PROPOSAL TO REDUCE CHILD DEATHS DUE TO MALTREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

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PROPOSAL TO REDUCE CHILD DEATHS DUE TO MALTREATMENT

WEDNESDAY, DECEMBER 12, 2012

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC.

The subcommittee met, pursuant to call, at 2:11 p.m., in Room 1100, Longworth House Office Building, the Honorable Erik Paulsen [Acting Chairman of the Subcommittee] presiding.

[The advisory of the hearing follows:]

HEARING ADVISORY

Acting Chairman Paulsen Announces Hearing on Proposal to Reduce Child Deaths Due to Maltreatment

Wednesday, December 05, 2012
By (202) 225–3625

Congressman Erik Paulsen (R–MN), Acting Chairman of the Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing to discuss a bipartisan proposal to establish a commission tasked with developing recommendations for reducing child deaths due to maltreatment. **The hearing will take place at 2:00 pm on Wednesday, December 12, 2012, in Room 1100 of the Longworth House Office Building.**

In view of the limited time available to hear from witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include experts on child abuse and neglect and child fatalities due to maltreatment. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

BACKGROUND:

According to State reports, over 1,500 children in the U.S. died in FY 2010 due to maltreatment. However, research has shown that these reports substantially understate the number of children who die due to maltreatment each year. To gain a clearer understanding of this issue, Ways and Means Committee Chairman Dave Camp (R–MI) asked the Government Accountability Office (GAO) to review what is known about the circumstances of child deaths and near deaths due to maltreatment, State approaches to gathering and reporting this information, and what the Department of Health and Human Services (HHS) has done to support the collection and accurate reporting of this information. GAO testified about the findings of their review and released its report during an earlier Human Resources Subcommittee hearing held on Tuesday, July 12, 2011.

Since the earlier hearing, Members have continued bipartisan discussions on ways to reduce fatalities due to maltreatment. Specifically, full Committee Chairman Dave Camp (R–MI) and Subcommittee Ranking Member Lloyd Doggett (D–TX) have developed a proposal, the Protect our Kids Act, to establish a commission that would examine the issue and recommend ways to improve current policy and practices. The purpose of this hearing is to review that proposal and solicit input from key stakeholders and other experts on how such a commission might best undertake this work. A draft of this proposal, on which witnesses will be asked to comment in their testimony, can be found at the following link: *http://waysandmeans.house.gov/UploadedFiles/Commission_Draft.pdf*.

In announcing the hearing, Acting Chairman Paulsen stated, "The death of any child is a tragedy, but there is nothing more heartbreaking than when a child dies at the hand of someone who should have cared for them most. Our hearing last year highlighted this issue and what can be done to collect better information on the problem. Now we have a bipartisan proposal to investigate this issue further and produce real reforms. I look forward to hearing our witnesses' thoughts on this proposal so we can ensure that more kids are protected from abuse and neglect."

FOCUS OF THE HEARING:

The hearing will focus on the bipartisan proposal, the Protect our Kids Act. The draft legislation establishes a commission to examine the issue of child fatalities from abuse and neglect, review the effectiveness of current programs and policies, and recommend ways to reduce child fatalities due to maltreatment.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. Attach your submission as a Word document, in compliance with the formatting requirements listed below, **by Wednesday, December 26, 2012.** Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

The Committee relies on electronic submissions for printing the official hearing record. As always, submissions will be included in the record according to the discretion of the Committee. The Committee will not alter the content of your submission, but we reserve the right to format it according to our guidelines. Any submission provided to the Committee by a witness, any supplementary materials submitted for the printed record, and any written comments in response to a request for written comments must conform to the guidelines listed below. Any submission or supplementary item not in compliance with these guidelines will not be printed, but will be maintained in the Committee files for review and use by the Committee.

1. All submissions and supplementary materials must be provided in Word format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone, and fax numbers of each witness.

The Committee seeks to make its facilities accessible to persons with disabilities. If you are in need of special accommodations, please call 202–225–1721 or 202–226–3411 TTD/TTY in advance of the event (four business days notice is requested). Questions with regard to special accommodation needs in general (including availability of Committee materials in alternative formats) may be directed to the Committee as noted above.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://www.waysandmeans.house.gov/*.

Mr. PAULSEN. Good afternoon. I call the subcommittee hearing to order.

The purpose of today's hearing is to discuss a proposal designed to reduce the number of children who die from abuse and neglect.

I would like to thank our colleague, Mr. Doggett, as well as Chairman Camp, for their work on this very important proposal that we will consider today. There are tragically too many examples, like Devin Drake, of why this is an important issue. Three-year old Devin Drake was brought to Mercy Hospital in Minneapolis, Minnesota, by his mother, Elizabeth Moorman, on August 30, 2011. She said that Devin had been completely normal until he collapsed at home just a few minutes earlier. After questioning by medical staff, and later police, her boyfriend, Anthony Urban, admitted to punching Devin the day before. He said the boy then fell

off a stool and hit his head on the bathroom ceramic floor. Even though Devin had trouble standing up and was obviously seriously injured, neither his mother nor her boyfriend took time to bring him to the hospital. The next day, even after Devin's condition worsened, they still did not get help for him. Finally, it was that evening that Devin's mom took him to the hospital.

Police reports revealed that this was not the first time that Devin had suffered abuse. Before his birth, Devin's mother was convicted on drug charges. After Devin was born, social workers contacted his mother because of alleged drug abuse. At the time of Devin's hospital visit, his mother had outstanding warrants for her arrest, which no doubt contributed to her reluctance to take her son to the hospital.

Her boyfriend had two felony drug convictions. Neighbors said they noticed Devin recently had had a black eye. One neighbor said she had planned to go to authorities the very day that Devin was taken to the hospital.

When Devin arrived at the hospital, medical staff realized his injuries were no accident. He was diagnosed with severe head trauma, punctured lungs, and a number of contusions. He was airlifted to Hennepin County Medical Center, where his injuries were found to be consistent with severe abuse.

Four days later, 3-year old Devin Drake died. Nothing is more breathtaking, heartbreaking than when a child like Devin dies at the hands of someone who should have cared for him the most.

And that is why we are here today, to review a proposal designed to reduce the number of these tragedies. Ultimately, the real solutions will come through the incredible work done by local child welfare agencies, education providers, police, healthcare providers and workers and many others.

While it won't be the Federal Government that solves this problem, we have a role to play. As the legislation before us suggests, we can bring together experts to review which of today's practices work, and don't work, to highlight what additional steps hold the most promise and ultimately help local officials incorporate that knowledge into their best practices.

In July 2011, we heard about the magnitude of the problem, including the fact that hundreds of child abuse deaths go unreported each year. Today we will review a bipartisan proposal to establish a commission to consider these issues and develop recommendations to ultimately reduce the number of those deaths.

This legislation would have a very small cost, which we would make sure is fully paid for by other savings. We believe it can move forward quickly through the House and then, hopefully, through the Senate.

Most importantly, we think it will help prevent future child abuse deaths. While that will come too late for Devin, we do owe it to the many vulnerable children who might be saved in the years ahead to make any progress that we can.

I look forward today to all of the testimony from our panel's witnesses and advancing the bipartisan legislation offered by Chairman Camp and Representative Doggett.

Without objection, each Member will have the opportunity to submit a written statement and have it included in the record at this point.

Mr. Doggett, would you care to make an opening statement?

Mr. DOGGETT. I would, Mr. Chairman, and thank you so much, Mr. Chairman, for the work that you and your staff have shown on this measure.

I am pleased that, with your personal leadership and that of Chairman Dave Camp, we are moving forward in a bipartisan manner to pass legislation to reduce the number of children who are exposed each year to abuse and neglect.

It is my hope that we can use today's hearing and the expert witnesses that we have together with us in the hearing to perfect this legislation before its bipartisan consideration here in the House.

At the hearing that we had in July of 2011 in this subcommittee, I expressed hope that we would be able to work together, and I think these more recent developments suggest we are doing that.

You know, as a grandfather myself of three little girls, who bring such tremendous joy to our family, it is just painful to even imagine a child being subjected to neglect and abuse, especially from a family member.

Yet we recognize each year that there are thousands of children who face this cruel fate. As District Judge Darlene Byrne, a leader in establishing, really across the country, but beginning in Travis County in Texas, our child protection courts, has said, "Childhood should be a time of innocence and freedom, but it is a sad fact that many children are vulnerable to injury and abuse. Our Nation's children need good leaders to stand up at a national level and find creative ways to protect them from harm. The creation of a national commission to end child fatalities is an important step in that direction."

We need thoughtful consideration of everything we can do to protect vulnerable children. And in some cases, we just need to share what is already working, what has been developed in some communities to try to avoid tragedy. And a lot of what we will hear today is that there are many areas of improvement in the fight against child abuse and neglect that we can, in fact, make.

The draft legislation that we are reviewing today represents an improved version of the original H.R. 3653, that I introduced exactly 1 year from tomorrow, and that is pretty quick for Congress to act.

It would establish a national commission to develop recommendations to reduce child fatalities stemming from abuse and neglect. In my home State of Texas, groups like TexProtects, Voices for Children San Antonio, CASA, children's shelters in Austin and San Antonio serve as a voice for the voiceless, protecting and advocating for children, as their counterparts do in other States around the country. Local leaders, like Texas State Senator Carlos Uresti, was a driving force behind getting our Texas Blue Ribbon Task Force to combat child abuse and neglect set up, and getting Bexar County's own task force to combat these problems.

There are a number of similar organizations in Chairman Camp's home State of Michigan, and I am sure in Minnesota as well, like Michigan's Early Childhood Investment Corporation,

Michigan's Council on Maternal and Child Health, and the Michigan office of Great Start. The important work that these folks are doing has been critical to improving the lives of at-risk children. Yet despite these developments, fatalities stemming from child abuse and neglect remain at epidemic proportions in Texas and in San Antonio, in particular. Last year there were almost 6,000 confirmed cases in Bexar County, that is San Antonio, the highest number in Texas, higher than even Houston and Harris County, which has a population that is about twice as large.

In the decade from 2000 to 2010, Texas had over 2,000 reported deaths from child abuse and neglect. And last year, Texas had nearly 66,000 confirmed cases of child abuse and neglect, and over 200 deaths during that one year alone. So there is much we need to focus on in my home State and around the country.

Mr. Chairman, in so many cases, we may never fully understand what causes this abuse and neglect, but we can understand ways to reduce it. And I think, by creating this national commission, we will be taking a step, an important step in the right direction. Thank you.

Mr. PAULSEN. Thank you, Mr. Doggett.

I want to remind our witnesses to limit their oral statements to 5 minutes. However, without objection, all of the written testimony will be made part of the permanent record.

On a panel this afternoon, we will be hearing from Bill Frenzel, guest scholar at the Brookings Institution; Teresa Huizar, executive director, National Children's Alliance; Madeline McClure, executive director, TexProtects; and David Sanders, Ph.D., executive vice president of Systems Improvement, the Casey Family Programs.

I would like to now introduce our very first witness, Mr. Frenzel. Bill Frenzel is a former Member of the United States House of Representatives, representing my district, actually, in Minnesota's Third Congressional District, where he had a very distinguished career for 20 years. He served as a member of this committee as well as a ranking member of the House Budget Committee and the House Administration Committee.

Upon leaving the House, Mr. Frenzel continued his public service, serving as a special advisor to President Clinton on NAFTA, as well as chairman of the President's Advisory Commissions on Trade Policy and Negotiations from 2002 to 2011.

Mr. Frenzel also served as the chairman of the Pew Commission on Children in Foster Care from 2003 to 2008.

It is an honor to have him testify here before the committee today.

Mr. Frenzel, please proceed with your testimony.

STATEMENT OF THE HONORABLE BILL FRENZEL, GUEST SCHOLAR, BROOKINGS INSTITUTION, FORMER MEMBER OF CONGRESS, AND FORMER CHAIRMAN, PEW COMMISSION ON CHILDREN IN FOSTER CARE

Mr. FRENZEL. Mr. Chairman, thank you.

Chairman and Members of the Committee, it may be bad form, but I want to say, first of all, what a great privilege and pleasure

it is for me to testify before a committee chaired by a Congressman From the Third District of Minnesota. My elation knows no bounds.

Mr. Chairman, I want to testify on the structure of the committee and the remarks that I make are based on my own experience in a number of commissions and panels. And I hope that they will be helpful, and I realize that there are lots of other points of view that will be and can be made.

First of all, the draft bill of Congressmen Doggett and Camp, provides for a Presidentially appointed commission. And that is a good idea if you are looking for prestige. However, Presidential commissions don't have a glorious history of success. My guess is that this particular commission is going to succeed no matter who appoints it, but I believe you are likely to come to a better outcome if you appoint it through the Congress.

The trouble with Presidential appointments is that you aren't there to see that they get made. You may have trouble with what I call geographical distribution, which I think is important and I will talk about more later. And the President may want to reward other people, and his personnel department may have restrictions that make it difficult to put the kind of people you want on there.

So I would say it would be a lot better to have the commission selected by Congress, and by your subcommittee and its Senate counterpart, I think they could work with the appointing authorities, all four of them in Congress, to get the right kind of commission.

With respect to size, I think the draft bill has it about right. I would suggest a few more, but certainly no more than 20. So I think you are okay there.

The qualifications are something that I am not myself qualified to speak about, but it looks like you have the bases pretty well covered.

I think, however, I am going to suggest that you might try some former Members of Congress in leadership jobs, and they might not qualify under the qualifications listed in the draft bill.

I talked about regionality before. You need to get a spread. The States are all different. The regions are all different. You can't avoid California and New York, where certainly a lot of these problems exist, and you need a spread elsewhere. That is one of the reasons why I prefer a little larger commission than is outlined in the draft bill.

With respect to congressional membership, it is up to you. I believe that Members have got a lot of things to do, and probably shouldn't be on the commission and might not be reliable attendees.

As to commission leadership, I have always thought that having a former Congressman to enforce management and leadership and look for consensus is a really great idea. I had a wonderful experience on the Pew Commission on Children in Foster Care working with Bill Gray, who had formerly been chairman of the Budget Committee when I was the ranking member. And I think neither of us knew very much about children in foster care, but I think we kept the commission going and aimed in the right direction.

I have a note here on consensus. It is, I believe, very important to have the members come to a fairly unanimous agreement. Sepa-

rate or minority remarks blunt the thrust of these kinds of commissions. I think that proper leadership will get you there.

My time is expiring, but let me just say, with respect to congressional approval, I hope that this committee would see that there is some kind of action immediately following the report, because then, local agencies, private organizations, State, and other agencies will pay a lot more attention to it if they believe that the Congress thinks it is a good report.

Congress may not be able to pass a bill to say this, but I think the committee could indicate approval somewhere along the line.

Mr. Chairman, I have other thoughts, and I will leave them for the question period. Thank you very much.

Mr. PAULSEN. Thank you, Mr. Frenzel, very much.

[The prepared statement of Mr. Frenzel follows:]

Bill Frenzel
Brookings Institution
1775 Massachusetts Av. NW
Washington, DC 20036

WAYS AND MEANS COMMITTEE'S SUBCOMITTE ON HUMAN RESOURCES
HEARING ON ESTABLISHING A COMMISSION TO DEVELOP RECOMMENDATIONS FOR REDUCING CHILD DEATHS DUE TO MALTTREATMENT; DECEMBER 12, 2012

Mr. Chairman and Members of the Subcommittee:

My name is Bill Frenzel. I am a Guest Scholar at the Brookings Institution, but my testimony today is mine only and has nothing to do with Brookings.

I have been advised by your fine staff to concentrate my remarks on the commission, its structure, its outlook, and possible results. I have served on several commissions: (1) the National Economic Commission in 1988, appointed by the President and Congressional leaders; (2) The President's Advisory Commission on Social Security in 2001 and 2002; (3) The President's Advisory Commission on Tax Reform 2005; (4) the President's Advisory Commission on Trade Policy and Negotiations from 2001 to date; and (5) several private commissions, most notably the Pew Commission on Children in Foster Care, from 2003 to 2007.

The first three of the above were colossal failures. The Pew Commission was judged successful, even though some of its most important recommendations were enacted long after it had disbanded. I have some opinions on how best to structure and manage a government (or private) commission. Mostly they depend on what the commission is intended to do. Some of them follow.

Appointing Authority Presidentially appointed commissions, and those appointed jointly by the President and Congressional leaders carry substantial prestige, and few potential appointees have nerve enough to decline them. They, however, are more appropriate for frontline issues, and they labor in the national spotlight. None have been successful in my memory except the Social Security Commission in 1982 and 1983, and a couple of base closing commissions.

If you want it to be on the six o'clock news, have the President appoint the commission. If you want results, you may want to choose another appointing authority.

Presidential problems abound. Presidents like to stack commissions with people to whom they owe something. You will get good people, but they may not exactly be the

qualified people you want. You may not get geographical distribution you want. You may not get other balances you seek.

Worst of all, Presidents are too busy. If recommendations are not a slam dunk, or important enough, they lie there and die. I believe that is what happened to President George Bush's Tax Reform Commission in 2005, or more recently to President Obama's Fiscal (Bowles-Simpson) Commission.

If the commission's sponsors can advise the legislative leaders on appointments (I presume they can), it will be much easier to get the skills and experience, the regional balance, and such other balances as are thought necessary, through Congressional appointment. Here I assume that child mistreatment is not a subject that will engender partisan problems, and that House and Senate sponsors themselves can agree on commission member selection.

Net, net, I believe that Congressional appointment is more likely to produce a better distribution, and better talent, and a better outcome, than if the President is involved.

Size Less than a dozen members won't give you the geographical nor the experience spread you will need. More than 20 is likely to cause difficulties of less than orderly process. The draft bill of Congressmen Doggett and Camp has it about right, although I believe 15 to 18 is optimal, particularly if you choose leaders as described below.

You will also have to have a method for replacing members who are obliged, for reasons of health, family, etc., to leave the commission.

Qualifications This subject is not my strong suit, but, in general, the draft bill covers the waterfront well. It also describes millions of people, and you want the very best. Your staff will have to call in the best advisors it can locate to identify the best of the best, both in talent and temperament. And don't eliminate all lobbyists. They can't taint this kind of commission.

I hate to mention the phrase, but bi-partisan cooperation will produce the best commission. One of my Pew Commission's greatest strengths was that if anyone knew anybody else's party leanings, they were never mentioned. Members could have been all Democrats, or all Republicans. What mattered was their experience and their unrelenting desire to help children.

Because that also matters in this case, the House and Senate sponsors of this commission should be able to agree on a slate and to convince the leadership appointers to ratify it.

Regionality The kind of people you choose for the commission will mostly be nationally known, and will know others of national renown in their fields. But America is

pretty big, and communities, states and regions are different, even when pursuing the same goals. You need wide geographical and cultural distribution on your commission.

The locals will know all the other good locals, and they will be helped by the local peers who seek the same outcomes the commission seeks. You can never cover all the bases, nor get perfect representation, but you need to make a good try.

However, I believe it would be unwise to write distribution requirements into the bill. They would be long and confining. I believe that the sponsors, aided by the Subcommittee staffs will understand their responsibility to take geography into careful account.

Congressional membership This is for you to determine. My own feeling is that members of Congress ought to be committed to other duties, and are too busy to be dependable members of such a commission. If you put one member of Congress on the commission, with two houses and two parties you will have to have at least four members of Congress, and that may make it impossible to include the other experiences and talents you want on the commission. I would not preclude members of Congress, but neither would I appoint any to this kind of commission.

Commission Leadership When you assemble an all-star line-up of commissioners, with experience and ability, you may find among them a natural leader who can manage the work plan, handle the schedules, instill a sense of practicality, keep the commissioners happy and engaged, and maintain regular communication with this Subcommittee and its staff. That is possible, but it's also highly unlikely.

If my Pew experience is any guide, it is a good idea to go outside the fields of endeavor for leadership. I believe I was chosen as Chair precisely because I had no experience in foster care. The same may a little less true of the Co-Chair, former Congressman Bill Gray. Having multiple leaders, a Democrat and a Republican, was for optics. In practice, either of us could have done, and did, the same job.

My highly subjective recommendation is that you pick a former member of Congress, or two, for the chair.

She/he might, or might not, have experience in the field (from this subcommittee, for instance). More than keeping the program on the move in businesslike manner, the chair has to remind, constantly, the real enthusiasts on the commission that perfection

in recommendations is not always possible in a contentious and budget-restricted Congress, and that a consensus report multiplies its impact.

Consensus Unanimity is contrary to human nature, but commission reports have far greater impact if they represent a consensus of the full commission. Minority or

dissenting remarks may often be appropriate, and they may make the objectors fell better, but they really weaken the thrust of the report. In a child maltreatment commission, every effort must be made to have a unanimous set of recommendations.

Consensus seeking is a duty of leadership. It's one more reason in favor of appointing some kind of professional chair, or chairs, who can encourage commission members to hang together.

Congressional Approval When the commission reports, its recommendations may include requests for Congressional actions of some sort. It is highly desirable that this subcommittee react to those recommendations as swiftly as possible. The Pew Commission on Children in Foster Care referred to earlier, reported in 2005, had part of its recommendations enacted that year, but some not until 2008.

The Report will also include recommendations for state and local government units in all branches, and for private organizations, too. Those units can move without federal approval, but the federal blessing will nurture far more enthusiasm.

Honoraria First-class people will fight to get on this commission. You should pay their necessary expenses of travel, etc., but it is not necessary to award them honoraria. After you hire a first staff and pay commissioners' expenses, there won't be much money left anyway.

Staff $2 million won't buy a large staff, but you won't need many people, because plenty of resources, private and governmental, national and local will be available to the commission. The staff should be competent, but lean, less than 10. It does not have to do the research. It just has to sort it out. Spare no expense on a first-rate staff director. She/he will save you a bundle in the long run.

Your staff, and the Senate's, ought to help the commission and its staff director identify and recruit the staff, but the commission needs to maintain its independence.

Operations, **Hearings**, **etc**. Other things being equal, the commission should do its business here in Washington. Its staff should be here, in close contact with your own staff and with other federal agencies. Hearings in other locations sound like wonderful

ideas, and sometimes are, but field hearings usually turn out to be mostly for show. It is usually cheaper to bring commissioners to Washington than to New York, LA, or Chicago. It will be hard to find child mistreatment in the boondocks. I believe that you will find witnesses happy to come to Washington to testify about their local conditions.

However, the commission may find it necessary and helpful to travel to national meetings of court personnel, and governmental or private organizations. There is a cost, but to learn and to inspire, such meetings may be needed.

Term I believe the draft bill has the term limits thing right. Two years is plenty. More time means the idea will get stale. However, depending on the date of creation, please be sure the final Report due date does not occur in an election year.

Budget I lack experience and information to analyze the budget. It appears adequate if you don't pay commission members. A lean staff alone, as I have described it, depending on quality and experience, might cost as much as half your budget annually. I don't suggest raising the budget (you will have trouble enough with $2 million), but I do suggest consulting a HR specialist in some of the fields described so that you will have an idea of the costs. If you can arrange to use federal facilities (one advantage of Presidential appointment), you could save a bundle on rental costs.

