard --

**COMMISSIONER RUBIN:** We just had testimony yesterday about cosleeping deaths and substance abuse treatment here in --

**CHAIRMAN SANDERS:** But we seemed to question that. That's what I'm saying is I think let's make sure --

**(SPEAKING OVER EACH OTHER).**

**CHAIRMAN SANDERS:** Let's make sure that we have that link there between treatment being effective in impacting the mental health issue --

**COMMISSIONER PETIT:** David, that, I think we know.

**(SPEAKING OVER EACH OTHER).**

**COMMISSIONER RUBIN:** We know a very strong link between substance abuse and cosleeping deaths.

**COMMISSIONER MARTIN:** When you talk over each other, none of us can understand what we're saying.

**COMMISSIONER PETIT:** The cases that we've been looking at frequently have mental health issues -- wait a minute -- frequently have mental health and substance abuse associated with them.

So the -- now, the child is dead. So there's no knowing whether or not you could have prevented a death by giving that person something. And what we know is that the best mental health treatment has a success rate of less than a hundred. We know that it's not sky high.

But the question is, if mental illness and substance abuse are associated with killing of children, then it seems to follow that you'd want to provide mental health services and substance abuse treatment services in order to shrink the number of people who are acting out by killing their kids. But we don't know for a fact that anybody has linked that back to reducing childhood fatalities.

**CHAIRMAN SANDERS:** So we're going to recommend potential spending when we don't know that it will actually impact fatalities?

**(SPEAKING OVER EACH OTHER).**

**COMMISSIONER RUBIN:** But we had testimony yesterday that the plans of safe care, right, for substance abuse treatment, reduced -- increased permanency and reduced recidivism to the system. If we believe recidivism to the system is a proximal outcome to child abuse and neglect fatalities, which I believe, you know -- you know, they can be, then I think it is an obvious link that you haven't -- you can't provide multidisciplinary services to a family without addressing the elephant on the table.

**CHAIRMAN SANDERS:** But we haven't used that standard. I mean, we could. We could say as a proxy to fatalities, that reentry into care is a proxy. We just haven't said that.

**COMMISSIONER RUBIN:** But we've created a vision that multidisciplinary collaborative -- that we -- one of the things I started out yesterday, I said that there is no magic ingredient. You show me anything that anyone's presented to us here that has a really obvious evidence-base for reducing child abuse and neglect fatalities.

What we're doing is we're taking promising programs and we're looking for common themes, right, and trying to facilitate state experimentation in an area where we believe those themes emphasize collaborative assessment, interdisciplinary treatment approaches.

And so to not put mental health treatment and substance abuse treatment for the parents on the table as part of that strategy for a state, I think would be -- we would be remiss if we weren't doing that.

**COMMISSIONER MARTIN:** So I just want to add something quickly. To 8C, I think we also need to add foster care. Because we didn't include that in there. So that's --

**COMMISSIONER DREYFUS:** I have a --

**CHAIRMAN SANDERS:** We -- if we have -- we have gone through the document identifying where we believe we have findings. We did not identify successful mental health treatment or substance abuse treatment as one of the findings that we felt contributed to reduction in fatality. That's the link that I'm making.

If we want to put this in as a recommendation, we need to build the evidence before that to say we heard this in these three jurisdictions or we've reviewed this and we have that. I'm just saying we don't have it.

**COMMISSIONER RUBIN:** So maybe the compromise is that -- this is such -- this is obviously a flash point, right, and an important discussion that we should have a session where we bring in folks from substance abuse and mental health field to talk about the link to children in imminent risk.

But that said, we've all agreed that we need to do collaborative assessment. If the collaborative assessment is Mom needs substance abuse and mental health treatment to reduce the imminent risk to the child and we're not providing those services, what's the point of doing collaborative assessment?

**CHAIRMAN SANDERS:** But what I've understood from the communities that we heard that there was success was the idea of making sure that children didn't fall between the cracks was critical.

