

STRENGTHENING PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT

HEARING

BEFORE THE

SUBCOMMITTEE ON CIVIL RIGHTS AND HUMAN
SERVICES

COMMITTEE ON EDUCATION
AND LABOR

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED SIXTEENTH CONGRESS

FIRST SESSION

HEARING HELD IN WASHINGTON, DC, MARCH 26, 2019

Serial No. 116-12

Printed for the use of the Committee on Education and Labor



Available via the World Wide Web: www.govinfo.gov

or

Committee address: <https://edlabor.house.gov>

U.S. GOVERNMENT PUBLISHING OFFICE

36-587 PDF

WASHINGTON : 2019

COMMITTEE ON EDUCATION AND LABOR

ROBERT C. "BOBBY" SCOTT, Virginia, *Chairman*

Susan A. Davis, California	Virginia Foxx, North Carolina,
Raúl M. Grijalva, Arizona	<i>Ranking Member</i>
Joe Courtney, Connecticut	David P. Roe, Tennessee
Marcia L. Fudge, Ohio	Glenn Thompson, Pennsylvania
Gregorio Kilili Camacho Sablan,	Tim Walberg, Michigan
Northern Mariana Islands	Brett Guthrie, Kentucky
Frederica S. Wilson, Florida	Bradley Byrne, Alabama
Suzanne Bonamici, Oregon	Glenn Grothman, Wisconsin
Mark Takano, California	Elise M. Stefanik, New York
Alma S. Adams, North Carolina	Rick W. Allen, Georgia
Mark DeSaulnier, California	Francis Rooney, Florida
Donald Norcross, New Jersey	Lloyd Smucker, Pennsylvania
Pramila Jayapal, Washington	Jim Banks, Indiana
Joseph D. Morelle, New York	Mark Walker, North Carolina
Susan Wild, Pennsylvania	James Comer, Kentucky
Josh Harder, California	Ben Cline, Virginia
Lucy McBath, Georgia	Russ Fulcher, Idaho
Kim Schrier, Washington	Van Taylor, Texas
Lauren Underwood, Illinois	Steve Watkins, Kansas
Jahana Hayes, Connecticut	Ron Wright, Texas
Donna E. Shalala, Florida	Daniel Meuser, Pennsylvania
Andy Levin, Michigan*	William R. Timmons, IV, South Carolina
Ilhan Omar, Minnesota	Dusty Johnson, South Dakota
David J. Trone, Maryland	
Haley M. Stevens, Michigan	
Susie Lee, Nevada	
Lori Trahan, Massachusetts	
Joaquin Castro, Texas	

* Vice-Chair

Véronique Pluviose, *Staff Director*
Brandon Renz, *Minority Staff Director*

SUBCOMMITTEE ON CIVIL RIGHTS AND HUMAN SERVICES

SUZANNE BONAMICI, OREGON, *Chairwoman*

Raúl M. Grijalva, Arizona	James Comer, Kentucky,
Marcia L. Fudge, Ohio	<i>Ranking Member</i>
Kim Schrier, Washington	Glenn "GT" Thompson, Pennsylvania
Jahana Hayes, Connecticut	Elise M. Stefanik, New York
David Trone, Maryland	Dusty Johnson, South Dakota
Susie Lee, Nevada	