Purpose The commission is intended, I believe, to shine a light on an important problem, to inspire citizens, organizations, and various governmental units to combat it, and to develop recommendations for them to make substantial reductions in child mistreatment and fatalities. It will have recommendations for every person and agency involved, and it is likely to recommend changes in national policies.

The draft bill's instructions to federal agencies to report to Congress in 6 months is a great idea. In addition the commission ought to report recommended changes in law directly to this Subcommittee and its Senate counterpart. As noted above, if Congress does not take the commission seriously, nobody else will either.

I request unanimous consent that this written testimony be made a part of the record. I will answer questions as best as I am able.

Mr. PAULSEN. Ms. Huizar, please proceed with your testimony, you are recognized.

STATEMENT OF TERESA HUIZAR, EXECUTIVE DIRECTOR, NATIONAL CHILDREN'S ALLIANCE (NCA)

Ms. HUIZAR. Thank you.

Chairman Paulsen, Ranking Member Doggett, and Members of the Subcommittee, thank you for holding this important hearing on child abuse fatalities and the effort to establish a commission that would shed light on this issue, highlight evidence-supported interventions, and convene a national dialogue about the protection of the nation's most vulnerable children.

I represent National Children's Alliance, which is the national association and accrediting body for the nation's 750 Children's Advocacy Centers. CACs coordinate a multidisciplinary team approach to the investigation, prosecution, and treatment of child abuse. In the case of child abuse fatalities, our CACs are often used for the interviews conducted with other siblings and child witnesses of these tragedies. So we know far too well the tragedy of children killed by their caretakers and the toll this takes on communities, the remaining family members, and the professionals who must investigate these sad cases.

Because we believe these deaths are preventable, NCA has joined with other members of the National Coalition to End Child Abuse Deaths to raise awareness of the problem.

Over the past decade significant gains have been made in child abuse prevention and intervention generally. The overall rates of sexual and physical abuse have declined, but what has not declined and in fact has either remained flat or increased, is the rate of child abuse fatalities or near fatalities. The horrifying persistence of fatal child abuse, despite the implementation of effective prevention and intervention measures for most other forms of abuse, calls for a deeper examination of its causes and scope.

Official child welfare records indicate that at least 1,500 children are fatally abused annually. However, that number does not capture the scope of the problem, nor the scope of the suffering. Indeed, a recent GAO report indicates that the NCANDS data due to the voluntary nature of the data collection and the fact that in many States only one data source is used for the reporting, substantially undercounts fatal child abuse. And moreover, restrictive confidentiality laws and regulations make it difficult to thoroughly examine abuse fatalities when they occur so that we can learn how to prevent them and what risk factors are associated with them.

What is sorely lacking in all of this is a comprehensive national strategy to combat the tragedy of child abuse fatalities. Rather than a piecemeal approach to preventing these deaths, children at risk of eminent harm need and require the government's protection. And as a public health problem, child abuse fatalities can be approached as any other and successfully combatted.

Key to this national strategy is the establishment of a bipartisan commission empowered by Congress to thoroughly examine the problem, particularly as it relates to children within or previously known to the child welfare system. States vary widely in their child abuse fatality rates. Guidance provided through the work of a commission can ensure that a child's chance of surviving his or her childhood is not an accident of geography.

By scrutinizing the effectiveness of Federal, State, and local data systems and identifying the most effective prevention and intervention practices, the commission can lift up successful examples for widespread dissemination.

Reducing child abuse fatalities is a complex matter. It requires investigating and addressing many issues, including evidence-supported prevention and intervention efforts aimed at strengthening families and preventing maltreatment in the first place; workforce training; a risk-assessment practice within Child Protective Services; strengthening child death review teams; encouraging CAC's to expand their services; strengthening the medical examiner and coroner systems within the U.S. to ensure accurate designations of the cause of death in these cases, which are often among the most medically complex; providing training to law enforcement and prosecutors to hold offenders accountable; and creating data-sharing systems that allow agency to cross share information so that children can be saved and research can inform our practice; and of course, educating the public so the communities can protect their own children.

Because of the complexity of these issues, a coordinated and thoughtful approach is critical and can only be achieved through the work of a commission to end child abuse and neglect fatalities. Our efforts on behalf of these children must go beyond finger point-

ing, the blaming and firing of individual caseworkers, and scattered prevention and intervention strategies if we are to prevent future deaths. Our best hope of reaching a comprehensive strategy is the establishment of a commission to end child abuse and neglect fatalities, empowered to investigate, make thoughtful recommendations, and lift up promising practices. The lives of more than 1,500 children each year absolutely depend upon it.

Thank you.

Mr. PAULSEN. Thank you very much, Ms. Huizar.

[The prepared statement of Ms. Huizar follows:]

Testimony
Before the Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives—

Teresa Huizar, Executive Director, National Children's Alliance

Chairman Paulsen; Ranking Member Doggett, and Members of the Subcommittee:

Thank you for the opportunity to address the important issue of child abuse fatalities in the US and what may be accomplished through the Protect Our Kids Act and the establishment of a national Commission to End Child Abuse and Neglect Fatalities. As the Executive Director of National Children's Alliance, the national association and accrediting body for more than 750 Children's Advocacy Centers in the US serving more than 279,000 abused children last year[1], I know too well the tragedy of children killed by their caretakers and the toll this takes on communities, their remaining siblings and extended family members, and the multidisciplinary teams who must investigate these sad cases.

Children's Advocacy Centers (CACs) are child-friendly facilities in which multidisciplinary teams of law enforcement, child protective services, prosecutors, medical professionals, mental healthcare providers, and victim advocates coordinate their efforts to investigate and treat child abuse while holding offenders accountable.[2] In the case of child abuse fatalities, our CACs are often used for the interviews conducted with other child witnesses and siblings. I have personally observed the interviews of small children who watched as their sister was purposely thrown out of a multi-story apartment window to her death. And, I have held the hand of the tearful, tough, and experienced detective who had left the side of that broken little 2 year-old body to come to the CAC to interview the siblings and was undone at the prospect. Child abuse fatalities are heartbreaking in every way: the loss and waste of a precious young life; the profound and traumatic grief of siblings, grandparents, and extended family members; the loss of innocence of a community that thought children were protected; and the secondary trauma suffered by the child abuse professionals who intervene.

Recognizing that these tragic deaths are preventable the National Coalition to End Child Abuse Deaths[3], of which National Children's Alliance is a member, has been working since 2010 to

[1] 2011 National Children's Alliance National Statistics
[2] For more information about CACs visit www.nationalchildrensalliance.org
[3] The National Coalition to End Child Abuse Deaths is comprised of member organizations: Every Child Matters, the National Association of Social Workers, the National District Attorneys Association, the National Children's Alliance, and the National Center for the Review and Prevention of Child Deaths.

raise awareness of the problem, to encourage bipartisan policy solutions, and to call for a national strategy to end child abuse deaths in America. For the most vulnerable victims of abuse—those at imminent risk of fatal harm—only the protection of the government stands between them and death. Ensuring that their lives are protected has been the ongoing work of this Subcommittee through your hearing on Child Abuse Fatalities and the GAO report on the same in 2011, and now this one to directly address the establishment of a national Commission to End Child Abuse and Neglect Fatalities. Thank you for your ongoing commitment to this important issue.

Child Abuse Fatalities in the US

Over the past decade significant gains have been made in child abuse prevention and intervention: the overall rate of abuse has declined as evidenced by a series of National Incidence Studies; substantiated sexual abuse cases have declined by 47%; and while the data is more mixed about physical abuse, overall substantiated physical abuse appears to have experienced some decline as well[4]. What has not declined, and in fact has either remained flat or increased during this more general decline, is the rate of child abuse fatalities or near fatalities that warranted emergency department treatment[5]. The horrifying persistence of fatal child abuse despite the implementation of effective prevention and intervention measures for most other forms of abuse calls for a deeper examination of its causes and scope.

In 2010 (the last year for which we have a full data set) US official child welfare records captured through NCANDS (National Child Abuse and Neglect Data System), indicate 1,537 children were fatally abused[6]. Of these, and consistent with prior periods of reporting, approximately 80% of children who died from maltreatment were 3 years old or younger, and more than half were infants.[7] However, that number does not capture either the scope of the problem or the scope of the suffering. Indeed, a recent GAO report indicates that the NCANDS data, due to the voluntary nature of the data collection and the fact that in many states only one data source is used for the reporting, substantially undercounts fatal child abuse and estimates that roughly 2,500 children are fatally abused each year.[8] Of those fatally abused, at least 14% were previously known to child welfare agencies or in their care.[9]

Moreover, restrictive confidentiality laws make it difficult to thoroughly examine abuse fatalities when they occur so that we can learn how to prevent them and what risk factors are most

[4] Finkelhor, D. & Jones, L. "Have Sexual Abuse and Physical Abuse Declined Since the 1990's?", 2012.
[5] Leventhal, J.M. and J.R. Gaither, Incidence of serious injuries due to physical abuse in the United States: 1997-2009.Pediatrics, 2012. 130(5): p. 1-6
[6] Department of Health and Human Services, Administration for Children and Families, "Child Maltreatment 2010"
[7] Ibid.
[8] US Government Accountability Office, "Child Fatalities From Maltreatment: National Data Could Be Strengthened", July 2011.
[9] Ibid.

associated with them. Recent rules promulgated by HHS to clarify the CAPTA confidentiality requirements were marginally helpful. While making clear that States may provide information necessary so that child death review teams and policymakers can examine the particular child welfare case in which the child died, it did not indicate that information on past child welfare reports or investigations involving the same child or siblings could likewise be provided. If as Justice Brandeis once said, "the best disinfectant is sunlight," then the inability for policymakers to thoroughly examine all of the factors that lead to a child's death means that we continue to view these tragedies as though through a glass darkly and with little hope of system reform.

And as important as delving into the specifics of a given case to learn from it, we also lack meaningful aggregate data. As the GAO concluded in their 2011 report "Child Fatalities From Maltreatment: National Data Could Be Strengthened," weaknesses in our current NCANDS data collection effort include:

- Roughly half of all States reporting through NCANDS do not use multiple data sources—such as death certificates, state child welfare agency records, or law enforcement reports—in collating their reports for submission;
- Inconsistent State definitions of maltreatment, differing State legal standards for substantiating maltreatment, and missing State data complicate reporting these deaths through NCANDS, and thus our understanding of the scope of the problem;
- And, that additional demographic, family composition, and risk factor information has been collected by NCANDS but as yet is unreported to policymakers and the public in the annual HHS annual publication of Child Maltreatment. (Administration officials now plan to release this information in the 2013 report, which we welcome.)

What is sorely lacking in all of this is a comprehensive national strategy to combat the tragedy of child abuse fatalities. Rather than a piecemeal approach to preventing these deaths, children at risk of imminent harm need and require the government's protection. Fatal child abuse is preventable. And as a public health problem, can be approached in a thoughtful and analytical manner, much as the US has successfully combated other public health threats. States are the great innovators; while the federal government has a unique role as a convener of States and policymakers to hold up examples of successes which may be emulated.

Commission to Eliminate Child Abuse and Neglect Fatalities

Key to this national strategy is the establishment of a bipartisan commission, empowered by Congress to thoroughly examine the scope of the problem particularly as it relates to children within, or previously known to, the child welfare system. States vary widely in their child abuse fatality rates. Guidance provided through the work of a Commission can ensure that a child's

chance of surviving his/her childhood is not an accident of geography. By scrutinizing the effectiveness of federal, State, and local data collection systems and identifying the most efficient practices, the Commission can lift up examples from within the States of effective child abuse fatality prevention and intervention practices for widespread dissemination.

In many ways, opening a national conversation on child abuse fatalities through a Commission to End Child Abuse and Neglect Fatalities mirrors and strengthens the process by which States review child deaths to strengthen their own prevention efforts. In 1996, Congress authorized CAPTA and included issues related to fatal maltreatment through public disclosures of the existence of child maltreatment fatalities and the establishment of Citizen Review Panels to review and make recommendations for improvement in child fatalities, foster care, and intervention.[10] In some states these CRPs also serve as Child Death Review teams. Since that time, the Children's Bureau within HHS has supported the development and continuance of Child Death Review and now all States conduct Child Death Review in some capacity.[11] For a decade the Maternal and Child Health Bureau has funded the National Center for the Review and Prevention of Child Deaths. The resource center provides training and technical support to all states to help establish and improve the review process, and manages a national Child Death Review Case Reporting System. While an invaluable resource to Child Death Review teams within States, the resources allocated to the National Center for Review and Prevention of Child Deaths are minimal and State participation in the Child Death Review Case Reporting system is voluntary. Undoubtedly, more resources are needed to improve child death review within States, with a special emphasis on child abuse fatalities. And, in a complementary way, the National Commission to End Child Abuse and Neglect Fatalities can take case studies within States and across States for examination of what has worked to reduce these preventable deaths--and what strategies should be discarded as failing to produce desired outcomes.

Reducing child abuse fatalities, particularly those involving prior contact with the child welfare system, is a complex matter. We, the National Coalition to End Child Abuse Deaths, strongly support the establishment of a Commission to End Child Abuse and Neglect Fatalities to investigate and address issues such as:

- Building upon the best of current child protection systems and evidence-supported prevention and intervention efforts, to develop a national strategy to end maltreatment deaths, including public health and social services aimed at strengthening families and preventing maltreatment in the first place;
- Workforce training, caseload, and risk assessment practice within child protective services so that at-risk children may be identified to prevent fatal or near-fatal risk of harm;

[10] Covington, T. & Petit, M. "Chapter Five: the Prevention of Child Fatalities," The Children's Bureau: Shaping a century of child welfare practices, programs, and policies., Children's Bureau, Department of Health and Human Services, Draft 2012.
[11] Ibid.

- Better protect children at risk of imminent harm by encouraging Children's Advocacy Centers to expand their services to include severe physical abuse and neglect cases so that the child abuse experts represented on their multidisciplinary team can ensure close coordination of criminal legal proceedings and civil child protection systems, as well as medical care and mental healthcare for child victims;
- Strengthening the medical examiner and coroner system within the US to ensure proper and accurate designations of cause of death in child abuse fatalities, which are often among the most medically complex;
- Providing training to law enforcement and prosecutors to thoroughly investigate and prosecute cases of fatal and near-fatal abuse in order to hold offenders accountable;
- Creating data-sharing systems that allow agencies to cross-share information about near-fatalities and fatalities so that children can be saved and research can inform our practice;
- Through tested public education campaigns, enabling the public to identify and report child abuse and neglect, thereby engaging communities in protecting their own children.[12]

Because of the complexity of each of these issues, a coordinated and thoughtful approach is critical and can only be achieved through the work of the Commission to End Child Abuse and Neglect Fatalities that may examine them in depth and prevent the sort of unintended negative consequences that too often attach to well-meaning public policy conducted in a less comprehensive way.

In Summary:

Child abuse and neglect fatalities are preventable tragedies. And, our efforts on behalf of these children must go beyond finger-pointing, the blaming and firing of individual caseworkers, and scattered prevention and intervention strategies if we are to reform child protection systems in a way that prevents future deaths. A national strategy to end child abuse fatalities is critically needed in this country. And, our best hope of reaching a comprehensive strategy, given the complexity of the subject, is through the establishment of a Commission to End Child Abuse and Neglect Fatalities empowered to investigate, make thoughtful recommendations, and lift up promising evidence-supported practices. The lives of more than 1,500 children each year depend upon it. Thank you.

[12] We Can Do Better, "Child Abuse and Neglect Deaths in America", 3rd Edition, 2012.

Mr. PAULSEN. Mr. Doggett, I understand you would like to introduce our next witness, Ms. McClure, who I understand is from your home State of Texas.

Mr. DOGGETT. She is, indeed, Mr. Chairman.

Thank you. I am pleased to formally introduce Madeline McClure, who is the Director of the Texas Association for the Pro-

tection of Children. She serves as the appointee of Lieutenant Governor David Dewhurst and Texas House Speaker Joe Straus on the Texas Blue Ribbon Task Force on Child Abuse, Prevention, and Child Welfare, and she is the chair of the Child Protection Roundtable, which she founded.

She has a career of about a decade making money successfully on Wall Street before she turned to making lives better for children on Texas streets. She also works as a therapist now, has worked as a therapist with the Dallas Children's Advocacy Center. I believe she has done much to help prevent abuse and neglect in Texas, more than anyone I know, and is a tireless advocate to have made this special trip from Dallas to be here today.

Thank you, Madeline, for coming to join us.

Mr. PAULSEN. Thank you, Mr. Doggett.

Ms. McClure, you may proceed.

STATEMENT OF MADELINE McCLURE, EXECUTIVE DIRECTOR, TEXPROTECTS, THE TEXAS ASSOCIATION FOR THE PROTECTION OF CHILDREN

Ms. McCLURE. Thank you for that lovely introduction, Ranking Member Doggett, and Chair Paulsen, and committee members, thank you so much for inviting me to testify today on this most critical issue of child maltreatment fatalities. I am honored to be here.

Given that child maltreatment deaths stem primarily from child physical abuse and child neglect, I am going to focus my comments today on child maltreatment prevention, and given my background in economics and social work as you just outlined, I think it would be most helpful for the committee if I talk a bit more about monetizing the benefits and the costs, if that would be all right.

So, first, let me put into perspective the incidence. We need to know what the size of the problem is before we attempt solutions. As you may know, the National Data Collection Systems and the National Incidence Studies, as well as national surveys, showed that 1 to 10 percent of our child population are abused annually. That is a big range. But whether it is 750,000 children or 7.5 million children, one abused child is one child too many.

So just to put this in perspective on the screen, imagine an aerial view of the following stadiums filled to capacity. Hopefully, most of these are from your hometowns, the Hubert Humphrey Metrodome, Dallas Cowboys Stadium, the Cotton Bowl, Yankee Stadium, Sanford Stadium, Neyland Stadium, Tiger, Century Links Field, and the Rose Bowl.

There wasn't a stadium from North Dakota that was large enough that I could include in this, sorry, Congressman Berg.

But imagine that instead of adult fans filling those seats, picture all of those seats now filled with children, abused children, almost 50 percent that are less than 4 years old. So hold those nine stadiums, packed to the gills, brimming with just children. That is what 753,000 looks like. And that is the lowest incidence number, just to contextualize the problem.

The consequences of child abuse and neglect, I think this committee has heard several times. But just because you mentioned Devin and his parents, Chairman Paulsen, I want to remind us

that children that are abused and neglected have impaired brain development, 85 percent more likely to have that and, in stepwise fashion, very often have cognitive difficulties, impaired learning disorders and then self-anesthetizing abusing substances which leads to doing poorly in school and also, teen pregnancy and school dropout, often leading to juvenile delinquency.

We talk about the associations, but there is a lot of cause and effect here. Most importantly, children that are abused are six times more likely to abuse their own children. I can only imagine what Devin's parents had gone through in their earlier lives.

But child abuse also exacts a very high financial price. As you can see on this next slide, the Center for Disease Control's recent study monetizing the outcomes of the consequences of child abuse and neglect found that for every child abused in their lifetime it will cost $210,000 per victim. That is for those who survive abuse. For those who die, for every child abuse fatality, we as taxpayers spend $1.3 million per victim. So, in 2012 inflation-adjusted dollars, that is $124 billion that we are throwing out the window just on the consequences of child abuse.

But the monetary calculations cannot begin to place a value on the incalculable cost of lives lost, unseen scars of potentials quenched, spirits extinguished, and souls murdered.

These human and financial costs are unacceptable and unsustainable, and they do represent an enormous financial burden on our taxpayers.

The good news is that child abuse is largely preventable. We have found net cost savings of child abuse prevention programs that are of high quality that return on average $3.50 for every dollar invested, up to $14.50 for every dollar invested. Here is an example of a program that is entitled The Positive Parenting Program, and this particular program actually is cost neutral within a year. But it returns about $6 for every $1 invested, as you can see in terms of the costs of reducing out-of-home placements and also CPS cost, and other costs.

So for a relatively modest investment up front, we will not only break the intergenerational cycle of violence, we can reduce an enormous economic tax burden on taxpayers immediately and the long term.

And where we are today in preventing child abuse is akin to where Congress was 70 years ago in exploring the use of antibiotics to kill infections. So when you look back, or your children, or your grandchildren look back on this 10, 20, 50, 70 years from now, this is going to be that inflection point where we really go through this process of putting enough money up front to change that whole trajectory, not only for at-risk kids and their families, but our great country at large.

This national commission is a right first step, and I really am excited about this commission helping all of the States have an accessible blueprint for implementing a meaningful child abuse prevention strategy. I thank you for your time.

Mr. PAULSEN. Thank you, Ms. McClure.

[The prepared statement of Ms. McClure follows:]

COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON

HUMAN RESOURCES

US HOUSE OF REPRESENTATIVES

HEARING ON "PROTECT OUR KIDS ACT"

December 12, 2012

MADELINE MCCLURE, LCSW

FOUNDING EXECUTIVE DIRECTOR, TEXPROTECTS, THE TEXAS ASSOCIATION FOR THE PROTECTION OF CHILDREN

Chairman Paulsen, Ranking Member Doggett and Subcommittee Members, it's an honor to be invited to testify today on Child Maltreatment in the US and specifically, on this important legislation.

I serve as the E.D. of TexProtects, the Texas Association for the Protection of Children, which I founded in 2004 to organize stakeholders across Texas to build consensus on the best public policy solutions for reducing child abuse and neglect and to improve our child proactive services and healing systems based on solid, rigorous, best practice research. Over a period of 4 TX legislative sessions, we have provided the blueprint and facilitated passage of over 26 bills and provided input into 2 other omnibus reform bills and raised over $45 million in private and public investments in evidence-based child abuse prevention programs. Prior to founding TexProtects, I worked as a clinician providing therapy to child and adult victims of severe child abuse.

Texas has the dubious distinction of having the highest rate of child maltreatment fatalities in the nation, increasing from 103 to 281 deaths, a 124% increase over a 15-year period, while the child population grew at only 19% over this same period. Given that child maltreatment deaths stem from child neglect and mostly, child physical abuse, my testimony will focus on the root causes of child abuse / neglect (CA/N). Because my background is in Finance and Economics as well as Social Work, I believe I may be helpful on this subject with a focused presentation on projected costs of CA/N and cost-benefits of child maltreatment prevention, and how we can get in front of this problem.