I haven't heard yet -- and I'm not saying it doesn't exist -- I didn't hear them say this substance abuse treatment actually was what we provided to impact that. I heard that it was more the collaborative -- the collaborative work together to make sure children weren't falling through the cracks.

**COMMISSIONER COVINGTON:** Well, I mean, to me, the other option is -- and I'm kind of where David is. Yeah, we remove the kid and get them out of the situation or you help the families and you strengthen the families through treatment and support so they can go home and be in a safe environment.

**CHAIRMAN SANDERS:** I agree in terms of philosophy. I'm just saying in terms of building a case, I haven't heard it. And I haven't heard us make the link. If we -- and so I think if we're going to make a recommendation, we need to have a stronger link that we have made earlier.

**COMMISSIONER COVINGTON:** Well, I think we could play -- I could play devil's advocate on that in a couple ways. I'm not sure we've even made a link that MDTs have prevented fatalities. I mean, I think there's a lot of this --

**COMMISSIONER MARTIN:** But, remember, that was our close discussion about what's the point --

**COMMISSIONER COVINGTON:** Can I finish just for a second?

**COMMISSIONER MARTIN:** You're correct. I apologize.

**COMMISSIONER COVINGTON:** Sorry. I think there's lot of what we're putting in this report that is sort of our best guess on a lot of things because I really, truly believe a lot of this field is so unexplored, unresearched. There hasn't been a lot of energy. There hasn't been a lot of federal dollars to support a lot of what we're going through.

And I think a lot of what we're doing is sort of our gut that's leading us to a lot of our recommendations. And I think, for some reason, this one triggered some response because I think it's got money tied to it.

But I think a lot of our recommendations, as you look through this, are sort of our best guesses. And maybe we have some examples in the states where things do seem to be working, but I don't think we have some really strong universal research that shows all of this is super proven.

**CHAIRMAN SANDERS:** And let me just say, I agree with that. I think, to me, there is a distinction if we're saying, we want to create opportunities for our states to experiment further and to test ideas and to evaluate them versus we want to make sweeping changes that will impact -- that will have a fiscal impact and that we're certain enough that the return on investment will be significant. So I think there is a distinction.

**COMMISSIONER COVINGTON:** So maybe the way to frame that would be to allow flexibility for states who want to try some of these models out.

**COMMISSIONER MARTIN:** But I'd like to remind everyone, we had a detailed conversation about what's the point of MDT. And the idea was, I thought that we agreed that it was for investigation, to make certain that we didn't lose kids through systems.

And so, if that was the point, we had determined that kids dropping out of a system and losing kids in the system had a direct link to deaths, and that was the point of the multiple disciplines -- multi discipline team for the investigation.

It wasn't that MDT reduced deaths. It was that it kept kids from getting lost in the systems, between systems. And we were plugging up the holes, if you will, between the systems to reduce kids not being to the attention of authorities.

**COMMISSIONER COVINGTON:** I think it's two things, though. I think MDTs are also used well to do wrap-around service provision in addition to just the early investigation. I mean, that's the world I envision. That's what I think our prevention group has been thinking about is, how do you wrap kids around multiple services.

**COMMISSIONER HORN:** So I just sort of want to remind us that best guesses sometimes turn out to be not only wrong, but counter-productive. Take a look at scared straight programs. The evidence on scared straight programs are they not only don't work, they actually make things worse. And so we've got to be a little humble about best guesses, particularly when we're --

**COMMISSIONER RUBIN:** I'm sorry. I can't we -- we can't compare scared straight programs --

**COMMISSIONER HORN:** Can I talk? Can I talk? I mean, I'm usually pretty polite, but it would be nice if you didn't talk over me.

So -- so the question -- you're asking something fundamentally different. You're not asking for a targeted intervention for a group of kids, which I think what you're asking. You're saying, let's expand Medicaid to the entire population below a certain FPL with the hopes that somehow that will capture enough of the people who would eventually cause harm to a child.

I'm not saying that's a bad thing. I'm not saying in some other context I wouldn't agree with that. What I'm saying is that this is a Commission that is supposed to be focused on this population.