C O N T E N T S

	Page
Hearing held on March 26, 2019	1
Statement of Members:	
Bonamici, Hon. Suzanne, Chairwoman, Subcommittee on Civil Rights and Human Services	1
Prepared statement of	3
Comer, Hon. James, Ranking Member, Subcommittee on Civil Rights and Human Services	4
Prepared statement of	5
Statement of Witnesses:	
Jackson, Dr. Yo, Ph.D, ABPP, Professor, Psychology Department and Associate Director, Child Maltreatment Solutions Network, The Penn- sylvania State University, Pennsylvania and Research Professor, Uni- versity of Kansas	7
Prepared statement of	10
King, Ms. Judy, MSW, Director, Family Support Programs, Washing- ton State Department of Children, Youth, and Families, Olympia, WA	20
Prepared statement of	22
Thomas, Mr. Bradley, CEO, Triple P, Positive Parenting Program, Co- lumbia, SC	30
Prepared statement of	32
Rose, Mrs. LaCrisha, Facilitator of the West Virginia Circle of Parents Network, Team for West Virginia Children, Miami, WV	40
Prepared statement of	42
Additional Submissions:	
Chairwoman Bonamici:	
Link: Strengthening National Data on Child Fatalities Could Aid In Prevention	64
Article: The Economic Burden of Child Maltreatment in the United States, 2015	65
Dr. Jackson's response to question submitted for the record	85
Schrier, Hon. Kim, a Representative in Congress from the State of Wash- ington:	
Prepared statement by Melmed, Mr. Matthew E., Executive Director, Zero To Three	73
Scott, Hon. Robert C. "Bobby", a Representative in Congress from the State of Virginia:	
Question submitted for the record	84
Trone, Hon. David J., a Representative in Congress from the State of Maryland:	
Link: Within Our Reach	49

STRENGTHENING PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT

**Tuesday, March 26, 2019
House of Representatives,
Subcommittee on Civil Rights and Human Services,
Committee on Education and Labor,
Washington, DC.**

The subcommittee met, pursuant to notice, at 2:45 p.m., in room 2175, Rayburn House Office Building, Hon. Suzanne Bonamici [chairwoman of the subcommittee] presiding.

Present: Representatives Bonamici, Schrier, Hayes, Trone, Lee, Scott, Comer, Thompson, Stefanik, Johnson, and Foxx.

Also present: Representative Langevin.

Staff present: Alli Tylease, Chief Clerk; Jacque Mosely Chevalier, Director of Education Policy; Paula Daneri, Education Policy Fellow; Christian Haines, General Counsel, Education; Alison Hard, Professional Staff Member; Ariel Jona, Staff Assistant; Stephanie Lalle, Deputy Communications Director; Max Moore, Office Aide; Banyon Vassar, Deputy Director of Information Technology; Cyrus Artz, Minority Parliamentarian; Marty Boughton, Minority Press Secretary; Courtney Butcher, Minority Coalitions and Members Services Coordinator; Bridget Handy, Minority Legislative Assistant; Blake Johnson, Minority Staff Assistant; Amy Raaf Jones, Minority Director of Education and Human Resources Policy; Hannah Matesic, Minority Director of Operations; Kelley McNabb, Minority Communications Director; Jake Middlebrooks, Minority Professional Staff Member; Mandy Schaumburg, Minority Chief Counsel and Deputy Director of Education Policy; and Meredith Schellin, Minority Deputy Press Secretary and Digital Advisor.

Chairwoman BONAMICI. The subcommittee on Civil Rights and Human Services will come to order. Welcome everyone. I note that a quorum is present and apologize for the late start. We were voting.

I ask unanimous consent that Mr. Langevin of Rhode Island be permitted to participate in today's hearing with the understanding that his questions will come only after all members of the subcommittee on Civil Rights and Human Services on both sides of the aisle who are present have had an opportunity to question the witnesses.

Without objection. So ordered.

The committee is meeting today in a legislative hearing to hear testimony on strengthening prevention and treatment of child abuse and neglect. Pursuant to committee rule 7(c), opening statements are limited to the chair and ranking member. This allows us to hear from our witnesses sooner and provide all members with adequate time to ask questions. I recognize myself now for the purpose of making an opening statement.

We are here today to discuss our responsibility to protect the health and safety of our Nation's children. Child abuse and neglect, collectively, child maltreatment are quiet nationwide tragedies that unfold every day in communities across the country.

In 2017, state child protection services agencies received a total of 4.1 million referrals of possible child abuse or neglect involving 7.5 million children. All together, child maltreatment affects as many as one in seven children. Victims of child maltreatment typically suffer both immediate and lasting harm. In the short-term, maltreatment can result in significant physical injuries in addition to emotional and psychological disruption, and the effects can last over a lifetime.