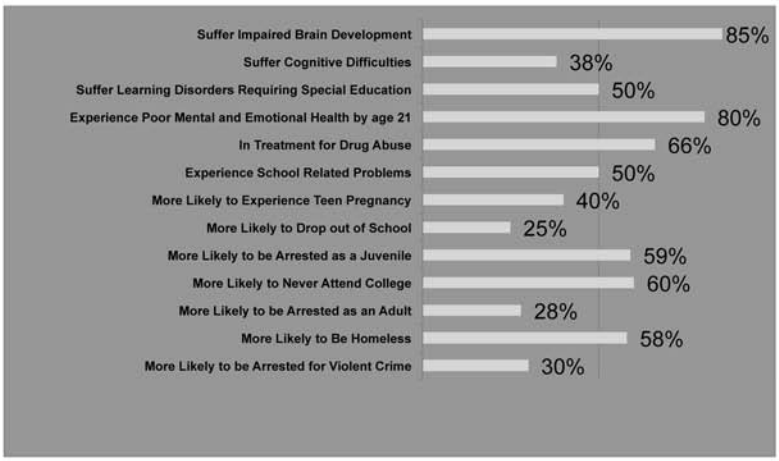
To understand costs, we need to understand actual incidents and incidence rates. The National Survey of Children's Exposure to Violence (NatSCEV) from 2008 was the first national study to examine children's exposure to violence in homes, schools, and communities across all age groups (Finkelhor, Turner, Ormrod, & Hamby, 2009). In terms of maltreatment, NatSCEV found that more than 1 in 10 children surveyed (10.2%) suffered some form of maltreatment during the past year and nearly 1 in 5 (18.6%) did so during their lifetimes (Finkelhor et al., 2009).

However, the incidents of child abuse/neglect that are actually reported, investigated and subsequently substantiated by our state's CPS systems, which are subsequently reported to

the NCANDS, tell a different story, which is that 1% of our child population is abused in a given year. US Department of HHS ACF's Fourth National Incidence Studies concluded that CA/N are underreported by 50%. That would indicate that the actual incidence of child/abuse and neglect is 2% of our population.

Whether 1%, 2% or 10%, one abused child is one too many, let alone the 753K that reflect the 1% figure. To put the lowest estimated incidence in context, consider the following: Imagine an aerial view of the entire: Hubert Humphrey Metro dome, Dallas Cowboy Stadium (80K-TX), The Cotton Bowl (100K-TX), Yankee Stadium (50.3-NY, Sanford Stadium (92.7 –GA), Neyland Stadium (102K-TN), Tiger Stadium (92.5K- LA), Century Link Fields (67K-WA), and the Rose Bowl (92.5) all filled to capacity crowds. Imagine in your mind an aerial view of all 9 of these enormous stadiums, completely packed with fans, all at once. Now, picture each of all those seats filled with children-abused and neglected children, 40% who are under the age of 4. All those seats combined are still 11,000 seats short of the 753K children that are severely neglected, sexually molested, or physically brutalized every year in the greatest nation on earth. This is a national epidemic, and that is why this task force is so desperately needed.

The consequences of child abuse and neglect have been well documented from vast volumes over multi-decades of research. In brief, abused and neglected children, compared to their non-abused counterparts, are significantly more likely to:



Impaired Brain Development[i]; Cognitive difficulties[ii]; Learning difficulties requiring special Ed[iii]; Poor mental health and emotional health, especially depression[iv]; Abuse of alcohol and illicit drugs[v]; School related problems[iii]; Teen pregnancy[vi]; School drop out[iii]; Juvenile delinquency[viii]; Under and unemployment[viii]; Adult incarceration[vii]; Homelessness[ix]; and Violent crimes[vii] (in about that order).

Madeline McClure, LCSW
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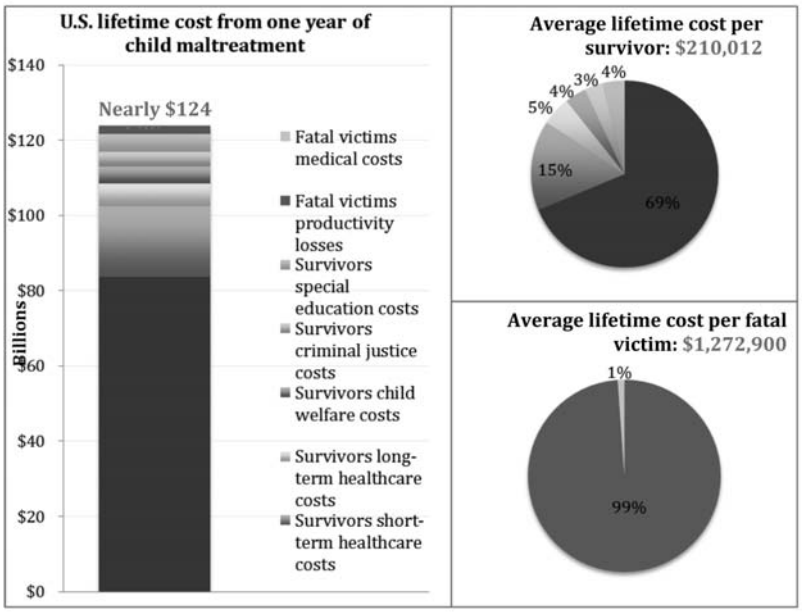
Society pays a high price for child abuse, including but not limited to the costs from: Law enforcement, CPS/Child Welfare Costs, judicial system, hospital and health care costs, mental health treatment, direct costs stemming from substance abuse outcomes and from treatment, juvenile delinquency and criminal justice costs, lost productivity, et. al.

The Centers for Disease Control (CDC) recent study monetizing these consequences found that the lifetime financial cost for just one year of new confirmed cases of child maltreatment (75% of confirmed cases) is about $124 billion; we spend about $1.3 million for every child that dies from abuse and over $210 thousand for an abused child who lives.



Inflation adjusted, the lifetime cost per CA/N victim is $222,785 and for every child fatality, the cost is $1,350,317 in 2012 dollars.

This is actually a conservative estimate because the CDC only considered costs of abuse for ages 6-64, and we know that the most serious injuries – and costs – occur to children under 6, and health related costs continue to accrue past age 64. In addition to the NIH findings that actual occurrences of abuse are 50% higher than confirmed, research shows that between 50-60% of child *fatalities* due to maltreatment are not recorded as such on death certificates. Therefore, the CDC fatality victim costs are under-calculated by a factor of 2.

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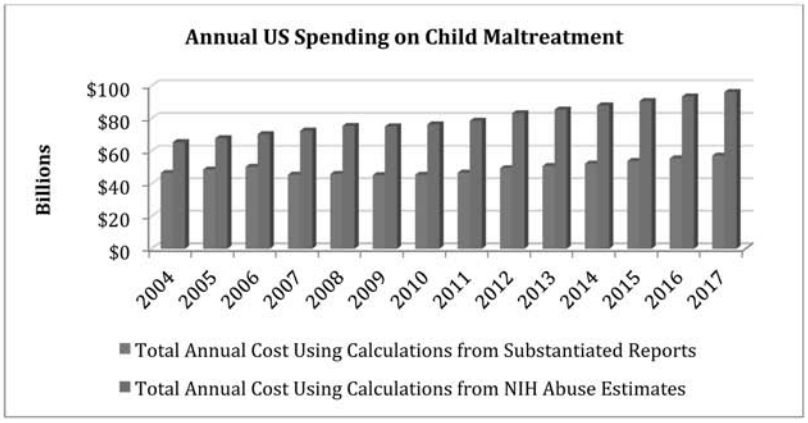
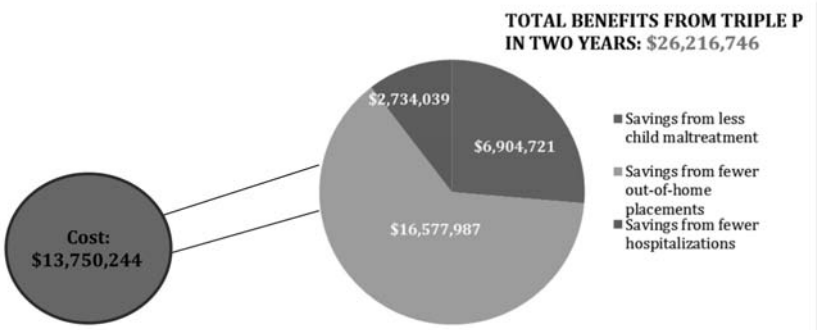
Another study published in PCAA calculated the annual costs per victim as $63,871 by combining direct costs (i.e., child welfare and law enforcement) with indirect costs (i.e., special education, early intervention, emergency housing, mental/physical health care, juvenile delinquency, adult criminal justice, lost worker productivity).[xi] They did not use a different cost for children who die from abuse, which, as the CDC showed, means this cost per child is likely higher if a child dies. Nevertheless, we used this annual cost per child to project annual spending (adjusting for inflation and population growth and assuming a steady rate of abuse in future years).



Therefore, we have spent over $83 Billion on the calculable financial consequences of CA/N in 2012 alone. **We cannot continue to hoist this enormous financial burden on the back of taxpayers. These costs are not only unacceptable for a society, they are unsustainable. And yet, they are preventable.**

The social sciences has evolved to a level such that experimental research trials, such as the double blind studies used by drug companies, are able to isolate proposed interventions from other variables so that we can now *identify and measure hard outcomes between demographically matched intervention groups and control groups.* This "emerging" area of evidence in social sciences-while in use for several decades is still in its infancy-has allowed us to test the efficacy and cost-effectiveness of a myriad of social programs, including child abuse prevention programs.

In monetizing the benefits of the best prevention programs, we have found a net cost savings ranging from $1.18 to $14.65 for every dollar invested.
To illustrate more clearly, one prevention program (Positive Parenting Program, a.k.a.: Triple P) is estimated to return over $6 for every $1 invested, and the cost of the program can be recovered in a single year.[xii] It is estimated that the pilot program in Houston, Texas will show almost a 2:1 return in just two years:[xiii]



However, even the best calculations cannot begin to monetize the incalculable costs of not only lives lost, but the unseen scars of potentials quenched, spirits extinguished and souls murdered. But there is a way to offset the billions we can quantify that we are currently wasting on CA/N consequences – we need to invest and bring to scale the cost savings of CA/N prevention programs. But we need a well designed, well thought out implementation strategy with continual evaluation for Quality Assurance and Quality Improvement, as well as impact outcomes, which will provide a toolkit that the states can access and if desired, implement depending upon their unique population needs, culture and best fit.

For a modest investment, not only will we break the intergenerational cycle of abuse and the myriad of negative social outcomes, we can reduce an enormous economic burden on taxpayers immediately and in the long term.

Need for a task force

Texas Experience: Blue Ribbon Task force
Our research over 3 years has shown that if states have child abuse/neglect prevention strategies, they lack evaluations showing outcome data. None of the existing National organizations as shown in the appendix, have developed nor distributed a child abuse prevention strategy blueprint for use at the state or local level. That is a glaring missing critical gap that I believe this task force must address.

Conclusion

For a minimal investment in a National Commission, as outlined in the Protect Our Kids Act, we can encourage states to adopt proven preventative measures that can create a big impact: Saving lives and saving scarce resources. As a result, we can significantly change the trajectory and realize positive outcomes for our children, our families, our communities and ultimately, our great country.

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APPENDIX I

Website	URL	Goals/Summary	Other Notes
National Data Archive on Child Abuse and Neglect (NDACAN)	http://www.ndacan.cornell.edu/	To facilitate secondary analysis of research data relevant to the study of child abuse and neglect	This site lists a variety of other data sets available: http://www.ndacan.cornell.edu/NDACAN/Datasets_List.html and support documents for some of those data sets (e.g., Longscan): http://www.ndacan.cornell.edu/NDACAN/UserSupport.html
National Child Abuse and Neglect Data System (NCANDS)	http://www.nrccwdt.org/ncands/	NCANDS consists of two components: (1) Summary Data Component (SDC) is a compilation of key aggregate child abuse and neglect statistics from all states, including data on reports, investigations, victims, and perpetrators; (2) Detailed Case Data Component (DCDC) is a compilation of case-level information from those child protective services agencies able to provide electronic child abuse and neglect records	Here is a helpful summary of NCANDS: http://www.ndacan.cornell.edu/ndacan/Datasets/Related_Docs/NCANDS_Fact_Sheet.pdf
Child Welfare Information Gateway	http://www.childwelfare.gov/can/	Provides access to print and electronic publications, websites, databases, and online learning tools for improving child welfare practice, including resources that can be shared with families On this website, you can review recent publications and other reports on CAN, but it is not the website to actually analyze data and/or track specific outcomes of interest; it also links people to other clearinghouse locations; see http://www.childwelfare.gov/can/statistics/stat_natl_state.cfm for an example:	This site also is useful in that it allows a comparison of state statues on child welfare topics To note: there are other websites that compile references/ publications on the topic (e.g., U.S. Department of Justice, Crimes against Children Research Center, Kempe Foundation, Prevent Child Abuse America, etc.), but I am not listing all of those as well – none provide data or exactly what we are looking for here
Child Welfare Outcomes Report Data	http://cwoutcomes.acf.hhs.gov/data/overview	Child Welfare Outcomes is a report that is published annually by the U.S. Department of Health and Human Services and provides information on the performance of States in seven outcome categories (e.g., reducing reoccurrence of CAN, reducing CAN in foster homes, increase permanency, etc.) Through this site, you also can view the data before the full report is published	This website does have an easy-to-use map for state-by-state comparisons of child victim rates and other data, and you can create a state profile of these rates - broken down by age, race, maltreatment type, etc. You also can look at other outcomes measures for the state such as reoccurrence of maltreatment; It is a useful and easy-to-use website for summarizing *some* of the data; see the data table as well: http://cwoutcomes.acf.hhs.gov/data/downloads/pdfs/texas.pdf
Child Maltreatment	http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2010	This site has a report and various national data (broken down by state as well) on CAN known to child protective services agencies in the United States during a particular federal fiscal year (currently 2010 is posted)	This is a useful site for obtaining the various data sets from CPS across the country, but it is limited to that type of data (imagine each state's DFPS databook compiled and focused exclusively on CAN)
National Resource Center for Child Welfare Data & Technology (NRC-	http://www.nrccwdt.org/	NRC-CWDT is comprised of a diverse group of consultants with a range of skills and experience from State Child Welfare agencies and technical information technology firms; technical	Again, this site does not provide the actual data or analyses options, but it does provide links to other useful websites and databases (e.g., NCANDS,

CWDT)		assistance is available at no charge to States, Courts and Tribes to improve the quality of data reported to other groups (i.e., AFCARS, NCANDS, SACWIS, and NYTD)	NYTD, CSFRm etc.); see: http://www.nrccwdt.org/federalreporting/
Adoption and Foster Care Analysis and Reporting System (AFCARS)	http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/afcars	AFCARS collects case-level information on all children in foster care and those who have been adopted with title IV-E agency involvement	On this site you can see state-by-state statistics, trends, and other information, but it does not contain information specific to abuse
Children's Bureau (CB)	http://www.acf.hhs.gov/programs/cb/monitoring	The CB monitors state child welfare agencies through a number of assessments and reviews (Child and Family Service Reviews, Title IV-E Foster Care, Adoption and Foster Care Analysis and Reporting System, and the Statewide Automated Child Welfare Information System reviews. Through this website you can gain access to all reports.	Not a very useful website if you want specific child abuse statistics, but useful if you want to see how state child welfare agencies are doing at achieving positive outcomes for their children and families in their systems
KIDS COUNT	http://datacenter.kidscount.org/	KIDS COUNT data center is a project of the Annie E. Casey Foundation.	Quick and easy website if you are looking for basic child abuse statistics for states or communities
Longitudinal Studies of Child Abuse and Neglect (LONGSCAN)	http://www.iprc.unc.edu/longscan/	LONGSCAN is a consortium of research studies. Each site conducts separate and unique research projects on the etiology and impact of child maltreatment. While each project can stand alone, through the use of common assessment measures, similar data collection methods and schedules, and pooled analyses, LONGSCAN is a collaborative effort. The goal of LONGSCAN is to follow children and their families until children become young adults. Comprehensive assessments of children, their parents, and their teachers are scheduled to occur at child ages 4, 6, 8, 12, 14, 16, and 18. Maltreatment data is collected from multiple sources, including record reviews, at least every two years. Yearly telephone interviews allow sites to track families and assess yearly service utilization and life events. NDACAN makes a restricted dataset available to members	You can also search through data sets on this site; for instance, I did a search of domestic violence as reported by the child (you can select caregiver, CPS, Interviewer, or Teacher) at ages 6, 8, 12, 14, and 16; the website provides a link to that data output; this is more useful to a researcher, though (not in user-friendly format - I have to use the codebook to know the labels, etc.); the measures manual is a little easier to use, but it is still targeted at a research audience; plus, a lot of data have restricted access for members only; on this website, you also can view publications and reports from these data

APPENDIX II: Annual US Spending on Child Maltreatment

Data for Bar Graph Titled: Annual US Spending on Child Maltreatment

Year	Total Annual Cost Using Calculations from Substantiated Reports	Total Annual Cost Using Calculations from NIH Abuse Estimates
2004	$46,473,544,260	$65,364,475,657
2005	$48,587,344,020	$67,763,436,732
2006	$50,266,009,710	$70,234,862,834
2007	$45,457,333,700	$72,431,068,542
2008	$45,894,805,560	$75,313,730,193
2009	$45,198,380,360	$75,045,777,066
2010	$45,376,896,797	$76,276,390,219
2011	$46,633,611,066	$78,472,060,187
2012	$49,406,598,277	$83,138,265,835
2013	$50,727,949,679	$85,361,751,523
2014	$52,237,077,850	$87,901,215,954
2015	$53,827,514,908	$90,577,501,785
2016	$55,462,810,526	$93,329,272,734
2017	$57,111,989,984	$96,104,406,521

Annual Cost Using Calculations from Substantiated Reports

- Cost = Number of Confirmed Victims * Cost Per Victim
- Number of Confirmed Victims:
  - For 2004 – 2010: data compiled from 2008 – 2010 Child Maltreatment Data Report (from US Children's Bureau)
  - For 2011 – 2017: calculated the average rate from 2004 -2010 (confirmed victims/child population); used that average rate and the projected child population for each year until 2017 (from childstats.gov) to project number of victims each year
- Cost Per Victim:
  - Equals $63,871 in 2012 dollars (from Gelles & Perlman 2012)
  - This value was adjusted annual for inflation/deflation (http://www.usinflationcalculator.com/)
    - For example, this amount equates to $52,159 in 2004 and $62,110 per victim in 2011
    - Inflation for 2013-2017 was assumed at a linear rate of increase from 2004-2012 rates

Annual Cost Using Calculations from NIH Abuse Estimates

- Cost = Total Number of Victims as Estimated by NIS * Cost Per Victim
- Total Number of Victims as Estimated by NIS:
  - NIS-4 showed a total of 1,257,600 victims of child abuse in 2005 compared to the 901,000 substantiated cases of abuse shown by the Child Maltreatment Data Report
  - We calculated the difference in the abuse rate (total victims/child population), between NIH and substantiated cases for this year, and applied that difference across each year to determine the number of children likely to have been abused each year
- All other projections of cost, population growth, and inflation adjustments were completed as previously described

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Mr. PAULSEN. Mr. Sanders, you may proceed.

STATEMENT OF DAVID SANDERS, PH.D., EXECUTIVE VICE PRESIDENT OF SYSTEMS IMPROVEMENT, CASEY FAMILY PROGRAMS

Mr. SANDERS. Good afternoon, Chairman Paulsen, Ranking Member Doggett, and Members of the Subcommittee. I am David Sanders, executive vice president of Systems Improvement at Casey Family Programs, a national foundation committed to improving the lives of vulnerable children and families in America by building Communities of Hope.

We thank the committee and, in particular, Chairman Camp, Subcommittee Chairman Paulsen, and Subcommittee Ranking Member Doggett, for their leadership and commitment to reducing child fatalities due to abuse and neglect.

The discussion draft that has been shared would establish a commission to develop a national strategy and recommendations on this issue. We commend the vision and overall believe that such a commission would provide an incredible opportunity to better understand how we can prevent child fatalities.

We offer two comments for your consideration. First, we agree it is important the 12 commission members represent a number of key expertise areas outlined in the draft. While the discussion draft states that each member should possess at least one area of expertise, it is important that the commission represent a broad range of issues. As currently drafted, it appears possible that all of the commission members could come from a single area of expertise.

Second, the discussion draft limits the purview of the commission to programs funded under Titles IV and XX of the Social Security Act. There are a broad array of programs that provide upfront prevention and intervention services, such as Medicaid, maternal and child health programs, and substance abuse funding. We, therefore, urge the inclusion of a broader spectrum of programs.

In an effort to influence and mobilize national efforts to prevent child maltreatment-related fatalities, Casey Family Programs launched a series of forums in the fall of 2011. The Administration on Children, Youth and Families, the Centers for Disease Control joined Casey Family Programs in hosting these events that were attended by experts, policymakers, advocates, researchers, practitioners, and child welfare leaders, as well as public health leaders. These forums provided us a tremendous opportunity to explore the issue of child fatalities from different perspectives.

Findings explored in the Safety Forums that will guide our future work and recommendation center around four areas: Number one, risk factors for severe maltreatment and fatalities. Research in California linking birth records and CPS records has found that a report for child maltreatment before the age of 5, whether substantiated or not, is a risk factor for a later fatality from intentional or unintentional injuries. Other researchers found the rates of abusive head trauma identified among children under 5 years of age increased significantly at several major pediatric hospitals during the 2007 and 2009 period and were associated with increased economic hardship at the community level.

Number two, child maltreatment is a public health issue. A significant proportion of child maltreatment-related deaths occur in families who have no history of involvement in the child welfare system. Therefore, it would be prudent for us to look at the issue of child deaths, not just through the lens of child welfare but from a broader public health perspective.

Number three, informing child protection policies and practices for reducing child maltreatment-related fatalities. There are several areas we need to consider to improve child protection policies and practices. The public's perception of child welfare in this country is generally painted by media reports of isolated cases of tragedy. The gap between public perception and the realities of child welfare administration drives public policy in ways that are not always the best for keeping children safe.

And finally, number four, measurement and classification of child fatalities. Experts agree that improving the measurement and classification of child fatalities is critical to understanding and preventing child maltreatment and fatalities. Building effective cross-sector multi-agency collaborations is essential for obtaining accurate data on the incidence of preventable child deaths and serious injuries, and implementing successful prevention strategies. Multidisciplinary local and State child death reviews teams play a critical role in identifying patterns in child death and serious injuries, identifying common risk factors, and developing and implementing preventive efforts.

The work of Casey Family Programs' Safety Forums has led us to believe that we can succeed in this. Successful strategies are comprehensive. Strategies are not limited to one sector or agency. Successful strategies are focused. High quality data, as well as other kinds of research evidence, are essential to inform strategies and assess results, and finally, we currently have some important knowledge and experience in regards to data, but there are glaring gaps; gaps that we can close.

Casey Family Programs has used its national platform and its resources to work with State child welfare administrators and other key voices to elevate this issue. We stand ready to work with this commission or any other group or organization focused on child fatality.

Thank you and I am happy to address any questions you might have.