And, therefore, it seems to me that we should have at least some evidence that the broad based view that's going to cost a lot more money is going to actually address this question more effectively than a much more targeted approach that David is -- Michael is suggesting.

So I just don't know the answer to these. I'm just saying that, you know, I think those are legitimate questions to be raised.

**COMMISSIONER RUBIN:** I just -- I just strongly disagree to even comparing the evidence on scared straight programs to the evidence on mental health and substance abuse treatment for people in this country.

The evidence on scared straight programs never existed, all right. There are decades of evidence to the value of mental health treatment and substance abuse treatment for individuals in this country. And so when you talk -- if we're going to talk about the evidence, you have to start there.

The second thing I would say as well, too, we had testimony in Oregon, all right, about coordinated care organizations. And we know that the fatality rate was lower in Oregon. Can you make the empiric leap that the provision of services is what caused or reduced fatality rate in Oregon? I'm not sure you can make that leap because it's very hard to test that empirically. But I believe that their approach, that interdisciplinary approach, is why we're seeing value there.

Now, I also didn't say that we were going to expand Medicaid to everyone. I said that I was in favor of trying to investigate whether we could create a state option to allow the provision of mental health and substance abuse treatment services as a part of EPSDT requirement for children.

That's not an open-ended entitlement. Many states might not exercise that, but some might. And so, you know, so I think that -- so, to me, that was a hedge to say, why don't we allow states to play in this a little bit and then, test and evaluate it.

**COMMISSIONER DREYFUS:** So just three things. First of all, I agree with Wade. And I don't think we ever envisioned this massive expansion. I think the question here is EPSTD for these kids that are involved in the child protection system.

I think we've got to really clear the population that we're talking about. Because I agree, there is no way we could be talking about all kids that get EPSDT. But I do think about as a requirement of children where the state's involved in their lives, right, and EPSDT is required. And that EPSDT, this two-generation idea, I think does merit something.

I also think, David, to your point about proof, I agree with you on that. But I think part of what this Commission is trying to do is we have been told that there is a -- there is a connectedness between certain prevalent issues in a home and child fatalities. And substance abuse and mental health have been right up there.

And what we're trying to do is reduce those risks. So I don't see this as solving, you know, it's going to eliminate fatalities. I'm looking at risk reduction in a home and reducing a parent's symptoms that are -- relevant to substance abuse and mental health, reducing those things, I think is something we need to care about.

But that being said, Jim is simply saying that treatment is what does it is not right. And if we're going to look at this issue, I'd want us to separate mental health treatment from substance abuse treatment and bring in Dr. Wayne Ondersma from University of Michigan and the phenomenal research he has done that just turned me on my head about all the assumptions I made, that if you are a typically a woman substance abusing and we're going to take your kids, that we're going to require treatment.

And he found that when he used PCIT, parent/child interactive therapy and motivational interviewing, 50 percent of the women didn't need treatment. So I just don't fast forward to treatment means --

**COMMISSIONER COVINGTON:** Residential care for substance --

**COMMISSIONER DREYFUS:** Yeah. So I'm just saying, there's more to this than just a straight shot. It's risk reduction, it's EPSDT on this population of kids. And the dual generation idea, I think that's merit. But also, not just assuming that treatment is what -- as we think of substance abuse treatment is the answer.

**CHAIRMAN SANDERS:** Amy?

**COMMISSIONER AYOUB:** Yeah, I have to leave, so I apologize. I just wanted to jump ahead to some logistics and make some suggestions that after August, we don't have scheduled meetings. And that we really be careful about booking those -- you know, like the August meeting is already booked six hours with things.

You can see from this discussion, we're going to have to have another extension. The report's not going to be due. It's a tremendous --

**CHAIRMAN SANDERS:** Let me just distinguish, there has been requests for six hours.

**COMMISSIONER AYOUB:** I'm sorry?

**CHAIRMAN SANDERS:** There have been requests. We haven't booked anything.

**COMMISSIONER AYOUB:** So I'm just going to recommend that we're really careful about booking any future meetings and booking speakers, that maybe we could take Susan's recommendation and have conference calls in between with one specific person at a time or something.