Emotional and psychological abuse can hinder not only social growth but also the physical growth of the brain itself. As adults, victims of child maltreatment can suffer from inhibited memory processing and struggle to control their emotions and behaviors. As a result, they are 7 percent more likely to drop out of high school and nine times more likely to be involved with the juvenile justice system than their peers. The trauma suffered by these children and families will stay with them for a lifetime, and in Congress, we should always look for ways to support trauma informed care.

In addition to the high personal costs, child maltreatment also carries devastating societal costs. Research shows that the long-term effects can have lifetime costs of more than \$800,000 per child all together. This is a public health crisis that costs more than \$400 billion each year.

Since the passage of the Child Abuse Prevention and Treatment Act, or CAPTA, more than 3 decades ago we have made progress toward reducing cases of child maltreatment. In fact, from 1990 to 2009, rates steadily declined and then plateaued through 2012. Despite that, we face new challenges in our efforts to address child maltreatment. Since 2013, the rate at which children are abused and neglected has steadily increased, and with it, tragically, the rate of child deaths has also gone up. In the year 2017, child deaths from maltreatment reached an all-time high; 1,720 children lost their lives.

Evidence suggests that the opioid crisis is giving rise to new challenges in protecting vulnerable children. In my home state of Oregon, I have met with parents, healthcare professionals, community leaders, veterans, and people from all walks of life who have shared heart wrenching stories about how the opioid crisis is taking lives and inflicting pain on families. This crisis can be particularly devastating for mothers and newborn children.

As our understanding of child abuse and neglect deepens, we must update our approach accordingly. We cannot continue to address this public health crisis by just reacting after child maltreatment cases arise. As this committee considers reauthorizing the

Child Abuse Prevention and Treatment Act, last updated nearly a decade ago, we must shift our focus to preventing, preventing the maltreatment from occurring in the first place.

We need a CAPTA reauthorization that strengthens federal investments in community-based prevention services so families across the country can receive help before children suffer. We need to build networks of wraparound services that lower the risk of child maltreatment by helping families navigate complex health, educational, and financial hardships, and we need to streamline communication between and among states so child protection agencies across the country can connect the dots and prevent cases of child maltreatment, no matter where they occur, from slipping through the cracks.

All of us in this room recognize that Congress has a responsibility to protect children. We must work together to invest in services that prevent, not just treat, child abuse and neglect. Today's hearing is an important step toward making sure that all children grow up in a safe and healthy environment that allows them to reach their full potential.

I want to thank all of our witnesses for being here today. I look forward to your testimony, and I now yield to the ranking member, Mr. Comer.

[The statement of Chairwoman Bonamici follows:]

**Prepared Statement of Hon. Suzanne Bonamici, Chairwoman,
Subcommittee on Civil Rights and Human Services**

We are here today to discuss our responsibility to protect the health and safety of our Nation's children.

Child abuse and neglect, collectively child maltreatment, are quiet, nationwide tragedies that unfold every day in communities across the country. In 2017, State child protection services agencies received a total of 4.1 million referrals of possible child abuse or neglect involving 7.5 million children. Altogether, child maltreatment affects as many as one in seven children.

Victims of child maltreatment typically suffer both immediate and lasting harm. In the short-term, maltreatment can result in significant physical injuries, in addition to emotional and psychological disruption. And the effects can last over a lifetime. Emotional and psychological abuse can hinder not only social growth but also the physical growth of the brain, itself.

As adults, victims of child maltreatment can suffer from inhibited memory processing and struggle to control their emotions and behaviors. As a result, they are 7 percent more likely to drop out of high school and nine times more likely to become involved with the juvenile justice system than their peers. The trauma suffered by these children and families will stay with them for a lifetime, and in Congress we should always look for ways to support trauma-informed care.

In addition to the high personal costs, child maltreatment also carries devastating societal costs. Research shows that the long-term effects can have lifetime costs of more than \$800,000 per child. Altogether, this public health crisis costs more than \$400 billion each year.