Mr. PAULSEN. Thank you very much, Mr. Sanders.

[The prepared statement of Mr. Sanders follows:]

Testimony of
David Sanders, Ph. D.
Executive Vice President of Systems Improvement
Casey Family Programs

U.S. House Committee on Ways and Means, Subcommittee on Human Resources
Hearing on Proposal to Reduce Child Deaths Due to Maltreatment
December 12, 2012

Good morning Chairman Paulsen, Ranking Member Doggett and Members of the Subcommittee. Thank you for the invitation to join you today.

I am David Sanders, executive vice president of Systems Improvement at Casey Family Programs, a national foundation committed to improving the lives of vulnerable children and families in America by building communities of hope.

Casey Family Programs has been serving children in foster care for more than 45 years. We believe that the goals of the nation around securing well-being for all children should be about both: 1) keeping children who have been abused and neglected safe from further harm; and 2) preventing abuse and neglect, the possibility of child deaths, and the need for foster care in the first place by strengthening vulnerable families and their communities.

Extrapolating from federal government statistics, every 24 hours in America, on average:

- Approximately 2,000 children are confirmed as victims of child abuse and neglect.
- Nearly 700 children are removed from their families and placed in foster care.
- About four children die as a result of child abuse and neglect, most of them before they reach their fifth birthday.

That is every day in America.

And these child deaths, 1,537 in 2010, are considered to be an under-count, according to the 2011 U.S. Government Accountability Office (GAO) report on child maltreatment and fatalities. Indeed, 2010 was the first time in a decade that the number of child deaths due to maltreatment declined instead of increased. But herein – in the data – lies the problem. Whether the numbers reported go up or down, for a variety of reasons there exists a common underlying concern among professionals in the field, scholars and many others about the accuracy of the data.

When Casey Family Programs developed its 2020: Building Communities of Hope strategy seven years ago, we were motivated to do so, in part, because of the number of child fatalities at that time. We had asked ourselves, what would happen to America's most vulnerable children if nothing changed. If we were to continue on the same trajectory we were on in 2005, we estimated that by the year 2020, at least

22,500 children will have died from abuse and neglect. At least, because as I explained, that estimate is most likely based on an under-counting of child fatalities.

Though we have made significant strides toward keeping children safe – children who have come to the attention of child welfare - we cannot fully or adequately address the issue of child fatalities until we know the full scope of the problem. Not until we have accurate numbers to give us a clearer picture of what's going on.

How do we go about getting reliable data that tell the whole story? Only after we know what we're dealing with – what the problem looks like – only then can we develop effective strategies and solutions.

We thank the Members of this Subcommittee for their leadership and commitment to reducing child fatalities due to abuse and neglect. The proposal would establish a commission to develop a national strategy and recommendations on this issue. We commend the vision and believe that such a commission would provide an opportunity to further inform how we can prevent child fatalities.

We offer two comments for your consideration. First, we agree it is important the 12 commission members represent a number of the key expertise areas outlined in the proposal. While the proposal says each member should possess at least on area of expertise, it is important that the commission represent a broad range of issues. As currently drafted, it appears possible that all of the commission members could come from a single area of expertise.

Second, the proposal appears to limit the purview of the commission to programs funded under titles IV and XX of the Social Security Act. There are a broad array of programs that provide upfront prevention and intervention services such as Medicaid, maternal and child health programs, substance abuse funding, etc. We, therefore, urge that a broader spectrum of programs be explored for inclusion.

Casey Family Programs "Improving Child Safety and Preventing Fatalities" Forums

In an effort to influence and mobilize national efforts to prevent child maltreatment related fatalities, Casey Family Programs launched a series of forums in the fall of 2011. The Administration on Children Youth and Families, and the National Center for Injury Prevention and Control at the Centers for Disease Control and Prevention (CDC) joined Casey Family Programs in hosting these events that were attended by experts, policy-makers, advocates, researchers, practitioners and leaders in the field of child welfare and public health.

The first forum entitled "Improving Child Safety and Reducing Child Maltreatment Fatalities" was held at the Urban Institute in Washington D.C. on November 9-10, 2011 with a group of 35 experts, policy-makers, advocates, researchers, practitioners and child welfare leaders. The second forum, which was attended by over 80 participants was held on March 21 and 22, 2012 in Atlanta, GA and focused on "Applying Public Health Approaches to Improve Safety and Prevent Child Fatalities." The Third forum took place on June 28-29, 2012 in Nashville, TN and was attended by over one hundred participants. The event was co-hosted by the Tennessee Department of Children's Services and focused on "Improving Safety and Preventing Child Fatalities: Focusing on Child Protection. Most recently, on December 11, 2012, Casey Family Programs hosted a "Safety Action Planning Summit" which was attended by public child welfare and public health representatives from ten states and the District of

Columbia. These jurisdictions met with experts to develop and refine specific action plans targeted towards improving child safety and preventing fatalities.

These forums provided us with the tremendous opportunity to explore this issue from different perspectives and focused on three major topics:

- **Measurement:** Developing more accurate ways to classify and count maltreatment related fatalities as a means of informing policy and practice, as well as developing better child safety performance measures.
- **Child Protection Policy and Practice:** Informing child protection policies and practices for reducing child maltreatment related fatalities.
- **Public Health Approach:** Exploring a new approach to child protection that emphasizes public health strategies for preventing child maltreatment fatalities.

The following six lessons learned emerged from these discussions:

- **We can succeed**. Public health and safety engineering efforts have reduced deaths and injuries in the U.S. from many causes that initially seemed intractable. This has been true even when, at the beginning of the effort, those causes seemed deeply ingrained in cultural and individual beliefs (drunk driving, smoking) and driven by interactions between human error (medical errors) and sheer, unpreventable bad luck (plane crashes).
- **Successful strategies are comprehensive.** This lesson emerges above all from the public health successes which are comprehensive in multiple ways. First, they are multi-level, potentially including components at the level of the individual, the family, the community, service systems and public policy, as well as broader public attitudes and beliefs. Second, they target several different levels of prevention – immediate prevention of death or injury, as well as more "upstream" prevention targeted at high-risk groups or individuals. They may also include universal prevention efforts, targeted towards an entire community or nation.
- **Strategies are not limited to any one sector or agency**. The theme of multi-agency and multi-sector strategies, including health, law enforcement and education, as well as child welfare systems and service providers, received particular attention. Other sectors or partners identified included the media, elected officials, the broader public and anti-poverty and affordable housing experts and activists.
- **Successful strategies are focused.** Comprehensive isn't the same as trying to do everything. The key is a focused approach, based on data and evidence, with high-impact opportunities that can make a difference. In the public health world, continuous attention is paid to what is working and to gaps that need to be filled.
- **High quality data, as well as other kinds of research evidence, are essential to inform the strategy and assess its results.** This starts with surveillance–being able to count and measure the problem. This strategy also includes data to identify families at the highest risk, which is necessary to target upstream prevention. And it includes data to place deaths, injuries and "near-misses" in a systemic context, to inform system improvements that have been crucial to safety engineering successes. In addition, evidence synthesized from past research should inform the initial choices of programs and strategies, which then can be tracked for effectiveness and fine-tuned over time.

- **On the data side, we have some important knowledge and experience right now – yet there are also glaring gaps.** We clearly know more than we are now putting into practice, but there are also substantive knowledge gaps.

The following presents some of the major themes that emerged from the Safety Forums convened by Casey Family Programs[1]:

1) Risk Factors for Severe Maltreatment and Fatalities

Large-sample research in California linking birth records and child protection services (CPS) records has found that a report for child maltreatment before the age of 5, whether substantiated or not, is a risk factor for a fatality from intentional or unintentional injury. The research using linked data found that factors at birth including Medicare health insurance, Black race, younger maternal age, and lack of established paternity for the child are associated with higher risk for report of child maltreatment, and especially for report of neglect, during the first 5 years of life. Of interest was whether children reported for nonfatal maltreatment subsequently faced a heightened risk of unintentional and intentional injury mortality during the first 5 years of life. Findings indicate that after adjusting for risk factors at birth, children with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than unreported children and died from unintentional injuries at twice the rate of unreported children. A prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before the age of five.[2]

Similarly other research suggests that there are risk factors that are predictive of severe child maltreatment and fatalities. For example, researchers found that rates of Abusive Head Trauma (AHT) identified among children less than 5 years of age increased significantly at several major pediatric hospitals between 2007 and 2009, and were associated with increased economic hardship at the community level.[3]

2) Child Maltreatment as a Public Health Issue

A significant proportion of child maltreatment-related deaths occur in families who have no history of involvement with the child welfare system. Since many of these cases are outside the oversight of child welfare, their numbers would not be reflected in agency reports. Therefore, it would be prudent for us to look at this issue of child deaths, not just through the lens of child welfare, but from a broader public

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[1] Chahine et al. (2012), Casey Family Programs Child Safety Forum Summaries: The Road Ahead: Policy and Practice Innovations Needed to Improve Child Safety and Prevent Fatalities. (unpublished)

[2] Putnam-Hornstein, E., Webster, D., Needell, B. & Magruder, J. (2011). "A Public Health Approach to Child Maltreatment Surveillance: Evidence From a Data Linkage Project in the United States". *Child Abuse Review* 20, 256-273. See also Putnam-Hornstein, E. (2011). "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study". *Child Maltreatment* 16(3), 163-174.

[3] Berger, R.P., Fromkin, J.B., Stutz, H., Makoroff, K., Scribano, P.V., Feldman, K., Tu, L.C., & Fabio, A. (2011). "Abusive Head Trauma During a Time of Increased Unemployment: A Multicenter Analysis". *Pediatrics* 128 (4), 637-643. See also Wood, J.N., Medina. S.P., Feudtner, C. Luan, X. Localio, R., Fieldston, E.S., Rubin, D.M. (2012). Local Macroeconomic Trends and Hospital Admissions for Child Abuse, 2000–2009. *Pediatrics.* Published online.

health perspective. A public health approach to the prevention of child maltreatment fatalities focuses on the health of populations rather than just the individuals, and aims to prevent critical events *before they occur.* This approach is more efficient, more effective, and is associated with better outcomes, compared to treatment after harm occurs. Prevention may take three basic forms:

a) Primary prevention efforts are intended to reduce risk and enhance protective factors in the general population (all children and families). *EXAMPLES*: Requiring use of child safety seats in all cars with young child passengers; delivery of safe sleeping guidelines to all parents of infants and toddlers.

b) Secondary prevention efforts consist of interventions designed to reduce risk and enhance protective factors among specific population sub-groups known to be at greater risk for child fatalities and serious injuries. *EXAMPLE*: Home visiting parent support and education programs targeted to low-income, first-time parents.

c) Tertiary prevention efforts, by contrast, are intended to reduce and prevent subsequent harm among families *where abuse or neglect has already occurred*. *EXAMPLES*: In-home safety planning in families who are subjects of child maltreatment reports; protective custody and out-of-home placement of child victims of abuse and neglect.

While most child protection activities in the United States have traditionally relied on tertiary prevention, the value of broader public health approaches is that they focus energy and resources on more "upstream" primary and secondary prevention activities, and thus have the potential to keep more children safe while reducing and preventing the trauma and disruption associated with removing children from their homes.

As demonstrated by the research, many high-risk family situations can be identified very early in the life of a child, providing opportunity for proactive support and intervention which may help save lives and prevent serious injuries**.** Information available from birth records regarding a small set of risk factors can be utilized to target high-risk children and families for outreach and offers of voluntary services.

Dr. Fred Rivara and Dr. Brian Johnston conducted a review of successful public health efforts for Casey Family Programs. They found that public health research has demonstrated certain types of interventions can help to reduce and prevent child fatalities and serious injuries, and some effective steps to prevention are neither costly nor difficult to implement.[4] Automobile child safety seats, bicycle helmets, and safety fences around swimming pools are examples of simple and effective steps that have saved many lives. The promotion of safe sleeping practices ("Back to Sleep") is an example of an initiative that reduced preventable child deaths and injuries and could likely save additional lives if consistently promoted by organizations that come into contact with families that have infants and toddlers in the home.

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[4] Rivera, F. P. and Johnston, B. (2012), Paper prepared for Casey Family Programs: "Effective Primary Prevention Programs in Public Health and Their Applicability to the Prevention of Child Maltreatment" (unpublished).

Public information campaigns are integral to effective public health efforts to reduce and prevent deaths and injuries. They also play a critical role in informing the public about the work of CPS agencies and in framing child safety as a community responsibility. Comprehensive media relations strategies are also recommended by child welfare leaders who have successfully incorporated public health approaches into agency policy and practice. Using information to help change culture within agencies and communities, and perseverance over time in change efforts, have been critical factors in the success of effective prevention campaigns. Twenty years ago it would have been difficult to find a bicycle helmet in a child's size, and available helmets were often unattractive to appearance-conscious consumers. Today, helmets are available in a wide range of styles and sizes, and helmet use by bicycle riders has increased tremendously. Lessons from this and other injury prevention campaigns can inform new and ongoing efforts to reduce and eliminate child fatalities and serious injuries.

It is encouraging that the CDC's Division for Violence Prevention is exploring the use of experiential learning tools (simulation modeling) to more effectively communicate the importance of addressing Adverse Childhood Experiences (ACEs) as an important public health issue. These tools will be embedded in a larger facilitated process that will culminate in participants – individual employers, community coalitions of employers, and/or the broader community – in developing action plans to ensure safe, stable, nurturing childhoods by building community capacity and citizen resiliency. Computerized simulation modeling can be a valuable tool in engaging community stakeholders in steps towards preventing child maltreatment injuries, and can be effective in supporting group learning processes within organizations.

3) **Informing child protection policies and practices for reducing child maltreatment related fatalities**

There are several areas that need to be considered in order to improve child protection policies and practices. The public's perception of child welfare in this country is generally painted by media reports of isolated cases of tragedy. Not only is this an inaccurate picture of the child welfare system, but worse, drives public will against that system's leaders and leaves them especially vulnerable to the fallout that occurs when cases of severe abuse and child death hit the front page. The gap between public perception and the realities of child welfare administration leaves the systems wanting for resources and allies and drives public policy in ways that are not always the best for keeping children safe. Thus, a key challenge in child welfare is transforming a culture of public blame leading to agency defensiveness and secrecy into a culture of learning. A key lesson from the successes in the safety engineering world is the importance of looking at incidents from a systems perspective and developing a "safety culture." One of the components of such a culture is that staff feel safe from unfair blame and as a result openly share information that the agency can use to learn. Also critical is building the Child Protection's decision-making and workforce capacity, skills, and training as well as advancing and supporting promising community and cross-systems approaches to preventing maltreatment and fatalities.

Dr. Eileen Munro, a professor of Social Policy at the London School of Economics and Political Science recently completed a review of the child protection system at the request of the British government. Dr. Munro was invited by Casey Family Programs to present at the Safety Forum held in Nashville in June 2012. Dr. Munro commented that the approach to child welfare management has not worked because it is based on a misunderstanding of the human factors in decision making as well as a mistaken

understanding of the nature of the skills required for child protection work. Dr. Munro applied a system's perspective to decision making in child protection, and she urged participants to be cognizant that errors in child protection are inevitable; and that agencies need to steadily work at minimizing errors without imagining that steadily increasing procedural requirements is the only or best approach to achieving this goal. Dr. Munro asserted that agencies need to create organizational environments in which ongoing learning about how to improve practice can occur and which value feedback from the recipients of agency services. She emphasized the need to reduce the punitive response to child deaths in which specific persons are blamed and punished. [5]

Dr. Tina L. Rzepnicki, a professor at the University of Chicago also presented at the Safety Forums. She similarly described the adoption and implementation of the Root Cause Analysis method of critical event review in Illinois – the application of a structured investigative and analytic process originally designed to achieve in-depth understanding of adverse outcomes in other high-risk enterprises (e.g., chemical factory explosions, airline crashes, failed military operations) to child protection. Dr. Rzepnicki advanced that system failures need to be reviewed and understood across systems (e.g., mental health, medical, law enforcement). Defensive practice does not avoid risk but displaces it. A safety/learning environment embraces mistakes as opportunities for adaptive learning to take place but for this to happen, it is necessary to make explicit the kinds of errors that are not acceptable (subject to consequences) and have clear guidelines for reporting mistakes and near misses. Transparent communication is essential. Such an environment also encourages critical thinking and active problem solving by peers in group context. [6]

Dr. Rzepnicki also addressed approaches for transforming child protection agencies into "High Reliability Organizations" during the Safety Forums. High Reliability Organizations (HROs) are organizations with systems in place that are exceptionally consistent in accomplishing their goals and avoiding potentially catastrophic errors". [7] Principles of HRO were first embraced by industries in which past failures had led to catastrophic consequences: airplane crashes, nuclear reactor meltdowns, and other such disasters. These industries found it essential to identify weak danger signals and to respond to these signals strongly so that system functioning could be maintained and disasters could be avoided. These principles are now being applied in health care and there is some emerging interest about potential applicability in child protection. For example, Tennessee is currently engaged in an effort to implement High Reliability Organizing to reduce child fatalities and serious injuries.

Finally, preventing child maltreatment injuries and deaths requires ongoing collaboration among a range of agencies across service sectors and the community. This cannot be accomplished by public child welfare agencies alone. There are examples from around the country of how cross system and community partnerships can improve child safety and prevent maltreatment.

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[5] Munro, Eileen, The Munro Review of Child Protection, Part One: A Systems Analysis, 2010 available at www.education.gov.uk

[6] Rzepnicki, T., Johnson, P., Kane, D.; Moncher, D.,Coconato, L., Shulman, B. (2012). "Learning from data: The beginning of error reduction in Illinois child welfare". In Rzepnicki, T.L., McCracken, S., and Briggs, H.E., eds. *From Task-Centered Social Work to Evidence-Based and Integrative Practice: Reflections on History and Implementation.* Chicago: Lyceum Books, Inc.

[7] Rzepnicki, T. L., Johnson, P.R., Kane, D., Moncher, D., Coconato, L. Shulman, B. (2010). Transforming child protection agencies into high reliability organizations: A conceptual framework. *Protecting Children, 25* (1). 48-62.

4) Measurement and Classification of Child Fatalities

Experts agree that improving the measurement and classification of child fatalities is critical to understanding and preventing child maltreatment and fatalities. Improved consistency in identifying and counting child maltreatment fatalities at the state and national level is seen as essential to determining whether efforts to reduce and prevent maltreatment fatalities are effective. A review of the child welfare, criminal justice, forensic, medical and public health literature highlights the lack of reliable and valid sources of local, state and national data on child maltreatment fatalities. The identification and investigation of child maltreatment fatalities face serious challenges that together lead to the well-documented undercount of child abuse and neglect related deaths. The reasons for this under-ascertainment and underreporting of child maltreatment deaths have been described in detail in several studies.

Building effective cross-sector, multi-agency collaborations are essential to obtaining accurate data on the incidence of preventable child deaths and serious injuries, and for the implementation of successful prevention efforts**.** Multidisciplinary local and state Child Death Review Teams play a critical role in identifying patterns in child deaths and serious injuries, in identifying common risk factors, and in developing and implementing preventive efforts. Moving beyond blame to focus on prevention is key to learning from critical events to avert similar incidents in the future.

For example, the child maltreatment fatality numbers in the National Child Abuse and Neglect Reporting System (NCANDS) - one of the primary sources of national child maltreatment data - are considered to be an undercount because most states include only child deaths from families known to child protection agencies. Research has demonstrated that more than half of the children who die from maltreatment are from families that were not known to or were never investigated by child protection agencies. State child protection agencies vary widely in their definitions of maltreatment adding to the concerns that the aggregate estimates are likely to be incomplete. However, being able to count child maltreatment deaths reliably and accurately over time and across jurisdictions is essential for making system improvements and developing long-term comprehensive child maltreatment prevention strategies.

Similar limitations exist for each of the other major data systems that are used to track child maltreatment fatalities. For example, law enforcement data sources tend to only track homicides (i.e., death at the hands of another).

Following the first Safety Forum in November 2011, Casey Family Programs brought together about a dozen nationally-recognized experts in several disciplines to form a Child Fatalities Measurement Workgroup. The objective of the Workgroup is to recommend more accurate ways to count and classify child fatalities so that ultimately the nation is better positioned to further improve child safety and prevent fatalities. The Workgroup will develop options for national, state, and local policy makers to consider in developing an ongoing strategy to improve measurement of maltreatment fatalities by early 2013. Our work builds on the findings of the GAO report and we are working in partnership with the Administration on Children, Youth and Families and the CDC.

To date, the Workgroup discussed several issues including (a) the reasons and limitations to improving coroners' and medical examiners' determinations of causes of child fatalities; (b) proposals for linking administrative data bases from multiple agencies to arrive at more accurate counts of child maltreatment fatalities; (c) the need for standard definitions of neglect that can be applied to accidental deaths in classifying child maltreatment deaths; (d) potential for learning from the standards for substantiation developed for use in the military services; (e) ways of improving NCANDS measures of child maltreatment fatalities (f) and ways that the National Death Review data base can be enhanced.

We are encouraged by the CDC and the National Center for Child Death Review (NCCDR) joint Sudden Unexpected Infant Death (SUID) Initiative. Under contract from the Health Resources and Services Administration (HRSA), the NCCDR currently provides training and support to state and local child death review (CDR) teams that now exist in every state. Initially in partnership with 17 states, NCCDR developed a web-based Case Reporting Form for collecting data from the team reviews. This online tool is provided to states and teams for no cost and is now in use in over 30 states. The aggregate multi-state data from this system have been used to explore the circumstances surrounding multiple causes of death to identify potential prevention opportunities (e.g., toddler drowning, violent deaths, sudden cardiac deaths, and now infant sleep related deaths). For the SUID initiative, NCCDR has worked with CDC to develop an expanded version of the Case Reporting Form to supplement the data elements on sleep related infant deaths. CDC has funded seven states to pilot the new form and procedures for quality data collection. To date, the results are impressive. All seven states have been able to collect all the major data elements with a confirmed extremely high level of completeness and quality in a timely manner. Several additional states have already adopted the new SUID data collection form. This Initiative demonstrates the feasibility of integrating the new public health child maltreatment definition into NCCDR's web-based data collection system and having it implemented effectively by state child death review teams.

Another hopeful example is how the U.S. Armed Forces were able to achieve greater consistency to the classification of child maltreatment. Amy Slep and Richard Heyman, both from New York University, presented to the Workgroup on their extensive research and development work which has culminated in a computer-guided decision matrix tool to support decision making among diverse stakeholders in determining whether to substantiate child maltreatment allegations. The tool was developed under contract for the U.S. Air Force, and is now used by all branches of the U.S. Armed Forces.

Cross-agency collaboration in tracking child deaths is possible and a variety of local models exist. Rules have also been developed for joining information regarding child fatalities from multiple data bases in order to derive the most accurate possible count of maltreatment fatalities. However, lessons learned about how best to do this still need to be discussed. A practical way of tracking injuries and near-misses is also urgently needed.