Because this kind of discussion isn't going to stop at this meeting. And it's very intense, very detailed and very necessary to get this report out.

The report's a tremendous -- tremendous effort on the staff's part. And so every time we have a meeting, that distracts from writing that report. And so I just -- I'm asking people to keep that in mind when you start talking about what the future is for your meetings.

And also, it just came up for me, I was wondering -- not to answer it now, but David kept -- Commissioner Rubin kept saying about not being too prescriptive, so I think that needs to be a consensus. We want to find a consensus on this Commission for this report, that we need to also maybe as a foundation find that do we have a consensus on that.

Are we going to have specifics? Are we going to be prescriptive or are we -- how general are we going to be? Because that might be also why reports sit on the shelves for a long time if there's not -- not enough direction. But, to your point, not being too prescriptive.

So I would just like to know in the future, not today, I'm leaving, if we have a consensus on how people agree. Because it's hard to start writing a report without having that kind of direction. Thank you.

**CHAIRMAN SANDERS:** So it sounds like there is -- that we definitely want to look at both the cost and effectiveness of being -- well, I have some different questions about C. But that we want to proceed with getting some more information about the effective approaches.

Now, I think part of the question is, how broad or narrow we're targeting here, too. And so do we want to continue that as a debate here or are there --

**COMMISSIONER PETIT:** If you want what? I missed that. What did you say.

**CHAIRMAN SANDERS:** Do we want -- how broad or narrow? Your proposal, I think, is fairly narrow in terms of who to target.

**COMMISSIONER PETIT:** Right.

**CHAIRMAN SANDERS:** And I heard --

**COMMISSIONER RUBIN:** I'm wide open because I think it's really problematic to link services in health to being involved in the child welfare system. I think history has proven that over and over again, that that then becomes the -- the child welfare becomes the gateway to provide families with health services. And I just think that's a wrong precedent to kind of go down, so...

**CHAIRMAN SANDERS:** So do we need something written up that we can actually take a closer look at?

**COMMISSIONER PETIT:** The piece that I'd be willing to take a draft of is if the following pieces were proposed as being responsive to this problem, what would it cost the federal government to do it? In other words, if you said that there are standards in CAPTA or CSFRs or whatever it is, and the states were to meet best practice standards -- so I'm saying just as a take off point. It's not necessarily what we're saying.

Whether it's CWLA standards or council on accreditation standards or whatever it is, what would it cost to do that? Forget federal share, forget state share. Just what does it cost?

If you said -- when we heard yesterday 4,500 staff in a state of seven million people, I mean, that's a huge commitment of resources to protect children. Is it a gold standard? Is it average? Is it below what they need? I don't know.

But there are questions that somebody needs to score, CBO needs to score, and we just need to ask the right questions. I'm happy to draft that with somebody and circulate it to the group or just work with two or three people on putting it together. But I think B and C are the heart of this resource issue here that we need to define.

**COMMISSIONER RUBIN:** And I agree. I think some commonality here, I mean, with Commissioner Horn is that I think we should have CBS score it, right? And so I think that when you look at the evidence of what provision of health services could do for parents of children who are at risk, there is obviously the cost of doing that, which is the provision of those services, but there's also reduction.

We -- there is clear evidence in terms of the impact on children, the science. If we got Jack Shonkoff in here from the Center for the Developing Child, the science is extremely strong. And then, we have clear impacts in terms of referrals to the child welfare system, which are costly.

And so, I think CBO should score this. And at least then it's guided by some level of what we're talking about here.

**COMMISSIONER PETIT:** Should score what? CBO should score what?

**COMMISSIONER RUBIN:** Score providing a state option that would allow a state to provide substance abuse and mental health services to a parent through their EPSDT requirement if it was considered to potentially impact the health of the child.