Since the passage of the Child Abuse Prevention and Treatment Act, or CAPTA, more than three decades ago, we have made progress toward reducing cases of child maltreatment. In fact, from 1990 to 2009, rates steadily declined, and then plateaued through 2012.

Despite that, we face new challenges in our efforts to address child maltreatment. Since 2013, the rate at which children are abused and neglected has steadily increased. And with it, tragically, the rate of child deaths has also gone up. In the year 2017, child deaths from maltreatment reached an all-time high—1,720 children lost their lives.

Evidence suggests that the opioid crisis is giving rise to new challenges in protecting vulnerable children.

In my home State of Oregon, I have met with parents, health care professionals, community leaders, veterans, and people from all walks of life who have shared

heart-wrenching stories about how the opioid crisis is taking lives and inflicting pain on families. This crisis can be particularly devastating for mothers and newborn children.

As our understanding of child abuse and neglect deepens, we must update our approach accordingly.

We cannot continue to address this public health crisis by just reacting after child maltreatment cases arise. As this Committee considers reauthorizing the Child Abuse Prevention and Treatment Act—last updated nearly a decade ago—we must shift our focus to preventing the maltreatment from occurring in the first place.

We need a CAPTA reauthorization that strengthens Federal investments in community-based prevention services so families across the country can receive help before children suffer.

We need to build networks of wrap-around services that lower the risk of child maltreatment by helping families navigate complex health, educational, and financial hardships.

And we need to streamline communication between and among States so child protection agencies across the country can connect the dots and prevent cases of child maltreatment, no matter where they occur, from slipping through the cracks.

All of us in this room recognize that Congress has a responsibility to protect children. We must work together to invest in services that prevent, not just treat, child abuse and neglect.

Today's hearing is an important step toward making sure that all children grow up in a safe and healthy environment that allows them to reach their full potential.

I want to thank all our witnesses for being with us today. I look forward to your testimony and I now yield to the Ranking Member, Mr. Comer.

Mr. COMER. Thank you, Madam Chairman, for yielding. Thank you all for being here today. As the dad of three young children, today's topic is a very difficult one to discuss. No child should ever have to endure the pain of abuse or neglect by a parent or caregiver. That is why today's hearing is so important.

The Child Abuse Prevention and Treatment Act or CAPTA is the key federal legislation that helps states combat child abuse and neglect. This legislation, which was enacted in 1974, provides states with grant funding to develop programs aimed at prevention, assessment, investigation, prosecution, and treatment.

The scope of this law is significant, and the number of children that are affected by abuse and neglect each year is staggering and absolutely heartbreaking. In 2016, Child Protective Services received over 4 million referrals involving 7.4 million children. Teachers, law enforcement, and social service professionals accounted for over half of all referrals. Of those 4 million reports, 2.2 million received a direct response from Child Protective Services. Of that number, approximately 676,000 children were determined to be victims of abuse or neglect.

While neglect is notoriously more challenging to confirm, it still accounted for close to 75 percent of cases reported to CPS. And while we know that abuse can have serious lasting impacts on children well into the latter parts of their lives, research shows that the effects of neglect can be just as detrimental. In fact, some studies have shown that neglect can have an even greater impact on a child's healthy brain development.

As this committee works to make CAPTA more effective in our fight against child abuse and neglect, our efforts should begin with prevention. Prevention takes a holistic approach to combating neglect and abuse by focusing on strengthening communities and educating parents and caregivers on how to keep children safe. CAPTA receives \$158 million in annual appropriations with \$39.8 million designated specifically for community-based child abuse prevention

formula grants. We support community level organizations focused on preventing child abuse and neglect.

In addition to bolstering our prevention efforts, this committee's work should streamline current assurances and requirements so states can focus on serving and providing treatment to children rather than spending more time filling out paperwork. State agencies benefit from increased flexibility that allows them to respond more swiftly and effectively to reports of abuse and neglect. We must equip states with the tools and resources needed to address maltreatment and keep kids safe.