Casey Family Programs has used its national platform and its resources to elevate this issue with a particular focus on engaging state child welfare administrators and other key voices. We stand ready to work with this commission or any other group or organization focused on child fatalities.

Thank you for the opportunity to share these remarks with you, and, above all, thank you for your commitment to the well-being of children and families.

Mr. PAULSEN. Mr. Frenzel, in your testimony, you mentioned that you feel a number of commissions have been unable to achieve their objectives. What do you think contributes to that failure? Is it that the missions are too broad or the recommendations are too difficult to implement, or something else?

Mr. FRENZEL. Well, I think those commissions, Mr. Chairman, and members, that we all know about, are the very high-profile, very difficult ones, such as the Simpson-Bowles Commission, usually dealing with economics or budget affairs. They only go to the commissions after the problems have become intractable and hard for the Congress and the President to deal with together.

It is very hard to move a report of one of those commissions, especially when the President designates the commission and the Congress is not interested in following it up. I cite the Bush 43's Commission on Social Security and one on tax reform. In that case, in the latter case, the part of Congress that didn't want to deal with it was President Bush's own party. And so it is just a long shot, I think. The problems are too tough.

This would be quite different. I think this would be something on which everyone can get together, and the reason I suggest that you might not want a Presidential commission, is that I am afraid you might not get the right people or the right spread of people. And therefore, I suggest a congressionally appointed panel. But the failure of the Presidential commissions is that the subjects were too tough to begin with, and they weren't going to be solved at that time.

Mr. PAULSEN. Do you have any other thoughts about what we might do to make sure that the recommendations of the commission remain within budgetary and political reason and don't become too expensive or too controversial for Congress to actually approve in the end?

Mr. FRENZEL. The reason I suggested you get a former Member of Congress to chair that commission is exactly that. I had some experience on the Pew Commission for Children in Foster Care where we had a lot of wonderful advocates for children who knew lots about the subject, but my cochairman and I were able to bring them back to reality, to a position where most of their recommendations could be passed.

You can have the best report in the world. If you can't pass it, the whole thing sinks. And you can't hold these people's enthusiasm back, but you can give them, I hope, leadership that won't let the enthusiasm run away with them.

Mr. PAULSEN. Ms. McClure, you are currently serving on a commission in Texas that is focused on preventing child abuse, and this commission has had to develop recommendations for State policymakers to consider and approve. What mechanisms does your commission have in place to actually see that the recommendations are adopted?

Ms. McCLURE. A reality check. I think, as the Congressman just mentioned, we have to be realistic. We can put out a report looking at the utopia or the ultimate solutions maybe for 20, 30 years, but we certainly have 2-, 4-, and 6-year goals that are realistic, given the resources, or scarce resources, I should say, and the political realities of our State. So I agree that what the Congressman is mentioning, you have to have the enthusiasts at the table, the experts, but we need some political and economic realists there as well.

Mr. PAULSEN. Thank you.

Mr. Doggett is recognized for 5 minutes.

Mr. DOGGETT. Thank you very much, Mr. Chairman.

And I think first I want to say to Ms. Huizar, I believe that it was your Coalition to End Deaths that really provided the impetus for the original legislation that I introduced and was introduced in the Senate last year, and I appreciate that and I think you helped to craft a good measure.

The changes that have been made in the bill since then, are to address some of the concerns that have been raised here today and also recognize the jurisdiction of the various committees and of this subcommittee. One of those changes really is designed to address precisely what Congressman Frenzel raised; we are not interested in just another report to sit on the shelf. We want some people who are actively involved, and so, since last year, changing it to have half of those appointees come from within the Congress in hoping that we will have people who work with the leadership here in the Congress, and the House, and the Senate to actually see something happen.

With reference to your comments, and particularly Mr. Sander's comments about Title IV and Title XX, that is the jurisdictional basis for this Committee. It is not my intention as an author to tie the hands of this commission. The commission may well consider matters that weren't even mentioned in the bill last year in trying to decide how to fulfill its mission. But as it reports back, the focus of this Subcommittee is Title IV and Title XX of the Social Security Act. It may deal with, as it looks at these issues, some advice to the States that it found some practice in Minnesota, or New York, or Michigan that is particularly valuable for a State or a city to use.

So I just wanted to make clear, while very sympathetic to the comments that you made, Mr. Sanders, that it was not my intention as we redrafted the bill to tie the hands of the commission or to deny it an opportunity to go wherever the evidence suggests. Even though its goal is to stick with a Title IV and Title XX, certainly our goal is to focus on prevention, and not just responses after this happens.

And I think Ms. McClure has made it especially clear, the dollar savings we can have, which is also something all of us are very interested in; how can we see the most efficient use of our Federal and other resources to address this problem?

Let me ask you, rather than use all of my time commenting on the excellent testimony that each of you gave, Ms. McClure, just to pick up with what the chairman was asking. From your work there on the Texas Blue Ribbon Task Force, which I understand is still a work in progress, and thinking about those experiences, if we have a State commission, and I am sure Texas is not the only State with a State commission, and there are a number of city commissions, what advantages do you believe we would gain from having a national commission to continue the review?

Ms. McCLURE. Well, first off, Congressman Doggett, let me just point out that one of the reasons we do have a commission in Texas is, alluding to your earlier comments, is that our child fatality deaths grew by 124 percent over a 15-year period compared to our population growth of 19 percent. Over that same time frame, we went from 103 children dying from child abuse to 281 child deaths over a period of 15 years.

So that was the impetus for the commission, but as we started getting deeper, we realized, what we really do need to do is address the root problem. But when we looked at national research, all of the national Web sites, and tried to study who has got a good blueprint or turnkey kit, if you will, on a child abuse prevention strat-

egy, there really wasn't anything. So we ferreted out different States' prevention plans and strategies, and we found about seven or eight States that had something in place, but what we couldn't find was outcomes from the implementation, nor evaluation of performance outcomes from these plans.

So what I see this commission doing is really putting the best of the best together and formulating something that is a flexible model that States can implement and access, of course, if they desire. It can be a kind of clearinghouse for a place to go that will be adaptable to each State's unique needs, and population, and culture. So I really wish we had had something like this in place to go to to make our 4 years of work a bit easier. It will be a great resource.

Mr. DOGGETT. My thanks to each of you. I think your testimony is really helpful and your ongoing participation. We still do have the possibility of action this year, and hopefully, with your input, not only to us, but to our colleagues in the Senate, we can get some movement and some action and get this underway none too soon.

Thank you, Mr. Chairman.

Ms. McCLURE. Thank you.

Mr. PAULSEN. Thank you, Mr. Berg is recognized for 5 minutes.

Mr. BERG. Thank you, Mr. Chairman.

I want to thank you, Chairman Paulsen, for holding this hearing, and certainly Mr. Camp and Mr. Doggett for being cosponsors. I think one good way to determine whether or not something coming out of this commission will be heard is when you have the ranking member as the sponsor of the legislation. So, hopefully they will be able to work through those things.

It is really unfortunate that child abuse is a challenge throughout our country. We just had a situation on one of our reservations in North Dakota that has really brought to light this very serious issue. It is unfortunate because it is out there all the time, and then you have one situation that comes up, and all of a sudden, it is on everyone's mind in the State and all of the elected officials, and then it kind of goes away. So I think part of why this is important to me is it is obviously important to our State right now. It has been an alarm.

So I am wondering if better communications from the different organizations involved could help move this along? And Ms. Huizar, I would like you to respond to whether or not there is a way to create a better communication process within the organizations.

Ms. HUIZAR. Sure. Thank you very much, Congressman, for asking that question. I think there are several ways to approach this. One, is in terms of collecting information itself, one of the things that we should probably recognize is that NCANDS right now, the information that States turn over to the Federal Government in regards to these records, doesn't even really require turning anything over in regard to near fatalities. There is no field for that. And so there is a lot of information that just gets missed in that way.

I think, at the local level, though, you see even misunderstandings about CAPTA confidentiality requirements and what information can be shared.

There was some recent clarification that HHS put out to indicate that in child abuse fatalities, that information involving the child who had died, that that information could be shared as a part of policymaking, and the investigation to determine what could be done to prevent these deaths. However, it did not clarify whether, in fact, information on other cases involving that child, prior cases of abuse, or even cases involving other siblings in the family could be shared. And you can imagine that because, as Mr. Sanders pointed out, in many of these cases, there had been prior reports and that is a factor in future death, that would be a very important thing to know. So I think that there are some significant issues yet to be clarified that could be very helpful in that way.

And finally, I would say that data systems can make that work easier. In our own Children's Advocacy Centers and multidisciplinary teams, the reason there such open information sharing is because we have systems in place that make that possible, including the use of technology in doing that. And in the absence of that, it is tremendously difficult for all of the professionals who need to share that information to do so. So I think there are some very practical steps we can take along this line that would make that job easier.

Mr. BERG. Well, maybe you can expand on that little bit. You have the data sharing between groups, getting on the same kind of platform, so same definitions maybe for abuse, or are some best practices that you can say, you know, here is how these groups can work better.

Ms. HUIZAR. Absolutely. Well, I would like to think that certainly that Children's Advocacy Centers are an excellent example of that multidisciplinary teamwork really coming together and sharing that sort of information. And what they have been able to demonstrate over 25 years in terms of their effectiveness in working in these cases, I think could be expanded to work in this arena as well. I think child death review teams are another excellent example, but their work has been somewhat limited. I mean, as you know, the resources that are actually going toward the work of those teams has have been very small. And so while there have been some good pilot projects in terms of cross sharing of information, there is a lot of work yet to be done, some of which will really require some additional resources.

And then you also touched on a critical matter which is this lack of standardized definitions. I mean, this is really core in lots of areas where there are problems in child abuse reporting overall, in counting fatalities, and many other things. The lack of standardized definition makes it very difficult to get our arms around this problem, and I think if we can address that, it is a good first step to addressing some of the other matters.

Mr. BERG. Thank you, and I yield back.

Mr. PAULSEN. Thank you. The gentleman's time is expired.

Mr. Reed is recognized 5 minutes.

Mr. REED. Thank you, Mr. Chairman.

And thank you, Mr. Doggett, for this important matter. I look forward to supporting it and working with you to get this to the finish line.

And I appreciate the witnesses' testimony today. And I wanted to continue on the issue of the standardization of definitions. This is one thing that, as I serve on this subcommittee, I am very interested in trying to pursue, making uniform, to make consistent the different terminology and language and data points that are being provided to the Federal Government, because I see a lot of just basic miscommunication and inefficiency associated with that. And so when we looked in particular at the definition of, for example, maltreatment, it varies State by State. And we have had a hearing on it back in July of 2011, and I am interested in hearing from the panel. Maybe Mr. Sanders to start with, why do the States do that? And what are the arguments for and against having those different definitional standards?

Mr. SANDERS. Thank you for the question.

I think there are a couple of perspectives on that. One is the Federal Government actually gives flexibility to States in the definition beyond the focus on physical abuse, sexual abuse and neglect. And States have taken that opportunity. And one example is educational, young children missing school. In some States, that is defined as maltreatment; in other States, it is not. And my guess is that it emerges as a concern from the local community or from the State as an issue that they want to address and feel that should be addressed under their child welfare agencies. So that would be an example of maltreatment being defined differently from State to State.

I think that the other piece of that is it is important for this issue to come to some consensus to develop consistency in reporting, because I think that to address this issue, there is going to have to be accurate measurement of how many children are dying due to abuse or neglect. So I think it is quite possible to come to that and I think that the commission really offers an opportunity for that to happen.

Mr. REED. Well, I appreciate that and I join in that sentiment. So if I am understanding your answer correctly, you think primarily the difference is the basic difference between communities coast to coast, north to south and the different community needs that they are identifying in the states where they have different definitions.

Are there any practical effects? Is there any funding that is tied to these different numbers? I am trying to see if there is something else that is driving this distinction, other than just the uniqueness of the areas of the country upon which the terms are being defined differently? Does anyone have anything to offer on that side? Is there any policy reason why they would be making those distinctions?

Ms. McClure.

Ms. McCLURE. I would just say that almost every legislative session in Texas, there are proposals to change the definition of child abuse and neglect in some way. So those definitions are, I think they are more culturally defined. I don't think that there is anything financial involved in making definition changes.

But back to your point on how to standardize measures, I think one of the ways of looking at child maltreatment fatalities is not so unlike looking at homicides versus manslaughter. So, in other words, an intentional death of a father, beating a child and putting him in the oven, versus the mom who is depressed, asleep, and her child runs out and gets hit by a car, are really different types of child deaths that we really need to consider.

So I would say that there are quite a few deaths due to neglect, but mostly they are physical abuse. And I would look at those very differently. I don't think it would cost the States much to stratify and come up with a consensus on a definition that would be acceptable to everyone, as long as they knew that the bottom line is that we are helping, trying to provide some tools to alleviate the problem.

Mr. REED. That is a great point, and that leads to one last quick question. So do you see any barriers that we would have at the Federal level coming up with a common definition that we would have to overcome in order to implement it? Are there parameters that we should be focusing on in regards to defining that term, maltreatment? Anyone? Do you see any barriers?

Ms. HUIZAR. Well, one thing that I would say is that your primary barrier may be people's just innate sense of attachment to what they are already doing and reluctance to change. Exactly, reluctance to make change. I think it is important to know that the CDC did a tremendous amount of work on setting up standardized definitions in the area of child maltreatment, and I think encouraging their usage might be a first good place to start in that regard because they certainly did very fine work. And it, you know, reflected a consensus of experts and others. So——

Mr. REED. Good. All right.

Well, thank you very much.

With that, my time is expired. I yield back, Mr. Chairman.

Mr. PAULSEN. Thank you.

With that, I just want to thank all of the panelists and witnesses for taking the time to be here.

I think, hopefully, we will be hearing from Chairman Camp and Mr. Doggett as they fine-tune some final changes that are consistent with today's testimony.

And with that, we are adjourned.

[Whereupon, at 3:02 p.m., the subcommittee was adjourned.]

[Submissions for the Record follow:]

Comments on Hearing Before the Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives

Submitted on behalf of the

Alliance for Children and Families by

President and CEO Susan N. Dreyfus

Thank you for the opportunity to submit comments on the Protect our Kids Act, an important piece of legislation that will promote the safety of our nation's children.

I represent the Alliance for Children and Families, a national organization dedicated to achieving a vision of a healthy society and strong communities for all children, adults, and families. The Alliance works for transformational change by representing and supporting hundreds of nonprofit human serving organizations located in North America to translate knowledge into best practices that improve their communities. Working with and through its member network, the Alliance strives to achieve high impact by reducing the number of people living in poverty; increasing the number of people with opportunities to live safe and healthy lives; and increasing the number of people on pathways to educational and employment success. Our members have significant experience in child welfare with many of them providing the case management function in partnership with the public sector. We represent a significant force in the nonprofit human-serving sector. Collectively, our network contributes more than $14.8 billion to local, state, and national economies, operate in 2,700 locations and serve more than 8,000 communities.

I have had responsibility for the public child welfare systems in the States of Wisconsin and Washington, working for both Republican and Democratic Governors, in addition to my experience in the non profit sector. I have helped shape major reform efforts in systems under class action litigation and have helped shape public policy which aligns with our child and family centered values and goals to ensure that every child who comes to the attention of the public child welfare system is safe and able to live their lives with permanency and enhanced well -being.

Most recently, I served as the secretary of the Washington State Department of Social and Health Services, where I had responsibility for child welfare, Medicaid, juvenile justice, aging and long term care, developmental disabilities, eligibility and TANF, mental health, and substance abuse. At a time of significant reductions in our budget, we led significant transformative change by focusing on impact, partnerships and seizing the integration across our systems that often sit in what I respectfully call, "cylinders of excellence".

It was a true honor to serve Washington Governor Christine Gregoire from 2009-2012. During my tenure, we successfully reduced child maltreatment rates by focusing on safety, doing an in -depth analysis of our fatalities and by using predictive analytics to determine which children were at highest risk. Through intense collaboration we arrived at new ways to identify risk and implement many effective strategies. For example, we instituted a policy of always screening children under two years of age, looking more closely at repeat referrals within a household regardless of screening decisions, and screening in any reports made by medical professionals.

A national commission, such as that created by the Protect our Kids Act, would serve an important function in gathering the best, most innovative solutions from both the public and non -profit sectors and recommending strategies that improve child safety and reduce the tragedy of child fatalities

In considering innovative solutions, the commission should include representation of the non profit child welfare agencies and their significant child welfare experience. States are increasingly looking to their private partners to carry out child welfare functions including, case management, and it is these private agencies that are leveraging both federal and private funds and creative community partnerships to create innovative solutions. Without private agency input, a large piece of the knowledge and experience needed by the Commission would be missing.

My experience has taught me that while our first inclination is to always want to quickly focus on improving results for children, we must first start with clear legislative policy on what we are to ultimately achieve and the principles through which we are to align and constantly improve the entire system beginning with intake. I would like to share 4 themes that I believe need to be included if the Commission is to be successful in achieving its goals.

Clear and Aligned Policy Creates True Reform

Among states, the policy often is fractured by numerous reform efforts over many years that attempt to fix only parts of the system from the outside/in. This leads to great confusion and inconsistency in performance. I believe that the recent Information Memorandum issued by the Administration for Children and Families is the first clear policy direction from the federal government in child welfare during my 20 years of experience. It states clearly what the system is to achieve, which is to promote the social, physical, and emotional well-being for children receiving child welfare services and to improve the behavioral, physical, and social, emotional outcomes for children who have experienced abuse and or neglect.

It is through this lens I suggest any review of the country's vision and direction be undertaken. One of the key principles should be a strong policy statement on the system's mission: to meet the unique needs of every child, every time, within the context of their emotional and physical safety. This is not just an ultimate outcome, but must be experienced by a child every day they are under the responsibility of the child welfare agency.

A Focus on Impact

I believe that a key to successful child welfare systems is the vision, transparency and leadership of the public sector agency in inviting the community, families, other state agencies, philanthropy, the courts and all stakeholders to actively participate and share accountability for the success of the system. Reforms from the top down may make for short term gains, but they do not bring long term and impactful change. As lawmakers, you can ensure that the other public sector agencies responsible for — education, mental health, substance abuse, developmental disabilities, TANF, Juvenile Justice, courts and law enforcement— are clear on their responsibilities to carry out your clearly articulated child welfare policy.

Powerful use of Data Analytics

To illustrate how private agencies are key to child safety, I would like to provide for you a vivid example of how Alliance members are using data and technology.

Data analytics is our next frontier in child welfare. If we use our data not to simply find out too late what is not working but we use it to help us with our daily work and decisions, to help us understand what is working and we use the data to continuously as the "why" questions, we can not only make better decisions for each child but constantly be improving our policy, practice and results.

Some of our member agencies in Florida have partnered with software company Mindshare to develop a system using predictive analytics to identify high risk children and families in order to target interventions to keep children safe. The results have been promising. Caseworkers receive real time updates that allow them to intervene before a situation becomes unsafe for the children.

By harnessing the power of technology they are able to transform massive amounts of data into useable information. The system integrates with the Statewide Automated Child Welfare Information System (SACWIS) and incorporates information from school districts, law enforcement , the health care agency and others. Using data from multiple sources has allowed agencies to identify children at risk even before they come to the attention of the child protection system.

In designing the system, they studied every child death in the state, and from there were able to create models that detect behavioral patterns related to risk. The process takes a great deal of subject matter expertise and they are continually refining and updating their rules to make it more accurate.

The use of data analytics in Florida points to a new direction in early detection and intervention, but barriers to full implementation remain. For example, confidentiality policies sometimes hinder the flow of information. And not all data is automated. For example, information from court records must be extracted and entered manually. In addition, agencies cannot claim federal administrative dollars to operate the system. These barriers represent the kind of issues that a national commission could address in their recommendations to Congress.

Sustainable Reforms Must be Aligned Across Systems

The constant churn of child welfare reform efforts seems to be never ending, and that is because we keep trying to fix the system from the outside in, one technical fix at a time. What is needed is to step back and ensure we have a clear and articulated policy and set of principles that are aligned across multiple systems and shared by the community. Then, using the power of data analytics, science, and creation of true partnerships that incorporate authentic voices of all involved, we will be able to implement sustainable solutions . I am convinced that child maltreatment is a major public health issue in America today, and that the Protect our Kids Act is an important step to reaching a solution.

In closing, the public agency responsible for child protection is but one part of the child welfare system. The safety and well-being of the nation's children are a shared and very serious responsibility, requiring a public child protection agency able to bring the many other parts of the system to the table in shared responsibility for our children. The national commission created by the Protect our Kids Act is an important step in that direction.

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AMERICAN
PSYCHOLOGICAL
ASSOCIATION

Written Statement of the American Psychological Association

Submitted to the

United States House of Representatives Committee on Ways and Means

Subcommittee on Human Resources

on

Proposal to Reduce Child Deaths Due to Maltreatment

December 13, 2012

On behalf of the American Psychological Association (APA), thank you for holding hearings on reducing child deaths due to maltreatment and for the opportunity to submit testimony for the record. APA, the largest scientific and professional organization of psychologists in the United States with more than 137,000 members and affiliates, works to advance psychology as a science, a profession, and a means of promoting health, education, and human welfare. APA promotes scientific inquiry, professional practice, training, and advocacy on the prevention of child maltreatment.

APA supports the Protect our Kids Act, a bipartisan proposal developed by Committee Chairman Camp and Subcommittee Ranking Member Doggett to establish a commission tasked with developing recommendations for reducing child deaths due to maltreatment. This draft legislation is an important step toward a national commitment to ending child deaths from abuse and neglect. APA and the psychology community appreciate and support the inclusion of those with expertise in "child psychology and mental health" on the commission.

Unfortunately, child maltreatment is a pervasive national problem. The congressionally mandated Fourth National Incidence Study of Child Abuse and Neglect (NIS-4) found that one child in 25 in the U.S., or 2.9 million children, experienced some kind of abuse or neglect in 2005–06. For fiscal year 2011, states reported 1,545 child deaths due to maltreatment to the National Child Abuse and Neglect Data System. This number is likely an underestimate, according to the Government Accountability Office report *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention*. The NIS-4, which relies on multiple sources of information on child deaths, estimated that 2,400 children died from maltreatment in a single year. The Centers for Disease Control and Prevention has estimated the total lifetime costs associated with a single year of confirmed cases of child maltreatment at $124 billion. The value of a child's life lost to maltreatment is incalculable.

Fortunately, child maltreatment can be prevented. Psychological research has produced programs that have been shown, through rigorous scientific evaluation, to be effective in preventing child maltreatment. Approaches used by effective programs include multilevel public health interventions, home visitation, and coordinated, family-centered services. Despite advances in the development of evidence-based prevention programs, however, more work is needed. Documented evidence of effectiveness through rigorous research is still the exception, rather than the norm, among child maltreatment prevention efforts. Effective prevention programs face challenges in large-scale implementation and in adapting to local conditions and cultures while maintaining fidelity to the elements of the intervention that make it effective. APA and the psychology community stand ready to support the commission in meeting these challenges.