**COMMISSIONER PETIT:** Yeah. And that's one of 20 pieces that we would ask them about financially. I mean, that's one slice. Then there's all the other stuff, right.

**COMMISSIONER RUBIN:** It's a big ticket item. But I think that's one we should have scored. I think we should see how that would come out.

**COMMISSIONER HORN:** So, although, that has the potential of putting people who then say, gee, that's not the right answer in a position where it looks like the people who say, yes, it's the right answer care more about kids.

So I think that the other question is a critical one, which is, what is the evidence that that is -- that that recommendation fits within the charge of this Commission, and what is the evidence that it will actually further the goals of this Commission? I think that is a legitimate one.

We could also ask CBO to score how much money would be required to cure cancer by 2020? It has nothing to do with this Commission. There would be a number attached to it. And if I were to say, gee, I don't think we should include that in the report, people would say, gee, Wade, you don't care about cancer victims, do you?

So I don't want to be set up. And so I just want to be very clear that I have no interest in being part of a process where I'm going to be set up where suddenly I'm the guy who doesn't care about kids because I'm not willing to spend as much money as somebody else is.

Which, by the way, somebody pays for that. It's not free. There's not a money tree in the backyard, you know, that people go to to get it. You know, it's somebody -- somebody earned a dollar. Every dollar we recommend that gets paid -- that gets spent, somebody earned it and we took it away from them, the government did, and spent it for them. So it's got to be connected to this charge.

So in some ways, David's recommendation, although, I don't agree with the ACA piece of it - - I mean, Michael -- sorry.

**COMMISSIONER MARTIN:** We'll put a name tag on.

**COMMISSIONER PETIT:** I'm flattered that you --

**COMMISSIONER HORN:** There's too many Davids on this.

That Michael -- Michael's, at least it seems connected, you know. And we're talking about kids who are involved in the CPS system, and so what would it cost if we were to provide all those kids and their parents who were involved in the CPS system these kinds of services?

That, at least to me, seems to be connected to the charge of the Commission. So -- and I'm not sure I agree with the ACA being there, but I think at this point, you've kind of withdrawn that as the vehicle. You're just saying what would it cost and we'll worry about the vehicle later.

**COMMISSIONER PETIT:** What I'm saying ultimately, from the beginning, before this Commission was ever formed, going back years and years and years and years, is that if you address the morality issue, you are inevitably going to address the morbidity questions that you're on all the time, which you're right to do.

But it's not what we come out of the chute on. We've got to stick with the deaths of children, and not too many American children living in less than ideal conditions.

**COMMISSIONER MARTIN:** So I'd like to offer an opportunity for me to look at the statute, our enabling statute, along with this conversation, and see if I can parcel out how this might look a little bit, okay.

**COMMISSIONER PETIT:** How what might look?

**COMMISSIONER MARTIN:** Well, kind of what this issue really looks like when we look at the legislative statute that enacted our Commission with Title IV-E and with our Social Security Act and everything. Let me just take a look at it.

**COMMISSIONER COVINGTON:** There's a -- after all of that, there's a sentence that said we are also supposed to come up with recommendations on how you prevent child abuse fatalities. It's a huge piece at the end of that whole charge, so --

**COMMISSIONER RUBIN:** A couple of things. First of all, I just want to make it clear, Commissioner Horn, I was only objecting to the comparison to scared straight. I actually -- I understand this is a flash point.

And -- and so to the extent we have disagreement about what population, whether this is even fiscally responsible I think is appropriate, right, it's totally appropriate. I was just upset about the comparison to scared straight.

But I will say that we could ask Emily Putnam Hornstein, right, to -- I believe her data shows that substance abuse issues and mental issues and recidivism to the system is associated with child deaths. We could ask for empiric data.

And so if you believe that there is a strong association of those things with child death, then it's not a huge leap to imagine that you can test whether the provision in a more standardized way of substance abuse and mental health services actually impacts child deaths. A lot of what we're going to be recommending is going to require evaluation. So I don't think it's a leap to say that.