Children who have suffered abuse and neglect have unique needs, and it is our duty to ensure that they receive excellent care. I have no doubt that this subcommittee can lead this effort and champion bipartisan initiatives that strengthen CAPTA.

I look forward to today's discussion about how we as a Nation can effectively and compassionately serve these children.

I yield back.

[The statement of Mr. Comer follows:]

**Prepared Statement of Hon. James Comer, Ranking Member,
Subcommittee on Civil Rights and Human Services**

Thank you for yielding.

As a dad to three young kids, today's topic is a tough one to discuss. No child should ever have to endure the pain of abuse or neglect by a parent or caregiver, and that's why today's hearing is so important.

The Child Abuse Prevention and Treatment Act (CAPTA) is the key Federal legislation that helps States combat child abuse and neglect. This legislation, which was enacted in 1974, provides States with grant funding to develop programs aimed at prevention, assessment, investigation, prosecution, and treatment.

The scope of this law is significant, and the number of children that are affected by abuse and neglect each year is staggering and absolutely heartbreaking. In 2016, child protective services (CPS) received over 4 million referrals involving 7.4 million children. Teachers, law enforcement, and social services professionals accounted for over half of all referrals. Of those 4 million reports, 2.2 million received a direct response from child protective services. Of that number, approximately 676,000 children were determined to be victims of abuse or neglect.

While neglect is notoriously more challenging to confirm, it still accounted for close to 75 percent of cases reported to CPS. And while we know that abuse can have serious lasting impacts on children well into the later parts of their lives, research shows that the effects of neglect can be just as detrimental.

In fact, some studies have shown that neglect can have an even greater impact on a child's healthy brain development.

As this committee works to make CAPTA more effective in our fight against child abuse and neglect, our efforts should begin with prevention. Prevention takes a holistic approach to combating neglect and abuse by focusing on strengthening communities and educating parents and caregivers on how to keep children safe. CAPTA receives \$158 million in annual appropriations, with \$39.8 million designated specifically for Community Based Child Abuse Prevention (CB-CAP) formula grants which support community-level organizations focused on preventing child abuse and neglect.

In addition to bolstering our prevention efforts, this committee's work should streamline current assurances and requirements, so States can focus on serving and providing treatment to children, rather than spending more time filling out paperwork. State agencies benefit from increased flexibility that allows them to respond more swiftly and effectively to reports of abuse and neglect. We must equip States with the tools and resources needed to address maltreatment and keep kids safe.

Children who have suffered abuse and neglect have unique needs, and it is our duty to ensure they receive exemplary care. I have no doubt that this subcommittee can lead this effort and champion bipartisan initiatives that strengthen CAPTA. I look forward to today's discussion about how we as a nation can effectively and compassionately serve these children.

Chairwoman BONAMICI. Thank you very much, Mr. Comer, for your statement.

Without objection, all other members who wish to insert written statements into the record may do so by submitting them to the committee clerk electronically in Microsoft Word format by 5 p.m. on April 8, and I will now introduce the witnesses.

Dr. Yo Jackson is a board-certified clinical child psychologist who studies the mechanisms of resilience for youth exposed to trauma. She is a professor at the University of Kansas and at Penn State University where she also serves as the Associate Director of the Child Maltreatment Solutions. Over the last 20 years, Dr. Jackson has developed an extensive body of research focused on the mechanisms that foster resilience for youth exposed to trauma. Throughout her career, she has served and continues to serve as the principal investigator on several grants from the National Institutes of Health.

And I am going to skip over Ms. King temporarily because we are hoping that Dr. Schrier arrives to introduce Ms. King.

Mr. Bradley Thomas has been the CEO of Triple P America since 2011. Triple P, Positive Parenting Program, is a system of evidence-based education and support for parents and caregivers of children and adolescents with a prevention focus. Prior to being appointed as CEO, he was involved in various capacities in working with public research organizations interested in transferring their research into the community. Following his work with research organizations, he accepted the position as CEO to focus on Triple P which to date has been provided in over 25 countries. In that capacity, he has overseen the expansion of the program's utilization in the U.S. from 11 to 38 states. He has a law degree and a Bachelor of Information Technology from Queensland University of Technology in Australia.