Prevention of child maltreatment is also hampered by lack of coordination across systems and jurisdictions. Multiple public and private systems are involved in preventing and responding to child maltreatment. Service delivery systems related to health care, mental health, substance abuse, housing, child care, and income support often are not integrated with each other. Mandated reporting laws vary from state to state with respect to how child abuse is defined and the minimal criteria that need to be reached in order for a mandated report to be made. States

also vary widely in their ability to investigate reports of child maltreatment and to provide services to families, largely due to resources allocated to child welfare services.

Overcoming these challenges requires a comprehensive national strategy to end child maltreatment deaths, based on accurate information about child maltreatment risk factors, barriers to prevention, and effective services and policies. This is exactly what a national commission, with expertise from a wide range of fields relevant to child maltreatment, would provide. The Subcommittee is to be commended for its leadership in advancing this important bipartisan legislation.

APA and the psychology community look forward to continuing to work with you to prevent child abuse and neglect, to intervene early when instances of maltreatment become known, and to provide effective mental health and related treatment to children and their families. Such efforts will help to ensure that all children are safe and that families receive the services and supports that they need and deserve.

Children's Advocacy Institute

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Testimony to the Subcommittee on Human Resources, Committee on Ways and Means, House of Representatives in support of the proposed Protect Our Kids Act

Acting Chairman Paulsen, Chairman Camp, Ranking Member Doggett, and Members of the Subcommittee:

We at the Children's Advocacy Institute are grateful for the opportunity to address the important issue of child abuse fatalities and near fatalities in the U.S. and the potential of the Protect Our Kids Act to help remedy this tragic epidemic. We support the adoption of this important legislation and hope that you will consider our recommendations as to how it may fulfill its potential once enacted.

Our Credentials

We have been working on issues pertaining to child abuse or neglect fatalities and near fatalities for a number of years and are recognized as one of the leading advocacy organizations in this space. The focus of our interest on this issue is on enhancing the public disclosure and transparency of these tragic incidents and using improved reporting and disclosure as a means to prevent future fatalities and near fatalities. CAI believes that states must be held accountable to the public regarding what led up to each child abuse or neglect deaths and near-death so that the public can identify and remedy systemic shortcomings.

In order to be eligible to receive federal Child Abuse Prevention and Treatment Act (CAPTA) funds, states must have provisions that "allow for public disclosure of the findings or information about…case[s] of child abuse or neglect [that have] resulted in a child fatality or near fatality."[1] Together with First Star, CAI has gathered and analyzed the provisions that have been adopted by states in furtherance of this mandate and published two reports on the subject, entitled "*State Secrecy and Child Deaths in the U.S.—An Evaluation of CAPTA-Mandated Public Disclosure Policies about Child Abuse and Neglect Fatalities or Near Fatalities, with State Rankings*."[2] The reports give each state a grade (A to F) based on the quality of the state's CAPTA-mandated public disclosure policy.

Our first report, published in 2008, found that a majority of U.S. states had adopted policies that did not provide adequate public access to information about fatal and life-threatening child abuse cases. The findings of our initial report generated substantial public attention and were key in prompting positive change with regard to child maltreatment laws and policies in several states.

[1] 42 U.S.C. 5106a(b)(2)(A)(x).
[2] The two reports, published in 2008 and 2012, are available online at www.caichildlaw.org/Misc/State_Secrecy_Final_Report_Apr24.pdf and www.caichildlaw.org/Misc/StateSecrecy2ndEd.pdf.

The Second Edition, released in 2012, provided an updated analysis of states' public disclosure laws and policies. Since the 2008 report, we found that 11 states improved their laws significantly, while a few others had actually reduced transparency—and several states kept the same low grades they had received in 2008.

CAPTA acknowledges the importance of public disclosure in order to identify and fix systemic problems that may unnecessarily lead to child deaths or near-deaths. Unfortunately, CAI and First Star have found that policies at the state level vary widely, and many states still have policies that fail to fulfill CAPTA's intent. Even in states where disclosure has been deemed an important goal, the requirement is often not adequately reflected in state laws or written policies and thus is not enforceable, or can be quickly undone by a change in administrations.

Because enforceability is the key concept to address in evaluating a state's policy regarding public disclosure of this information, a major goal of our *State Secrecy* report has been to encourage more states to formalize their policies in statutes or to issue binding regulations.

States must be held accountable and comply with existing law. But we have learned that they will not do so voluntarily. Until the federal government enforces its own laws mandating that each state releases accurate and thorough information in a timely manner, we will be hindered in our ability to identify and repair the fault lines in our child protective system or reduce the horrifying rate of child fatalities in this country.

Recommendation that the Commission Work to Strengthen Current Federal Law Governing Disclosure and Reporting of Child Abuse and Neglect Fatalities and Near Fatalities

We would recommend that one primary focus of the Commission to End Child Abuse Fatalities and Near Fatalities be to follow-up with the unfulfilled mandate from the 2010 reauthorization of CAPTA.

The primary federal law governing the public disclosure of information pertaining to child abuse fatalities and near fatalities is the Child Abuse Prevention and Treatment Act. In 2008, after the release of the 2008 edition of our report, we, along with advocacy groups including the entire National Child Abuse Coalition petitioned Congress to clarify and strengthen the reporting requirements imposed on the states by CAPTA.

Under current law, many States currently fail to re-shift the balance between confidentiality and public disclosure when a child dies or nearly dies from maltreatment. Many States' narrow reading of CAPTA frustrates the statute's purpose. And to be fair, in its current form, CAPTA's public disclosure mandate is unduly vague. We would be happy to work closely with the Commission toward identifying CAPTA amendments that would help bring State policies in line and result in more predictable, consistent, and enforceable disclosure of this critical information.

Recommendation that the Commission Hold DHHS Accountable for Implementing Regulations to Strengthen and Clarify Disclosure Requirements of CAPTA as Instructed in HELP Committee Report

Due primarily to procedural and not substantive hurdles, various proposed amendments to CAPTA were not adopted in 2010. However, the Senate HELP committee report did take an unequivocal position directing HHS to implement existing CAPTA law requiring child protective services "to provide for the mandatory public disclosure of information about a case of child abuse or neglect which has resulted in a child fatality or near fatality" in order to ensure "improved accountability of protective services and drive appropriate and effective systemic reform."[3] Recognizing that not all states are in compliance with the CAPTA requirements, the committee adopted report language calling upon HHS to develop clear guidelines **in the form of regulations** clarifying for and instructing States of their responsibilities under CAPTA.

See the Committee report at: http://www.gpo.gov/fdsys/pkg/CRPT-111srpt378/pdf/CRPT-111srpt378.pdf

The text of the relevant section reads:

DISCLOSURE OF INFORMATION ON CHILD FATALITIES AND NEAR FATALITIES
The committee believes that the duty of child protective services, required in CAPTA Sec. 106(b)(2)(x), to provide for the mandatory public disclosure of information about a case of child abuse or neglect which has resulted in a child fatality or near fatality ensures improved accountability of protective services and can drive appropriate and effective systemic reform. However, the committee is aware that not all States are in compliance with these CAPTA requirements. The committee calls upon the Secretary of Health and Human Services to develop clear guidelines in the form of regulations instructing the States of the responsibilities under CAPTA to release public information in cases of child maltreatment fatalities and near fatalities, and to provide technical assistance to States in developing the appropriate procedures for full disclosure of information and findings in these cases.

In September 2012, ACF did, in fact, finally respond to the Senate HELP Committee's directions, but it did not do what was requested of it. First, it issued program instructions rather than regulations. The distinction between the two is meaningful. Regulations are binding. Anything less is not. The intent of the Committee was also not respected. The HELP Committee called for regulations that would provide *greater* transparency, *better* information, and *more effective* public disclosure. What was released accomplishes the opposite. The cause of ensuring faithful compliance with CAPTA and, more importantly, accomplishes the desired goal of preventing further fatalities, requires rules that have the dignity and binding impact of regulations.

We respectfully request that the Commission put pressure on ACF to adhere to Congressional direction with respect to issuing these regulations.

Furthermore, we call upon the Commission to consider most carefully how to strengthen federal law as it pertains to disclosure, confidentiality, and reporting on this issue.

CAPTA needs to be amended to express stronger and clearer language that states cannot ignore.

DHHS must be held accountable for enforcing this law most stringently and should reprimand and penalize states that are out of compliance with these provisions.

Further legislative reform may also be required to obtain the data we need to track trends, identify fault lines across state systems, and implement meaningful reform that can save children's lives and reduce the alarming epidemic of fatalities. Those are our fervent aspirations for this Commission.

Thank you very much for your consideration.

Sincerely,

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The Children's Advocacy Institute was founded in 1989 as part of the Center for Public Interest Law at the University of San Diego (USD) School of Law. CAI's mission is to improve the health, safety, development, and well-being of children. CAI advocates in the legislature to make the law, in the courts to interpret the law, before administrative agencies to implement the law, and before the public to promote the status of children in our society. CAI strives to educate policymakers about the needs of children—about their needs for economic security, adequate nutrition, health care, education, quality child care, and protection from abuse, neglect, and injury. CAI's goal is to ensure that children's interests are represented effectively whenever and wherever government makes policy and budget decisions that will impact them.

FIRST FOCUS
CAMPAIGN FOR CHILDREN

COMMENTS FOR THE RECORD

Submitted to the Subcommittee on Human Resources, Committee on Ways and Means

Hearing on Proposal to Reduce Child Deaths Due to Maltreatment

December 12, 2012

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Chairman Paulsen, Ranking Member Doggett and members of the Subcommittee, thank you for this opportunity to submit a statement for the record regarding the December 12 hearing on *"a proposal to reduce child abuse deaths due to maltreatment."* We appreciate the attention that your Subcommittee is bringing to the weighty issue of child fatalities resulting from abuse and neglect and **urge you to ensure that in the course of your work, there is consideration of a broad array of effective prevention programs targeting child abuse and neglect.** Following on the heels of the July 2011 release of a Government Accountability Office (GAO) report entitled "*Strengthening National Data on Child Fatalities Could Aid in Prevention*," and a subsequent hearing held by your Subcommittee that same month to review the data on child deaths resulting from maltreatment, this hearing is bringing much needed attention to a devastating societal problem.

The First Focus Campaign for Children is a bipartisan organization advocating for legislative change in Congress to ensure children and families are a priority in federal policy and budget decisions. Our organization is dedicated to the long-term goal of substantially reducing the number of children entering foster care, and working to ensure that our existing system of care protects children and adequately meets the needs of families in the child welfare system. We are especially concerned with increasing our federal investments in prevention efforts and providing supports and services for at-risk families to ensure that they never enter the child welfare system in the first place.

As you know, each year, child protective service agencies receive over 3 million reports of abuse, close to 1 million of which are substantiated – making child abuse a national epidemic. Admittedly, the consequences of child abuse and neglect are well-documented. Exposure to child abuse, specifically recurring experiences of abuse and neglect can have a significant, cumulative and long-term impact on a child's development, often leading to deficits in interpersonal relationships, affect regulation, and self-development, as well as increased rates of multiple psychiatric diagnoses.

While not all abused children develop difficulties, many do experience a chronic course of psychopathology, with posttraumatic stress disorder (PTSD), depression, and behavioral disorders commonly reported in victimized children and adults. Society also pays a heavy price for child abuse. In addition to the costs incurred by law enforcement, child protective services, judicial, health and other systems, according to the Centers for Disease Control (CDC), the lifetime financial cost for a single year of new confirmed cases of child abuse totals roughly $124 billion.

The grim reality is that not all victims of child abuse and neglect survive. In 2011, according to the National Child Abuse and Neglect Data Systems (NCANDS), there were 1,570 child deaths as a result of abuse and neglect - with 81 percent of those deaths accounted for by children younger than four years old. While significant, this number is likely an undercount given that most states report only child deaths from families known to child protection agencies. We know from available research that more than half of children who die from abuse are from families who were never known to or investigated by child protection agencies.

Research has demonstrated that no single factor, but rather a combination of individual, familial, and community risk factors increase the risk for maltreatment. Family level risk factors include caregiver stress,

depression, caregiver's own history of maltreatment, limited social supports, and the experience of stressful life events. Parental substance abuse is estimated to be a contributing factor in one-third to two-thirds of all maltreatment cases, and both neighborhood and familial poverty are two of the strongest predictors of abuse and neglect. In fact, caregivers in poverty are more likely to struggle with substance abuse and mental health problems, experience greater cumulative negative life events, and live in substandard housing, factors all associated with increased risk for abuse and neglect.

Major challenges remain. The continuing high level of child deaths is the clearest indication of continued need for improvement in our child protective system. In addition, while evidence on the effects of the recession is mixed, recent data points to noticeable spikes in child abuse following the recession. One study, "*Local Macroeconomic Trends and Hospital Admissions for Child Abuse, 2000 to 2009*," links a rise in physical child abuse in the last decade to local mortgage foreclosures. The study, published in the journal *Pediatrics*, is the largest examination to date of the impact the recession has had on child abuse. The study, found that every 1 percent increase in 90-day mortgage delinquencies over a one-year period was associated with a 3 percent increase in children's hospital admissions for physical child abuse, and a 5 percent increase in children's hospital admissions for traumatic brain injuries suspected to be caused by child abuse.

These data, in addition to the notably low number of families who receive any service - even when maltreatment is substantiated – suggest that we need to strengthen efforts to identify and provide services to families that are at high risk for child abuse and neglect. Currently, the federal government spends approximately 10 times more on foster care than on preventive services. This is due to limited federal and state funding and current federal restrictions in the allowable use of funds, and as a result, the larger portion of federal dollars going to foster care. One potential solution might be for states to directly access federal funds such as under Title IV-E of the Social Security Act (P.L. 74–271) for investments in a broad continuum of services for children and families including prevention, early intervention, and post-permanency services. Absent such a broad reform of the federal funding structure, we need solutions now.

The Protect Our Children Act of 2011(H.R. 3653) establishes the Commission to Eliminate Child Abuse and Neglect Fatalities, tasked with conducting a thorough study on reducing fatalities from child abuse and neglect. The work of the Commission can lead to an increased understanding of deaths resulting from child abuse and can lead to improvements in agency systems and practices to protect children and prevent child abuse and neglect. **We urge you to ensure that in the course of the work of the Commission, there is consideration of a broad array of effective programs, including child health, mental health, juvenile justice and education services that are designed to prevent child abuse and neglect. In the process, it is also important to examine best practices in evaluating prevention programs for effectiveness. Furthermore, we urge you to ensure that the role of familial factors - including parental substance abuse, parental mental health and stress, domestic violence, and child care in precipitating child maltreatment and fatalities - and effective services designed to address these issues are considered.**

Proven prevention programs can yield considerable savings ranging from $1.18 to $14.65 for every dollar invested. Beyond the compelling financial argument, effective prevention measures can save lives. We owe it

to our children to continue to build on such efforts, and the Commission can do its part by ensuring that prevention is a key component of any recommendations it develops.

In closing, Mr. Chairman and members of the Subcommittee, the First Focus Campaign for Children stands prepared to work with you to ensure passage of H.R. 3653. We thank you for your leadership in addressing this critical issue, and protecting the health and welfare of our most vulnerable children. We look forward to working with you to ensure better care for our nation's foster children. If you have any additional questions, please contact me at (202) 657-0678.

George Lithco, Esq.
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December 24, 2012

Hon. Lloyd Doggett
United States House of Representatives
201 Cannon House Office Building,
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Hon. Erik Paulsen
United States House of Representatives
127 Cannon House Office Building,
District of Columbia 20515-2303

Hon. Dave Camp
United States House of Representatives
341 Cannon House Office Building,
District of Columbia 20515-2204

Thank you for the opportunity to comment on HR 6655, the Protect Our Kids Act.

I wish to express my support for the bill, but also to offer suggestions for improvement.

The goal of protecting children from abuse is vitally important, and I hope HR 6655 moves forward quickly towards enactment in the Senate.

My statement of support is intensely personal.

Our first son, Skipper, was born at dawn on Christmas Eve, 1999.

A week later, on New Year's Eve, my wife and I recorded wishes for the New Year, and the new Millenium. We wished Skipper health and well being, and the hope that he would see the turn of the next century.

We did not know it then, but he would not live to see his first birthday.

A week after Thanksgiving Day, 2000, Skipper was shaken by his childcare provider – a fifty-one year old grandmother, with four children of her own.

He never regained consciousness.

Although his date of death is officially recorded as December 3, 2000, the bright, intelligent child we knew left us late on the last evening in November, as he was being taken by helicopter from our local hospital to the regional trauma center.

With other family members, my wife and I spent the next three days at the pediatric ICU at Westchester Medical Center, in Valhalla, New York. That time started in hope, and ended in darkness.

At Skipper's bedside, we received an education in the causes of traumatic brain injury, and its progression in very young children.

Since that time, we have worked with family and friends, other advocates, hospitals and childcare organizations, schools and parenting educators, and elected officials at local, state and federal levels to help increase awareness about the vulnerability of young children to inflicted head injury, and educate parents and caregivers about how they can help keep children in their care safe from such preventable injuries.

► We joined the efforts of Sen. Paul Wellstone, Rep. Buck McKeon, and a diverse coalition of advocacy organizations to recognize the third week of April as Shaken Baby Syndrome Awareness Week, which culminated in a Joint Resolution of Congress recognizing National Shaken Baby Syndrome Awareness Week (H. Cons. Res 59, 2001). We have since worked with the National Coalition Against Child Abuse and other advocates to have the Week recognized by Senate resolution, and state action in New York, California, Texas and numerous other states.

► We have worked in New York and other states to enact legislation requiring hospitals to offer new parents the opportunity to learn how to keep their child safe, and to educate child care providers about the causes and consequences of inflicted head injuries.

► We have submitted testimony in support of prevention education to legislative committees and sponsors in New York, Massachusetts, Illinois, Kentucky, California, Arkansas, Nebraska, Minnesota, Oklahoma, New Jersey, Virginia, South Carolina, Hawaii and Wyoming.

► We have shared our at the 2005 Surgeon General's Workshop on Child Maltreatment, the 2004 Prevention Institute of the National Center on Shaken Baby Syndrome, and the 2005 Leadership Conference of the American Academy of Pediatrics.

My wife and I brought different skills and backgrounds to these efforts. I have an educational background in psychology, at the graduate and undergraduate levels, a legal education and twenty years of experience as a legal advocate for municipal clients. My wife has a master's degree in education and fifteen years experience as an educator.

We have ten years of experience in working with hospitals, child care providers and parents on awareness and prevention education.

The lessons we've learned about prevention education inform our recommendations and suggestions regarding the Protect Our Kids Act.

[Page number/line number references are to the discussion draft dated December 5, 2012]

1. The Act should expedite review and recommendations for implementing evidence-based, peer review practices exist that have been shown to be effective in reducing the incidence of inflicted head injuries.

If the ultimate goal of Congress, as Representative Camp appropriately said in his statement, is to do what it can to reduce child fatalities, the Act should include a directive to the Commission that prioritizes evaluation of existing evidence-based practices and identifies actions that can be taken to remove barriers to their implementation.

As an example, California maintains an inventory of such practices, with links to the professional literature demonstrating effectiveness.

As another example, in 2005, Pediatrics, the Journal of the American Academy of Pediatrics, reported on work by the Upstate New York Shaken Baby to educate new parents that resulted in a reduction of the incidence of abusive head trauma by 50%.

As the Act notes (p.2, lines 9-11), nearly half the children who die from abuse are under the age of 1. A 2004 study by Keenan et. al in the Journal of the American Medical Association estimated

that approximately 300 children die every year as the result of abusive head trauma, most of whom are children under age 2.

Action can be taken now to reduce that toll.

2. The objectives of the Act should include reporting of injuries and survivors of abuse.

Understandably, the findings set out in the Act focus on the failure of the report system to accurately track child fatalities due to abuse (pgs. 1-2, lines 1-19).

While we know too well that the death of a child is an enormous tragedy, we know that children may survive abusive head trauma with injuries that vary from traumatic brain injuries that results in coma that last for years, to "mild" brain trauma that leaves a growing child with behavioral issues and learning disabilities that impair their ability to function as adults in many different ways. Such inflicted disabilities consume the efforts of their families and caregivers and divert the resources of schools, social service agencies and the health care system.

At a time when healthcare and social service budgets are stretched beyond capacity, Congress should take into account the social and economic costs of preventable injuries.

3. If the goal of the Act is to protect children, not merely improve the accuracy of child abuse fatalities, the Act should ensure that members of the Commission have experience and expertise in sustainable prevention education.

Child abuse is a consequence. Most immediately, it is the consequence of physical violence by a parent or other caregiver. But there is growing evidence that education and awareness about the vulnerability of young children to inflicted injury can make a difference in a significant percentage of cases, especially with very young children.

In many cases, child abuse education has been left to the medical profession. In other cases, it involves the child protective services of state and local agencies. All of the professionals we have encountered who work in this area make extraordinary efforts to keep children safe and deserve the thanks of the nation.

However, the resources are not sufficient for the need, and too often the result is that efforts are focused on detecting abuse after it has taken place and preventing further abuse.

The cost in lives, emotions and resources to undo the consequences of abuse is simply not sustainable.

Primary prevention that provides parents and caregivers with the understanding and skills necessary to copy with the daily frustration of raising children is critical to changing the circumstances children now encounter.

Efforts such as the Education Begins at Home Act, which allows states to provide parenting education for new families, do much to help, but the Commission requires skills and expertise that have not traditionally been taught at medical schools and other institutions of higher education.

Our understanding of social psychology and cognitive behavior shows the importance of understanding the cognitive biases that parents and caregivers bring to their roles as guardians of young children in their care. That behavior is also influenced by stress and other social and psychological factors.

To understand the opportunities for behavioral interventions that promote prevention, the Act should require that one or more members of the Commission have experience in designing and implementing primary prevention programs with proven effectiveness, experience in social

marketing of primary prevention programs, or experience in implementing universal parenting education programs.

4. The Act should emphasize the need for universal prevention and awareness education.

The message of the "traditional" form of child abuse prevention is typically directed at a "high risk" population and takes the form that that the recipient - a parent or caregiver - should not abuse a child. The very act of doing so stigmatizes the recipient, and makes the effort harder for the educator and the educatee.

As a practical matter, the "child abuse" label also essentially eliminates the ability of most parents to informally educate the caregivers of their child about coping behaviors, the causes and consequences of inflicted injury and ways to protect children in their care.

Instead of just directing the Commission to study methods of "prioritizing child abuse and neglect prevention within [child protection] services for families with the highest need", we encourage an amendment to direct the Commission to study "methods of effective prevention education, including universal education of all parents and caregivers about what they can do to help keep children in their care safe and the promotion of informal behaviors by parents and caregivers to extend and support prevention education."