And I understand the trying to contain this by saying just within the child welfare system. I just believe, you know, fundamentally, that linking health services to child welfare involvement is going to, A, make the disproportionality issue go through the roof, right, and B, it's just not the effective way to address need. It's a reactive way of addressing need.

**COMMISSIONER COVINGTON:** I find it to be a reactive way, too, because it basically says, we want the child to come to harm before we're willing to address the needs of the family and the support systems that are in the family.

We've spent all this time on the Commission talking about kids at risk and how we identify kids at risk. And if we wait until they're into the system, which means they've already had harm come to them, then, to me, it's - - and I've always believed looking at child fatality reports that there's a really, really, really thin line between the kids who die and the ones who don't. I mean --

**COMMISSIONER MARTIN:** The kids that don't --

**COMMISSIONER COVINGTON:** It's a very thin line between a child who dies and the one who doesn't. I mean, I find it to be a matter of luck most of the time in terms of the kids who suffer.

**CHAIRMAN SANDERS:** But it shouldn't be a difficult link to show that access to substance abuse and mental health treatment has an impact. And we should be able to show that as part of the evidence that we built.

I think if we can show that greater access at least has a potential to impact overall fatalities, then we should do that and cost it up. I'm just saying I'm not sure we've yet demonstrated that link. I understand the strong feelings about it. I don't think we've demonstrated it.

And I think we should at least have reason to believe that that's the case. And I think we can point to some communities. What you just said about Oregon, I think Vermont could be another example. That if we can make that link stronger and say, you know, here was a correlation with the five states that we saw that had low -- low fatality rates also offered greater access to treatment, I mean, that, I think, would be helpful. But I think there's something that we need there.

**COMMISSIONER RUBIN:** Yeah. For me, I think that I don't want us to hold the treatment of a parent's mental health or substance abuse issues to a higher standard than we're holding any of our other recommendations, to some extent.

At the same time, I understand, you know, it costs money. But to me, I would be satisfied if I heard the evidence on, okay, is there a strong association between prior substance abuse and mental health issues and, you know, what is -- what is the fatality association data show us? So can we establish that link? What does the ACE literature and intervention and intergenerational trauma show us about the risk for serious harm for children?

These -- if I'm getting very specific about the research questions that I would need to ask, it would be that.

And then, third, what does the literature show us about treatment for mental health issues and parents and their impacts on the child? And if we can direct the staff to either obtain written testimony or do that review for us, I think -- in many ways, I think that evidence might even be stronger than collaborative team assessment. I'm not -- you know, because if you hold that to the standard, how do you know that's going to prevent fatalities?

**CHAIRMAN SANDERS:** But I think we've identified communities and said one of their approaches was collaborative team approaches and that that offers some promise. I think we had an extensive discussion about not overstating the promise that's offered.

So I'm just saying, it seems like there's something early in the report we should say, there's something here that offers at least some promise. I agree, we're not holding this to a higher standard, but I -- I'm just saying, I don't think we've yet made that link. And we need to.

**COMMISSIONER HORN:** And in some degree, the difference, to me, is -- with MDT is we're not saying every family in America should have a multidisciplinary team come into their home and do an assessment. What we're saying is, for those families who have been referred to CPS, there ought to be access to an MDT team, right, who then would do an assessment because they came in contact with the CPS system.

So you're asking for -- you're asking to -- and I understand your point, and I don't actually disagree with it -- which is, you don't want to have the law of unintended consequences rear its ugly head and say the only way that you can ever get services in America is to, you know, get somebody to report you for child abuse and neglect. I'm not at all disagreeing with that. I think that we have to be very considerate about it.

At the same time, it seems to me we also need to be considered about, so, therefore, now we're going to have a universal -- sort of a universal access to -- because we're so scared of, you know, the unintended consequences that we're going to universalize this and it's going to cost an enormous amount of money.

And the difficulty for me is not that it's going to cost a lot of money, is it's never going to happen. I mean, that's the problem. So - -

**COMMISSIONER RUBIN:** Yeah. I would just say, look, for states that have already expanded Medicaid, this is a nonissue, right, because they theoretically have the funds to pay for substance abuse and mental health if they do collaborative assessment.