Mrs. LaCrisha Rose is a resident of Cabin Creek, West Virginia where she is a loving wife and a mother of three children. Her own personal experiences with parenting have inspired her to be an advocate for all children and families. Mrs. Rose is here today to talk about her experience as a parent. Mrs. Rose is currently the facilitator of the West Virginia Circle of Parents Network which comprises parent-led self-help groups that allow parents and caregivers to share ideas, celebrate successes, and address the challenges surrounding parenting. She is a former home visitor through the Parents as Teachers program and currently serves as a board member to her local program. Ms. Rose is also active in her local community through volunteering with her local elementary school and youth sports.

And I know Dr. Schrier wanted to introduce Ms. King, but I am going to go ahead and do that. Ms. Judy King serves as the Director of Family Support Programs at the Washington State Department of Children, Youth, and Families. She has 30 years of experience in human services and family support and has worked at the community, state, and national levels. In her current role, she oversees work related to home visiting system development, child abuse prevention strategy, early intervention, therapeutic and trauma informed childcare, health and early childhood and infant mental health. Ms. King also serves as the Executive Director of the Pre-

vent Child Abuse America Washington State chapter and serves on the board of the National Alliance for Children's Trust and Prevention Fund.

Oh. I just finished, Dr. Schrier. Welcome.

Welcome to all of our witnesses. We appreciate all of you for being here today, and we look forward to your testimony.

Let me remind the witnesses that we have read your written statements, and they will appear in full in the hearing record. Pursuant to committee rule 7(d) and committee practice, each of you is asked to limit your oral presentation to a 5-minute summary of your written statement.

Let me remind the witnesses that pursuant to Title 18 of the U.S. Code, Section 1001, it is illegal to knowingly and willfully falsify any statement, representation, writing, document, or material fact presented to Congress or otherwise conceal or cover up a material fact.

Before you begin your testimony, please remember to press the button on the microphone in front of you so it will turn on, and the members can hear you. As you speak, the light in front of you will turn green. After 4 minutes, the light will turn yellow to signal that you have 1 minute remaining. When the light turns red, your 5 minutes have expired, and we ask that you please wrap up.

We will let the entire panel make their presentations before we move to member questions. When answering a question, again, please remember to turn your microphone on.

I first recognize Dr. Jackson.

STATEMENT OF YO JACKSON, PH.D, ABPP, PROFESSOR, PSYCHOLOGY DEPARTMENT AND ASSOCIATE DIRECTOR, CHILD MALTREATMENT SOLUTIONS NETWORK, THE PENNSYLVANIA STATE UNIVERSITY, PENNSYLVANIA & RESEARCH PROFESSOR, UNIVERSITY OF KANSAS STATE COLLEGE, KANSAS

Ms. JACKSON. Good afternoon, Madam Chair Bonamici, Ranking Member Comer, and members of the committee. My name is Dr. Yo Jackson, and I am a Professor of Psychology as well as the Associate Director of the Child Maltreatment Solutions Network at Penn State University. I am also a research professor at the University of Kansas. And I have worked for over 20 years as a board-certified clinical child psychologist and a researcher on the development of resilience for kids exposed to trauma and child maltreatment. Thank you for inviting me to speak with you today.

Child maltreatment is a significant public health problem. In 2017, 7.5 million children were referred to protective services with 3.5 million children meeting at least the minimum criteria to warrant an investigation. Of those, 674,000 children were determined to be victims of child maltreatment. That translates to a child being significantly harmed about every 45 seconds.

Child maltreatment includes experiences like neglect, physical abuse, sexual abuse, with neglect being the most common. Sadly, 1,720 children died as a result of child maltreatment in 2017, plac-

ing the United States second only to Mexico for the most intentional child fatalities in the developed world.