5. Child abuse is a consequence of behavior that crosses social-economic lines.

There is a growing body of evidence that the incidence of abusive behavior is not so different between social classes. For example, work by Runyan et al in 2005 shows that reports of abusive practices is not statistically significant between social-economic classes.

At the same time, the literature suggests that the diagnosis of abuse may vary inversely with social-economic class of the perpetrators, so as to make it less likely to be diagnosed and reported when the perpetrator is of higher social-economic background.

The result is that incidents of abuse are more likely to be missed or diagnosed as simply injuries when the family is of higher economic status. The difficulty in evaluating the nature and cause of head injuries, particularly when the child survives the injury, further impairs the accuracy of child abuse statistics and masks the extent of abusive behavior.

To improve the reporting of child abuse, the Commission should be directed to evaluate the effect of diagnostic bias on reporting, and estimate the extent to which it influences under-reporting, particularly among children who survive an incident of physical abuse.

This is particularly important because the prevalence of inflicted brain injury may be much higher than diagnosed. Limited research has found that between 2% and 5% of mothers report behaviors such as incidents of shaking children in their care. The military experience with blast trauma in Iraq and Afghanistan shows the pervasive impact that "mild" traumatic brain injuries inflicted by blast have on brain function over time. As we've learned from that experience, the cost of treating the survivors of brain injury will be enormous.

Likewise, the Commission should be directed to assess whether inflicted head injuries result in inflicted learning disabilities.

6. Other comments:

Page 2, lines 9 – 10, notes that 700 children under age 1 die of abuse. The importance of preventing inflicted head injuries is highlighted that estimates suggest more that 200 children under age 1 die because of inflicted head injuries.

Page 2, lines 16 – 20, improvement in understanding the causes of behavior that contribute to abuse can contribute to the improvement of primary prevention efforts directed at the general population, not just child protective services. That is especially important because the limited data available suggests that the majority of families of children who suffer inflicted head injuries have not been involved with child protective services.

Page 2, lines 21 – 23, given that the goal of the Commission is to "eliminate" child abuse, the name of the Commission should include "Injuries", not just "Fatalities."

Page 3, lines 16 – 18, qualifications of one or more members should include "experience in implementing effective primary prevention programs, cognitive psychology and parenting education, and…",

Consideration should also be given to including at least one parent-advocate and a foster-parent advocate as members of the Commission.

Page 4, lines 17 -19, should include "experience in implementing parenting education at an elementary or secondary school. "

Page 6, lines 11 – 16, should include "the number of injuries and the cost incurred by federal and state agencies for the care and treatment of children injured by physical and other forms of abuse, including foster care placement."

Page 6, lines 21 – 25, should include "as well as forms of abuse that are not well-correlated with those risk factors associated with intentional forms of child abuse."

Page 8, lines 1 -4, should include direction to "include recommendations for educating parents and caregivers on effective actions they can take to keep young children in their care safe from inflicted injury as part of a truly comprehensive national strategy to reduce fatalities and injuries."

Page 8. lines 9 -16, should include "The work of the Committee in developing such report shall accord the highest priority to evaluating and disseminating recommendations for action on existing, evidence-based practices that have been shown to be effective at reducing fatalities and inflicted injuries in young children, including the preparation and dissemination of white papers or other interim statements on the evidence-base for such practices and recommendations for their dissemination and implementation, prior to the final report of the Commission."

Page 9, lines 12 -13, should include "The Commission shall develop comprehensive methods of publicizing the work of the Commission, including opportunities for public comment and participation at hearings, that includes the use of common social media networks, websites that provide background information, agendas and ways to access the work of the Commission for individuals and organizations unable to attend hearings, at least equal to the efforts undertaken by the Interagency Autism Coordinating Council of the Department of Health and Human Services." See http://iacc.hhs.gov/

I respectfully submit these comments, suggestions and recommendations for consideration. I would be pleased to discuss them with Committee staff or provide more detailed supplemental references on any of the points discussed above. I can reached at (845) 778-2121

I thank the members of the Committee for their important work on this issue.

George Lithco, Esq.

Hon. Chris Gibson
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Disclosure Statement

This submission is made on behalf of the SKIPPER Initiative, 1011 Dutchess Turnpike, Poughkeespie, New York, and in memory of George "Skipper" Lithco.

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Proposal to Reduce Child Deaths Due to Maltreatment

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INTRODUCTIONS - I began with fatal child abuse in 1975, planning and building a structure for the world's first Child Death Review team. Deanne Tilton Durfee ran the largest Interagency Council on Child Abuse/Neglect housed this team in 1978. That gives us 71 years experience that continues today. I will present some of our experience and note people we admire.

OUR BACKGROUND Both of us had earlier experience. Deanne began as a line welfare worker and was asked to join a new profession, child protective services. She can still find the memory and image of a baby who later died. She helped create the LA County Dependency Court System and became a manager. She was asked to manage a small multiagency forum that she grew to 32 agencies, 20 committees, 12 community based child abuse councils, five conferences, multiple reports and a private charity. I helped create our annual report on child death and a report on multiagency data systems. Deanne became chair of the US Advisory Board on Child Abuse/Neglect that used our experience and contacts to create A National Shame, a report Fatal Child Abuse/Neglect in the US. Randy Alexander MD now in Florida helped with that report and later was the editor of the primary text on Child Fatality Review.

San Diego County formed the second Child Death Team Review in 1982. Their work suggested that such deaths peaked at age three. Our experience allowed me to suggest changes in their program that helped them find infants that they had been missing. Other counties and then other states followed. Canada and Australia had team reports in 1994. ICAN became the National Center on Child Fatality Review, the major source of support to others forming teams. We shared our work nationally and then internationally. The last state was added in 2001.

ICAN was the primary program and I was the primary advocate for teams from 1978 into this century and I had few people to back me up. I met with team members from half of the states and talked with most of the rest by phone. I initiated, chaired and managed the California state team with no money or legal mandate. The Coalition of teams in Southeastern States gave me the title of "Father of Child Death Review". I earned that title and value those words.

EARLY DAYS The early days were anchored in peer support. Teams called each other to ask for help. Regional groups formed that continue today. The Southeastern states have the largest group of teams with states from Virginia to Florida to Texas.

MEDIA - Much of the growth came in the 1990s with early press coverage with stories on individual cases. A series of articles in the Atlanta Constitution were nominated for a Pulitzer

Prize. A Washington Post reporter was given that award and a series in the Chicago Tribune received a Pulitzer. Media become part of this process. The death of Lisa Steinberg in 1987 was major print and TV news. Other famous cases followed with Susan Smith and Eli Creekmore. My computer news review noted most reporters were female as if this was a female issue. Most stories with pictures were white male toddlers. The years 2000 to 2010 brought complaints of agency failure and occasional Child Death Review team reports noting success with prevention programs. These stories are now larger with Governors or senior manager and media and arguments on confidentiality. Congress and federal officials have joined us.

TEAM REPORTS ICAN shared team reports in the 1990s with an annual press release. Newspapers TV and radio reporters were given different stories to cover with homicide, suicide or accident prevention. The LA Times Magazine had a cover picture of the LA County Team titled "The Worlds Worst Job". The public learned ways to protect children. Media contacts have been used for prevention programs including pool safety, Safe Surrender and Safe Sleeping.

FORMAL LITERATURE My formal medical literature includes *Origins and Clinical Relevance of Child Death Review* 1992, JAMA, Fatal Child Abuse Chapter Henry Kempe A 50 Year legacy 2012, Springer. Most of my work has been published in local reports and protocols with topics that needed to be addressed. Richard Bullock wrote a document for the creation of Child Death Review in the UK, "For the Scottish Executive, 2005 He noted conflicts and stated that, "once again it falls to Durfee to resolve this issue". Our experience had value in the UK. Many teams were formed, after a notorious child abuse death, by advocates on or near the line who were officially not important but knew how to protect children and to share resources.

INTERNATIONAL EFFORTS We have traveled to other countries with presentations at International meetings in Ireland, Australia and England and Canada. We met with Canadian officials in Ottawa. I was asked to present to new teams forming in London. We presented in Porto Portugal and met with experts in France and had contacts for Japan, Lebanon, Israel, England, Australia, New Zealand, China, Singapore, Russia, Sweden, Brazil, Argentina and Netherlands. I was asked to create an international curriculum for the Helfer Society for physicians and the International Society for Child Abuse and Neglect to use internationally.

ISSUES TO CONSIDER

1) TECHNOLOGY VS PEOPLE Technology and science are needed, but this is also a personal issue. The death of a child changes us. Line staff may be casualties. We need to temper the damage but keep the motivation that pain generates.

2) CITIZENS The major resource for children facing fatal and severe damage is the people around them. We encourage people to report but not to act. They can offer a parent help with child care or shopping. Friends, family and neighbors can temper isolation and secrecy that is a major part of the problem.

3) OTHER DEATH REVIEW Child Death Review, AKA, Child Fatality Review has been followed by: Domestic Violence Fatality Review DVFR, Elder Abuse Fatality Review and Dependent Adult Abuse Fatality Review. Domestic Violence Fatality Review exists in multiple nations and includes deaths of children. They serve some of the same families.

4) CHILD AND FAMILY GRIEF Neil Websdale trains DVFR teams, works with ICAN NCFR and shares the concern about children who survive fatal family violence. ICAN has a nine year old annual conference on child grief and trauma. We shared speakers on fatal family violence that is visible at http://www.youtube.com/watch?v=eYWxSmOWKII Neil has a video on a case with multiple child victims. http://vimeo.com/15147441 .

5) TEAM CONFLICT A common split in multiagency Child Death Review Teams causes a separation of criminal justice and human services. Major systems for "fatal child abuse" miss the word homicide that is common with some variation to Coroner, Law Enforcement, Vital Statistics and Prosecutors. Criminal justice data is part of this work.

6) TERMINOLOGY Coroners, law enforcement, and prosecutors use the word Homicide. Social services and media use fatal child abuse / neglect. We store data in handwritten documents and lump data tied as if Homicide, Abuse, Neglect, are the same.

7) PREVENTION VS INTERVENTION Some child fatality review teams believe that investigation and prevention must be separate. My 35 years with multiagency teams finds these activities more than compatible. They can support each other.

8) A SINGLE AGENCY–Various studies note 25-50% of fatal child abuse have previous CPS records. That means that 50- 75 % don't. CPS agencies may not be the local leader or investigator. These cases require multiple agencies working together mixing skills

9) FUNDING Funds and official status can create and destroy. If several people apply for the same grant, the grant score could include points for describing how the applicants will work with others applying for the funds. Grant funds should not separate programs.

10) CORONERS VARY California Coroners may be in Sheriffs Department. Other states may elect or appoint them. Some are morticians. Coroner Investigators may have a police background, but in recent years include Public Health Nurses that work well with infant toddler cases. Medical examiners may not be trained on infant toddler autopsy. The National Association of Medical Examiners, NAME is a resource working on this.

11) MIXED JURISDICTIONS. A child from Maryland injured in Virginia could be sent to Washington National Children's Hospital in Washington DC. If the child dies there could be a case with Maryland Child Protective Services for home of residence, Virginia Law Enforcement for the crime, and DC for medical care and coroner autopsy.

DATA IS A MAJOR ISSUE THAT IS MORE THAN NUMBERS

DATA The large scale national attempts to collect national data will only succeed when local data is improved. The issue of data is expanding with the growth of computer systems. Some simple models are possible using infants and the designation of homicide. I presented the ICAN study of infant homicide data that is lost in transfer from Coroner to Vital Statistics at the national conference for the National Center for Health Statistics and the National Association for Public Health Statistics and Information Systems. There was interest but no data repair.

Issues for local case managers need to mix data from different professions and different jurisdictions. Criminal justice data would include the FBI UCR SHR and criminal court outcome. DCFS and civil court outcome may display previous contact and show intervention with surviving siblings. Different jurisdictions will appear in criminal, social service and health data sets with access to cross lines between counties, states and international boundaries. We gather data on family risk factors while we miss other agency data and fail to gather data on our own action and inaction. When children die we need to measure ourselves.

COLD DATA AND HOT PAIN Case Review should be one case at a time. Done well the case presentation can capture the child and family as people and help others, for a moment create a personal sense of loss. Pictures of the child can make the child real. The words for the story and the picture are important. There is a balance between cold data and personal images. The team review can help professional staff feel less alone. The cold data may be easier to work with.

HOSPITALS ARE A MAJOR MISSING RESOURCE

HOSPITALS – Fatal child maltreatment lends itself to multiagency investigation, but the child needs to die before the review. The ICAN hospital program provides a program with liaison today in 126 hospitals including 32 PICU, 12 child burn programs, the majority of inpatient services for injuries under age three, about half of such children in Emergency Departments and about half of all births. Some hospitals and ICAN are working on software to automate systems. Hospitals probably have contact with the majority of children before their death. Hospitals are also the major private sector program in a field that is primarily government.

This system of hospitals includes peer support as a resource for quality control and program management. This system will first connect hospitals to themselves using computer data systems. Multiple models exist with growing connections from a national working group.

ICAN software is designed to fit the needs of hospitals that do not spend time on this issue and also meet the needs of staff who want to pursue details of child abuse. The digitized report can be sent to the investigating agency and digitized medical records can be added. There are also data elements to allow tracking and monitoring of case management. Guidelines for Ad Hoc team formation will allow joint case management with the hospital. Fatal cases can be tied to local child death review. Children who require intensive care can be designated nonfatal severe abuse for that special review.

This system is designed in part by previous experience in public health 1981-1986. We began with six hospitals with Suspected Child Abuse and Neglect, SCAN teams. By year five that had grown from 6 to 30 hospitals with SCAN teams and the number or reports had grown from 50 a month to 500 a month.

HOMICIDE SOFTWARE AND SYSTEMATIC CASE MANAGEMENT

This custom software is designed to define and automate multiagency records of value with child homicide cases with caretaker suspects. This system will begin with homicide but spread to other cause and manner of child death. This model began with a list of 20 records that were collected by an attorney in the LA County Dependency Court. Additional records were added and the software is approaching a beta version that can be tested by Child Death Review Teams. Both software programs should be available in 2013.

The homicide software will be managed on the Internet. Security measures roughly match or exceed the basic systems used to protect financial activity on the Internet. The access to medical records will make multiagency interaction easier. The review team can access records during review. The computer system can create reports and a system can be devised to monitor the quality of review.

PROTOCOLS MAY BE CREATED AND IMPLEMENTED

HISTORY The data collection instrument in the ICAN Hospital Software will help record collection. Previous well child medical records can increase the understanding of the child's health. However, many teams avoid investigation. LA County has seen 1,000 cases of homicide by caretaker since the team began in 1978. The experience of reviewing those cases leaves us impressed that multiagency review is useful for the investigation and should begin ASAP

There are special issues with investigation of the death of young children. DNA or other evidence can put a suspect at the scene of a crime. That may help with a suspect who should not have been at the scene but have no value if the child and perpetrator are supposed to be together. Young victims, particularly infants, are easier to kill and may have no visible lesions. If suffocated, there may be no findings and what happened may only come with confession.

Witness interviews are a special issue. Child witnesses may or may not quality for court, but may be able to provide critical evidence. The best person to perform these interviews may not be law enforcement. People who work with infants and toddlers will need help to address violent themes and law enforcement may need help with infants and toddlers.

There are some protocols for investigation. Bill Walsh, Dallas PD, created one for USDOJ in 2005 Steve Clark from Occupational Research Assessment in Michigan helped create the protocols *and training material for Sudden Unexpected Infant Death Investigation, SUIDI.* Victor Vieth DA now in Wisconsin provided us material from the National District Attorneys Association.

NONFATAL SEVERE CHILD ABUSE REVIEW

A growing number of states have some defined process for review of nonfatal severe child abuse. There are federal and state legal issues for these cases. Some child death review teams review such cases. Maine began some years ago because they had time with small numbers of deaths. Oklahoma built a separate team for review of cases reported from two hospitals Pediatric Intensive Care Units, PICU. California DSS asks counties social services for numbers for a state report. In 2013 the California network will begin connecting staff from PICU and building a system to identify PICU reports.

JOINT REVIEW OF CHILD AND DOMESTIC VIOLENCE

La County teams for child and domestic violence fatality review met to share two cases where fathers killed multiple children because their wife was going to leave. The reviews were useful for both teams and that review helped build bridges for future similar cases. That theme has been repeated at the ICAN conference on traumatic grief.

PROPOSED LEGISLATION AND RECOMMENDATIONS

The **central focus of the legislation** as presented for this hearing **is child protective service and child welfare systems.** These are important services but some would disagree with the emphasis on CPS The suggested focus, could create a commitment that would be hard to change. The first task I would suggest would also feature a mix of:
1 **prevention and intervention**. Both are necessary and they can support each other
2 **Addition of nonfatal severe cases** to expand prevention and early intervention
3 **Multiple professions working together** as it is with child death review

The first assessment would gather advice from multiple bodies.

HEALTH 1) The American Academy of Pediatrics has a strong history of work with child abuse including two Presidents and committees, 2) The Ray Helfer Society includes physicians who work with child abuse. They have created pediatric boards in child abuse and training fellowships 3) The National Association of Children's Hospitals and Related Institutions, NACHRI has a national study of child abuse programs in Children's Hospitals, 4) ICAN California Hospital Network and informal national working group have systems for peer support and for computer automation of child abuse reports.

PUBLIC HEALTH – 1) The American Public Health Association has a Forum on Family Violence and a Section on Health Informatics Information Technology, 2) Programs at CDC address violence and programs exist at NIH and HRSA.

JUSTICE 1) US Department of Justice has multiple programs. 2) There may be resources in national law enforcement associations. 3) The National Association for Medical Examiners, NAME, has roles with justice and health, 4) The National District Attorneys Association's National Center for Prosecution of Child Abuse 5) The National Association of Juvenile and Family Court Judges 6) Steve Clark with Sudden Unexpected Infant Death Investigation Protocols 6) Dallas Police Dallas Annual Training Conference

TEAMS 1) The network of teams and multistate clusters 2) ICAN National Center on Child Fatality Review 3) Michigan National Center for Child Death Review

CHILD PROTECTIVE SERVICES 1) National Association of Child Welfare Director, 2) National Association of Social Workers, NASW

OTHERS – 1) US Department of Defense, child death review teams 2) Children's Alliance has child advocacy centers that supply specialized evaluations of children for court.

DOMESTIC VIOLENCE – 1) Domestic Violence Fatality Review Training - Neil Websdale 2) Futures without violence San Francisco 3) Dr Jacqueline Campbell at Johns Hopkins

RESOURCES AND POTENTIAL RESOURCES

1) MULTIAGENCY TEAMS – There is no single central agency to do this work. The **teams** are the closest with a multiagency model. For Child Death Review, core Membership includes Coroner, Law Enforcement, Child Welfare, Health, Public Health, Schools, Civil Law, Criminal Law, Central focus for local multiagency teams could use a **national counterpart team**, perhaps USDHHS, USDOJ and USDOD with counterparts from other federal and national organizations.

2) **HEALTH SYSTEMS** Almost all babies are born in hospitals. One exception would be babies killed on the day they are born and those mothers might enter a hospital afterwards for medical care. Hospitals also see injuries and provide special care for trauma and burns. Most hospitals are private and offer a resource separate from the maze of government agencies

3) **DEATH REVIEW** There may be **1,000 multiagency child fatality review teams** in the US and a growing number of Domestic Violence Fatality Review Teams that may serve the same families.

4) **PREVENTION PROGRAMS**: Prevention Programs include Safe Sleeping, Safe Surrender, Don't Shake Your Baby and programs to prevent death from drowning and motor vehicle injury

5) **RISK PROGRAMS** – Home Visitors, Substance Abuse and Pregnancy and Program for underserved high risk pregnancy from child sex abuse and developmentally disabled mothers,

6) **GRIEF PROGRAMS** and **child trauma programs** for child survivors of fatal family violence

7) **CONNECTIONS BETWEEN AGENCIES** and professions with a focus on creating resources for line case managers. That is different from major funds for new staff and different from creating complex central data for data experts to analyze.

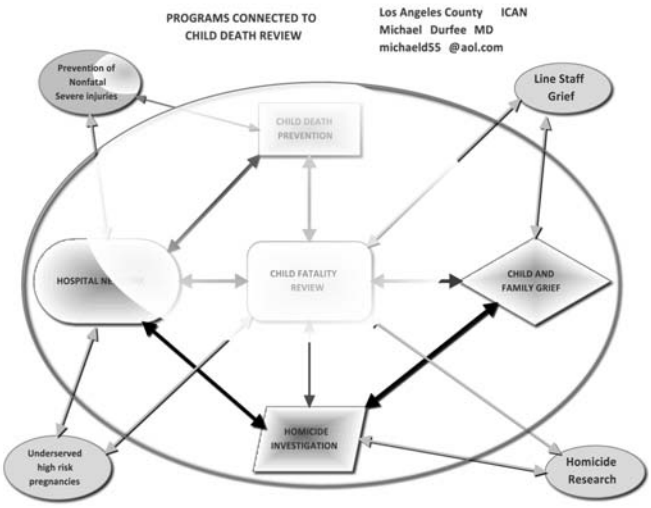
8) **Nonfatal severe child abuse review** should be reachable with hospitals and software. That software can address all reported cases as a population. Data study can provide direction to future screen evaluation and case management.

9) The **ICAN CUSTOM SOFTWARE** for hospitals and software for multiagency Child Fatality Review . Both of these programs should be available soon. The ICAN informal national working group on hospital and Child Fatality Review software has other models.

10) MEDIA NEWS **coverage** continues and a computer alert can scan various news. The news educates the public and prevents history.

A LESSON FROM HISTORY

The experience of French Physician Ambrose Tardieu may help us prepare for resistance that might otherwise surprise us. Dr Tardieu wrote about child abuse, including fatal abuse, in 1760 when we were beginning our Civil War. His work in French was detailed, clear and hopeful. But, almost nothing happened. The next medical article to address fatal child abuse was The Battered Child Syndrome, by Henry Kempe MD, 1962, 102 years later. This country did not develop many programs for fatal child abuse until the 1990s and we are generally cautious or seeking simple rapid cures. This journey may last longer than anticipated.



The programs on this chart are essentially new. The varied and open connections between these programs are also new. Most of this was created with little money.

A Submission for the Record
By Maura D. Corrigan, Director
Michigan Department of Human Services
to the Subcommittee on Human Resources,
Committee on Ways and Means, House of Representatives
Re: The Protect Our Kids Act

Chairman Paulsen, Ranking Member Doggett, and Members of the Subcommittee:

Thank you for the opportunity to comment about the tragedy of child abuse fatalities in the U.S. and what may be accomplished through the Protect Our Kids Act and the National Commission to End Child Abuse and Neglect Fatalities. The Michigan Department of Human Services received more than 150,000 complaints of abuse and neglect last year. We also considered reports on the fatal abuse and neglect deaths of 127 Michigan children from 2009-2010. We are thus acquainted with the costs of these deaths to children, their families, our communities, and the professionals who must respond to these deaths.