So, you know -- and many states have. So I'm really talking about places that have not -- whether there is value in providing a state option to states like Tennessee here who elected not to expand Medicaid to still be able to intervene on behalf of families.

Now, if I were costing -- and I'm interested to see how CBO would treat this. If I were costing out the provision that we do this under the rubric of within the child welfare system, part of that cost is the increased cost that's going to happen when people start flooding the system with calls because they have kids who are running around amok or parents with substance abuse treatment.

If you do it from a more public health approach, the hope is that you'll have fewer kids, and then, the evidence would suggest that safe plan of care actually results in less recidivism. So there's actually a benefit in terms of reducing the other systems' costs.

And so I think there -- I'd be interested to see how CBO treats this. But I'm not thinking about it in terms os everyone's suddenly going to be using this provision. Because most states don't need to use it if they've expanded Medicaid already.

**COMMISSIONER HORN:** And believe it or not, I am willing to be convinced that my existing opinions are completely wrong by evidence. And so I'm not at all -- I just don't want to be in a position at some point where suddenly there's a price tag on something, and if I don't agree with it because of other reasons, that somehow I'm then labeled as the guy that, you know, on the Commission that doesn't care about kids. That's my only -- I hope -- and I know you're not saying that.

So -- so and I agree with you about scared straight. And I should show other examples. There's the famous Summerville study, which back in the early '60s in juvenile delinquents had randomly assigned juvenile delinquents to a group that just did regular sort of, you know, stuff at the law enforcement, and those that got individual treatment and group therapy. And the ones that got individual therapy and group therapy did far more crime than the ones that didn't.

And part of that, the explanation was -- and it makes sense in retrospect, is you took all these juvenile delinquents, put them into group therapy and they joined -- they formed a gang.

So, you know, we just have to be -- it was that -- maybe I didn't mean it to be a flash point.

**COMMISSIONER SANDERS:** All right. We're at a point that we're going to have to --

**COMMISSIONER PETIT:** Are we adjourning now?

**CHAIRMAN SANDERS:** In a minute.

**COMMISSIONER PETIT:** Can I safely leave?

**CHAIRMAN SANDERS:** Say that again.

**COMMISSIONER PETIT:** Can I safely leave?

**CHAIRMAN SANDERS:** Yes.

**COMMISSIONER PETIT:** The last item on our report, that Item D, I think belongs someplace else. So it doesn't belong there. And I don't think there's anything controversial about it. It's what do we know about what works and what doesn't work based upon research. So we'll fold it into that.

Is the next time we're all together in Utah in three weeks, four weeks?

**CHAIRMAN SANDERS:** Yeah.

**COMMISSIONER PETIT:** And we may or may not talk before then and we've got individual things going on.

**CHAIRMAN SANDERS:** Yeah. So we'll get potential times up for -- at a minimum some conference calls. We'll also suggest that we have at least one or two meetings after the last meeting that we currently have scheduled in August.

**COMMISSIONER PETIT:** Yeah. And then, we're going to get updated rewrites of these things and we'll be going through this exercise again, dear God.

**CHAIRMAN SANDERS:** We'll have a more extensive outline of the content of the final report that we talked about today. And we'll have an opportunity, I think, to build on some of the things Teri started with, what more do we need to know, what might we need to pay attention to that we haven't yet?

**COMMISSIONER DREYFUS:** Can we start -- get the developing list of all the recommendations we've heard and the country? You know, we heard some very specific ones yesterday and we've had some of our presenters do that.

Is there a way for us to start bucketing those as well? Not that we're saying we're going to adopt them all, but at least they can get assigned to the right committees to make sure we really have taken a legitimate look at them?

**CHAIRMAN SANDERS:** I know we have a running list, so, yeah, we can do that.

All right. I think we're adjourned for today. Great discussion.

**MEETING ADJOURNED**