We know that Chairman Dave Camp commissioned the GAO study to investigate the problem of child maltreatment fatalities after learning about the tragic deaths of several young children from Michigan. Our state learned many lessons from those deaths. We have implemented numerous improvements within law enforcement, forensic investigations, health care, child welfare and criminal justice. We are still learning and taking actions to keep children safe. Michigan's efforts to learn from these deaths could provide valuable assistance to the proposed national commission.

Our state has a very well established and sophisticated multi-agency process, managed by the Department but in collaboration with other agencies, to identify, count, study, and respond to child abuse fatalities. We work to identify the risk factors and failures in our child welfare system so we can better protect our children. For over a decade, our Department has funded the Michigan Child Death Review Program and Citizen Review Panel on Child Fatalities. We support the Michigan Public Health Institute's management of multi-disciplinary teams covering all 83 counties in the state. These teams are charged with discussing the circumstances of all child deaths to improve investigations, services, and agency policies and practices. They submit comprehensive case reports to the State. We participate in the National Child Death Review Case Reporting System, which has been essential in helping us to record the number and circumstances of child deaths. This system was highlighted in the GAO Report as an important means to improve national counting and reporting on child maltreatment deaths.

Michigan has a state level advisory panel that meets several times a year to identify systemic problems and to make recommendations to our governor and legislature on opportunities to prevent these deaths. The Child Death State Advisory Team also

functions as Michigan's federally mandated Citizen Review Panel (CRP) on Child Fatalities. The CRP meets quarterly to examine deaths of children who were involved in the child protection system. This examination is a specialized, multi-step process that involves the identification of cases with the assistance of DHS, the collection of relevant materials and a thorough case review.

Because of our focused, multidisciplinary approach, we now know a good deal about the profiles of children who die from maltreatment in our state.

In 2009 and 2010, local Child Death Review teams reviewed 127 maltreatment deaths (38 abuse-related and 89 neglect-related fatalities). When local teams review a child's death, they are asked whether they believe that someone caused or contributed to the child's death by any action or inaction on their part. These numbers represent those cases where the team concluded that abuse or neglect either caused or contributed to the child's death. These reviews showed that infants under age 1 and children ages 1-4 are at an increased risk of fatality over all other age groups. For 2009 and 2010 reviews, a larger percentage of the deaths attributed to neglect were to infants than in the previous two years. This finding is due in large part to local review teams increasingly identifying sleep-related infant deaths as neglect.[1]

The CRP on Child Fatalities looks specifically at deaths of children who had previous interaction with the child protection system. In 2011, the CRP reviewed 93 such cases—41% of those cases were found as child maltreatment related fatalities (14 abuse-related and 25 neglect-related). In both review processes, neglect-related fatalities greatly outnumber abuse-related fatalities, indicating the importance of accurately identifying and preventing child neglect.

We don't stop at understanding the circumstances in the lives of children who have died—we work to develop and act on recommendations to prevent other deaths and to improve our system. A study of six years of our reviews, published in the Journal, Child Abuse & Neglect, found that we were able to significantly decrease child abuse deaths correlated with improvements in practice.

As outlined in the article by V.J. Palusci, many system changes were implemented as a result of Michigan's Child Fatalities CRP. These include statewide training for physicians, a new statewide protocol to determine cause and manner of sudden child deaths, a new protocol for joint investigation, a birth match system linking birth certificates with CPS records, as well as new training for CPS workers and supervisors. The study identified decreases in child fatalities associated with findings from the reviews among children known within the child protection system. The system changes implemented could also be associated with those findings and potentially linked to the fewer child maltreatment deaths shown in the study.[2]

While we have been hard at work in our state to protect children, we applaud the efforts of this Subcommittee through your hearing on Child Abuse Fatalities in July 2011, the GAO report, and now the Protect Our Kids Act that will establish a national Commission

to End Child Abuse and Neglect Fatalities. We know firsthand that a focused, dedicated, and multi-disciplinary approach to understanding why children die can help to prevent these deaths. We believe the Protect Our Kids Act will help us move toward a comprehensive national strategy to combat the tragedy of child abuse fatalities. This bipartisan commission, empowered by Congress to thoroughly examine the scope of the problem of fatal child abuse, is much needed. The Commission can study and recommend improvements to federal, State, and local data collection systems; identify State models of effective child abuse fatality prevention and intervention practices for widespread dissemination; and recommend improvements to Federal policies and practices.

We strongly support your efforts and hope you move this bill out of committee and work towards its speedy passage. Support and guidance from this Commission is greatly needed to move forward in improving our systems and services to children. America's children living at risk of dying of abuse cannot wait.

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1. Child Deaths in Michigan: Michigan Child Death State Advisory Team Ninth Annual Executive Report: A Report on Reviews conducted in 2009-2010. Compiled by Michigan Public Health Institute under contract with Michigan Department of Human Services.

2. Palusci, V.J., et al. Effects of a Citizens Review Panel in preventing child maltreatment fatalities. Child Abuse & Neglect (2010), doi:10.1016/j.chiabu.2009.09.018

Reducing Child Deaths Due to Maltreatment

Written testimony submitted by

Elizabeth J. Clark, PhD, ACSW, MPH
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National Association of Social Workers

to

Subcommittee on Human Resources
Committee on Ways and Means

December 12, 2012

Hearing on "Proposal to Reduce Child Deaths Due to Maltreatment"

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On behalf of the 145,000 members of the National Association of Social Workers (NASW), the world's largest professional association of social workers, I am pleased to submit written testimony for the hearing on the "Proposal to Reduce Child Deaths Due to Maltreatment" that was held by the Subcommittee on Human Resources of the House Ways and Means Committee on December 12, 2012.

NASW advocates for sound social policies that support children, families and communities and thanks the subcommittee for taking the issue of preventing child abuse fatalities so seriously. The committee's previous hearing on Child Abuse Fatalities and your committee's request for the Government Accountability Office (GAO) report on the same in 2011 are critical first steps towards resolving this issue.

Comments on the Discussion Draft of Protect Our Kids Act

NASW is pleased to offer testimony on the proposed bipartisan draft of the legislation, the "Protect Our Kids Act." This act would establish a commission to develop a national strategy and recommendations for reducing fatalities resulting from child abuse and neglect. NASW and the social work profession work tirelessly to safeguard children from child abuse and neglect. A commission to study the extreme outcome of fatalities is long overdue. In July 2011, the GAO found that children who have died from maltreatment are likely undercounted in the National Child Abuse and Neglect Data System (NCANDS) (GAO, 2011). A commission could look at this undercount and suggest changes to not only better count the data, but to also improve practices and policies to prevent such fatalities.

The composition of the commission is important. NASW urges Congress to focus on experts in child welfare including social workers. Since the founding of the social work profession over 100 years ago, enhancing the safety and well-being of children and families has been at its heart. Social workers can be found in a broad array of settings serving children and families including child welfare, mental health, health care, and schools, and in early childhood, juvenile justice and family support programs. All of these settings can play a critical role in children's safety and well-being. There is a long history of social work leadership in child welfare practice, research, training and policy. Social workers are invested in promoting policies and practices that will prevent child abuse and neglect and reduce the number of child abuse fatalities. Today more children may be at risk. There are concerns that the current economic climate is increasing family stress and causing cutbacks in education, mental health, and family support services (ECM, 2011; Sedlak, et al., 2010; Zagorsky, Schlesinger & Sege, 2010). Recent research by Putnam-Hornstein (2011) found that children who have previously been reported to a child protection agency due to physical abuse may be at the highest risk of fatality.

The duties of the commission as outlined in the discussion draft will help to reduce child abuse and neglect fatalities. The study on the use of child protective services and child welfare services will help Congress learn about the prevalence of the problem and potential solutions. Examining how multiple federal and state funding streams are woven together with Title IV and Title XX of the Social Security Act will be essential to more fully understand how child abuse prevention and intervention funding can be more fully actualized to keep children safe.

Providing the opportunity for graduate and doctoral students' research to be coordinated with the commission will help advance our knowledge and recognize the important contributions that early career researchers, including social workers, are making to this field. Social work students often research child protective services and child welfare services. Their research can help the commission better understand the service delivery systems' strengths and gaps.

The recommendations from the commission will help federal, state and local agencies better meet the needs of children and help reduce fatalities from child abuse and neglect.

The hearings set forth in the draft legislation will be imperative to gather information about the prevalence of child abuse and neglect fatalities as well as the innovative methods to prevent such fatalities that are occurring in the states and localities.

High Rates of Child Abuse Fatalities are a Great Concern to the Social Work Profession

While many valuable programs focus on child abuse prevention and intervention, our societal response is insufficient to prevent the estimated 2500 children's deaths due to abuse and neglect that occur each year (Every Child Matters Education Fund [ECM], 2010). Although federal reports indicate that overall child abuse and neglect rates are decreasing, child abuse deaths remain high, and children under age 4 are most at risk (U.S. HHS, 2012). The Government Accountability Office (GAO, 2011) found that the current data and tracking we have on deaths from child abuse and neglect is woefully inadequate and concurs with the National Coalition to End Child Abuse Deaths (NCECAD) that the number of deaths from child abuse and neglect are undercounted. The GAO recommends that there be greater federal investments in strengthening the quality of data as well as the information available on child abuse fatalities so that this increased knowledge can help prevent future deaths.

Identifying and Reporting Child Abuse and Neglect

Many of the deaths due to child abuse and neglect that were profiled in *We Can Do Better* (ECM, 2012), the third edition of a report about deaths from child abuse and neglect across the United States, prepared by the Every Child Matters Education Fund, were children who were not previously known to the child protective system. These deaths signal that as a society we need to do more to nurture and support both children and their caregivers and ensure that children are safe. Doctors, teachers, nurses, social workers, clergy, family members and neighbors all are stakeholders in protecting children. Slightly more than one half of child abuse and neglect reports are from professionals who come in contact with children suspected of being abused and neglected. The remaining reports are from friends, caregivers, coaches, neighbors and relatives (US HHS, 2012). We do know, also, that many children at risk are never reported to the child protection system (Sedlak, et al., 2010).

Professionals who are legally mandated to report children who are suspected of being maltreated should have confidence that the child protection agency has the necessary resources to make an adequate and appropriate response, and that such reports will be assessed and heeded in a timely fashion. However, high workloads, inadequate staffing and lack of resources and training often result in systems that do not respond adequately to maltreatment reports.

Addressing Child Neglect

It is important to note that child neglect is the most prevalent type of maltreatment (over 75 percent of maltreatment victims and 35 percent of child fatalities [US HHS, 2012]), yet we continue to have inadequate responses to what is frequently a chronic problem. The services offered to those who are

maltreated and their families are usually episodic and crisis-oriented rather than focused on long term concerns (Blome & Steib, 2009). To appropriately address chronic neglect there is a need for targeted on-going services and supports as well as early intervention services for new parents. The provision for the early childhood evidence-based home visiting program included in the Patient Protection and Affordable Care Act is one attempt to address this need for parents most at risk.

The Need for Skilled Social Workers in Child Protection Work

Each day, child welfare professionals work diligently to support families in creating healthy and nurturing environments for children; but, too often, there are barriers to successful outcomes for children, youth and families. Whether it is social workers, nurses, physicians or lawyers involved in the child welfare system, a skilled and stable child welfare workforce is critical to providing effective services.

Of particular concern to NASW, is the involvement of professional social workers in child welfare agencies. Research by NASW and others shows that personal factors, like commitment to child welfare and education, especially a social work degree paired with specialized education in child welfare, are important factors for successful child welfare outcomes. Yet, nationally, less than 40 percent of child welfare workers have social work degrees and in many states it is less than 20 percent (Zlotnik, DePanfilis, Daining & Lane, 2005; Social Work Policy Institute, 2011). Agencies must also ensure that a supportive organizational culture and climate is in place to effectively support their child welfare workers. High quality supervision and peer support strengthen competent practice and prevent worker burn-out. Cross-agency collaboration and communication, on-going training and available resources for the children and families can help ensure that workers can do their jobs.

As one of society's First Responders, front-line child protective service workers are challenged by low salaries, limited access to necessary technology, safety risks, and high caseloads and workloads. Too often, large caseloads and unsupportive work environments lead to high turnover, hindering agencies' attainment of key safety and permanency outcomes for children. Ensuring a supportive work environment helps our child welfare workers do their job well and demonstrates that ultimately we care about the well-being of children and families. Not only do we have too many child abuse fatalities, but there are also safety risks for workers, and too many child welfare workers have died doing their jobs.

Addressing Racial and Ethnic Disparities in Child Abuse and Neglect

Across the country, child welfare workers are working with children from diverse racial and ethnic backgrounds. Social workers play a critical role in ensuring that children and families of color receive quality services and that appropriate culturally responsive decisions are made to ensure their safety, well-being, and permanency. Nationally, and in most states, children of color, especially African American children, are overrepresented in the system, especially in foster care. We also see differential attention by the media and the public to child abuse deaths (Alexander, 2011). This disproportionality continues despite research indicating that there are no differences in the incidence of child abuse and

neglect by racial or ethnic group. In addition, a large number of children involved with the child welfare system are immigrants from all corners of the world.

It is largely caseworkers and supervisors who make decisions regarding keeping children with their families, placement of children in foster care, reunification and other permanency outcomes for children. At each decision point, culturally appropriate action can profoundly influence the trajectory of a child's life. Making sure the child welfare workforce is culturally competent, and has the prerequisite knowledge and skills, is essential to maintaining the community's trust that the system is truly about the welfare of children and families rather than about enforcing discriminatory and unnecessary interventions.

Recommendations

To prevent deaths from child abuse and neglect and to prevent and treat child abuse and neglect, NASW makes the following recommendations:

1. **Standards and Better Data Collection are Needed on Child Abuse Fatalities**

   NASW recommends that the Department of Health and Human Services standardize definitions and methodologies used to collect data related to maltreatment deaths and require states to provide such data. As highlighted in the recent report, *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention* (GAO, 2011), there is a need for consistent data collection and standards for defining child abuse and neglect fatalities. In addition, state child death review teams should be adequately funded. Such data and reporting will assist the federal government and states to identify more effective strategies to prevent future deaths from maltreatment and to address racial disparities that might be occurring.

2. **Education, Training and Workforce Standards Are Needed to Encourage Highly Skilled Professionals to Work in Programs that Promote the Safety and Well-Being of Children and Promote Family Self-Sufficiency and Family Stability**

   NASW recommends that federal funding be enhanced to support the education and training of professional social workers to work in public and private child welfare agencies, including support for the education and training of supervisors. In addition, child protection agencies should increase their staffing standards, by requiring a minimum of a bachelor's degree in social work (BSW) for front-line workers and a master's degree in social work (MSW) and experience for supervisors in child protection programs. Resources should also be available to ensure that other professionals, including physicians, lawyers, and nurses, have the necessary training to recognize and assess child abuse and neglect and to ensure that there are high quality multi-disciplinary services available. In addition, all health and behavioral health, legal, and social service professional should have training related to child abuse and neglect assessment and prevention.

3. **The Research Evidence to End Child Abuse Fatalities Should be Strengthened**

Additional research reviews and research studies are needed on topics such as:

- Reasons for under-reporting of child abuse and neglect.
- Exploring and addressing the reasons that mandated reporters do not always report suspected abuse or neglect.
- Increasing understanding of the specific service and information exchange issues that exist within agencies and across agencies that might result in fatalities and the strategies to ameliorate them.
- A comparative review of state policies (regarding reporting responsibilities and abuse and neglect definitions); funding methods (which federal, state and private funds support the programs for prevention and child protection services); and the variations in child abuse and neglect fatality data and how they are defined, gathered and reported. The outcome of this review will offer evidence on the potential linkages among these variables, and can identify factors that address the disparities in the number of reported child abuse deaths across states and potential prevention options.

4. A National Commission to End Child Abuse and Neglect Deaths Should be Created

A national commission to end child abuse and neglect fatalities should be created by Congress to examine the best of current child protection strategies, to address the complexities of gathering accurate and complete data regarding child abuse and neglect deaths and to make recommendations regarding a multi-faceted national strategy for stopping maltreatment deaths.

The National Association of Social Workers stands ready to work with Congress to address this epidemic of child abuse and neglect deaths and to address the critical workforce issues facing child welfare agencies. The safety of our children and the well-being of the workers who every day work with our most at-risk children and families deserve no less.

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Name: Rev. Stephanie Bingham Doss
Date: December 10, 2012
Organization: Student at University of Southern California School of Social Work &
Pastor at First Congregational Church of Tulare, United Church of Christ

Please see the editorial that we submitted to media sources on December 5th. We would like this to be considered for the record regarding the hearing on the **Protect our Kids Act** scheduled for **December 12, 2012**.

Does Every Child Matter?

America, let's be honest. In our political landscape of elections, budgets, deadlines and competing interests, children are not the priority. Children can't make campaign contributions or vote but they are simply put, the future. We have an ethical and economic imperative to protect them. When the day comes that the youngest in our society need to take up the reigns, will they be ready? Or will we see in our nation, legions of young people damaged by years of abuse that never have much of a chance for the American Dream. Or even more tragically will some of the visionaries of our future never live past the age of 4 and die at the hands of a caretaker? Just imagine for a moment the effect the tragic death of a child has on a family, a community and the nation.

According to a report put out by Every Child Matters Education Fund in Washington, DC, an estimated 2 thousand children are killed nationally each year by child abuse and neglect. These deaths are senseless, tragic, and can be prevented. Deaths by child abuse are a mere fraction of the 3 million reported child abuse and neglect allegations each year in the United States. With early intervention and education, many of these child abuse and neglect related deaths can be prevented. Additionally, with proper changes to regulations combined with coordination across states, improvements can be made. It is time to take a stand and support the future of our Nation by supporting The Protect our Kids Act (H.R. 3653 and S. 1984). Every

Child Matters Education Fund, along with the Coalition to End Child Abuse Deaths, worked with Congress to author this bill, which calls for a national commission to study child abuse fatalities and to make recommendations for our Nation's child welfare system.

The National Coalition to End Child Abuse Deaths (NCECAD) was formed out of concern about the increasing number of child abuse deaths across the Nation. NCECAD is composed of representatives from the National Association of Social Workers, National District Attorneys Association, and National Children's Alliance, National Center for the Review and Prevention of Child Deaths, and Every Child Matters Education Fund.

Last December, The Protect our Kids Act of 2011, also known as S. 1984 and H.R. 3653, was introduced to Congress. It is supported by Senators Kerry (D-MA) and Collins (R-ME), along with Ranking Member Congressman Lloyd Doggett (D-TX) and Representative Joseph Crowley (D-NY). With the lack of funding and attention, grassroots action is critical in order for this bill to succeed.

Child abuse and neglect have long-term physical and emotional consequences on the individual child, their families, and the communities in which they live. Studies of child abuse and neglect show that abuse leads to problems in society such as poverty, crime, gang affiliations, low self-esteem, alcohol and drug use, dropout rates, and teen pregnancies. Preventing child abuse before it starts through education and intervention programs could reduce the amount of money spent by our government each year. Current statistics show that child abuse and neglect cost the nation approximately 109.1 billion dollars each year. Unfortunately, we also hold the highest rate of death from child abuse in an industrialized nation.

As graduate students at the University of Southern California, School of Social Work, in cooperation with Every Child Matters Education Fund, we ask for your action on this important

piece of legislation because each and every child really does matter. Sign the petition at http://tinyurl.com/cks3cpp

Carolina Altamarino, Jodie Bechtel, Stephanie Doss and Anna Flores

Candidates, Masters of Social Work

University of Southern California (USC)

School of Social Work

Dear Ways and Means Committee

My name is Sylvia Randolph I have a Bachelor's degree in Liberal studies (psychology, sociology, urban development). I am currently in school for my MA in Public Policy. I also have professional development credits from several higher educational institutions. I have a long professional work history with experience in managing different components of the daily operating programs.

My most recent work consisted of researching and analyzing women and children issues in public policy with the National Organization for Women. Areas such as social security and wealth disparities amongst women, additionally, health care and education, as well as doing some project management for the National Women's Conference. I have also been influential in the passing of several legislative laws in the state of Maryland around issues of women children and families the past 2 years I have volunteered my time with congressional legislators, the Governor's Office and community programs addressing issues in Maryland's foster care, reunification and adoption program.

I am currently working in the field of Government Relations Public Policy on a special interest project around women and children's families; family law, education, finance and health care. The current project addresses the need of new legislation and policy that supports women and children in our court systems specifically foster care and adoption. At this time my research finds that although the federal government has legislation that supports the family environment legal, sociological and financial stand point, many states have failed to up hold and or successfully implement them into their own state legislation. For example the education law where the states are to assist children who are in foster care with some from higher education or career development and or training. Yet we find statistically that children are aging out of the system unskilled and unemployed where homelessness becomes their factor of life.

My question at the onset of my research looked at the dichotomy between federal and state legislation. I purposed my position on the matter that federal law should be and take precedence in the development or writing of state laws and that there is no room for subjection or juxtaposing the federal legislation in order for the states purpose and goals via it's courts and judicial setting. Second I have found the relationship between the legal judicial and departments are lacking in the inclusive and concrete practices. Although the language and the meaning provided by the federal government substantiate the practices in the courts we find that the lawyers and the departments are far reached in the area.

I looked over the past years academic syllabus the Children Advocacy Program (CAP) is perfect the courses as well as the guest speakers addressed the areas of my project most specifically how do we begin to address the needed changes in the legislative venue of the child advocacy and what that should look like for purpose of the working in the field.

I would like to offer Harvard's CAP program the chance to know face to face what law looks like in relation to women, children and families. In doing so, knowing the importance and relevance in consideration of legislative law and how that not only affects the families but the system as a whole. Understanding the difference between the family law procedural mandates vs. the Departments agenda and how the judicial system is the so to speak moderator of the combined. I would like to offer the program a case study that will give examples of how often times many issues that arrive through the systematic daily operations are often left out or ignored, that families are left in the system for the moderators to then set decisions over. We will find that in the worst case of all scenarios children are dying at the hands of the system. The day of the overworked case workers are gone amended legislation and new reporting systems have addressed that yet we still today find this as a major issue. More children than ever are suffering as a result of a failed system. Lawyers are at the will of stated departments; there only justification for representation is to follow what in the best interest of the system rather than the child or family.

As the students emerge from the CAP program what they will find is that there is disconnect between the purpose and events of time as it relates to children. That such federal agencies and the Children's Bureau no longer have an augmented purpose but has become another name in the federal Government. The briefings, testimonies, and hearings around children that impact the changes in child legislation remain unheard and therefore by those in these positions both on the state and federal level. The lawyers that I have met and talked with along with state government workers are unaware of the changes and that poses a great threat to the system as a whole. The goal of the my project is to ensure that there are changes made full circle in the system that points in the direction of the true advocacy in the future as we move forward.

Thank You,

Sylvia Randolph

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