Child maltreatment is second in terms of the most prevalent childhood public health problems in the U.S. just after obesity and ahead of things like attention deficit disorder, asthma, cancer, and autism. In 2015, the average lifetime public cost associated with child maltreatment is estimated to be over \$830,000 per victim, coming to a total of roughly \$428 billion in costs for the number of victims over the course of just 1 year, money that could have been saved if abuse and neglect were prevented.

Maltreatment is associated with a plethora of negative and often devastating outcomes. It is important to note that most victims are under the age of 7, a time of great plasticity in the developing brain and social interaction systems. Early childhood is a sensitive period for the development of social relationships and forming secure attachments, something that is not possible in abusive and threatening caregiver-child relationships.

Child maltreatment has serious negative consequences for brain development, impacting areas critical for learning, memory, emotion regulation, cognitive abilities, decisionmaking, and social skills. Beyond the grave neurological and biological effects, child maltreatment results in a lifetime of negative health behaviors such as risky sexual behaviors, obesity, substance use disorders, chronic pain, and cardiovascular disease.

Maltreatment is consistently associated with higher rates of all forms of mental health diagnoses including risk for self harm. Youth exposed to maltreatment are five times more likely than their peers to fail in school, to leave high school without a degree, to become a teen parent, to be consistently unemployed, to experience chronic physical and mental health problems in adulthood, and are three times more likely to be incarcerated, homeless, or live below the poverty line as adults.

The range of emotional, behavioral, cognitive, and social delays as a result of child maltreatment are limitations that some may be able to adapt to but most will never overcome. If adequate prevention programs were in place, these negative outcomes would not occur. Moreover, the negative effects of maltreatment are significantly increased with each revictimization making what was a hard to treat problem much worse and increasing the odds of long-term maladjustment.

Given that on average, a child referred for protective services will be referred for abuse concerns three more times before they reach the age of 18, child maltreatment is likely underestimated in terms of its impact in the research presented here.

The bulk of primary prevention efforts currently fall under the definition of home visiting where professionals visit parents in their homes and focus on the well being of children ages 0 to 5. Several of these primary prevention programs have been shown to reduce reports of child maltreatment. A paper in 2018 reported the cost benefit return of \$4 for every dollar spent on universal primary prevention programs.

In contrast, targeted prevention includes a host of programs implemented within protective services to improve home environments and protect children from another instance of child maltreat-

ment. A cost benefit analysis found that two of the most widely lauded targeted programs, Safe Care, returned over \$21, and parent child interaction therapy returned over \$15 in benefit for every dollar spent on implementation.

Although child maltreatment is pervasive, it is also preventable. Because most victims of maltreatment are young children, prevention programs are critical to avoid the biological and social development impacts, impairments, and downstream effects. Child maltreatment requires a comprehensive prevention strategy. The reauthorization of CAPTA is an exceptional opportunity to better support the systems that protect children from maltreatment. Through CAPTA, we seek to better coordinate our efforts across the patchwork systems of federal, state, and local agencies and services, to seek out efficiencies and best practices that are supported by an evidence base. Data driven approaches are necessary to increase the research base and to advance knowledge on what works for whom.

We also need to seek to find and develop innovative coordinated solutions that facilitate the feasible and sustainable involvement of schools, parents, adults, government agencies, and service providers.

Coordination, data focus, innovation. These frames are vitally important for prevention because what we know is that our current efforts have shown little to modest impacts. What we are doing now is not enough to stem the tide of child maltreatment.

[The statement of Dr. Jackson follows:]

Extended Testimony

Testimony before the Committee on Education & Labor of the U.S. House of Representatives
Chairman Robert C. "Bobby" Scott
Subcommittee on Civil Rights and Human Services
Hearing Title: Strengthening Prevention and Treatment of Child Abuse and Neglect

Witness:

Dr. Yo Jackson, Ph.D., ABPP
Associate Director, Child Maltreatment Solutions Network, Penn State University
Professor of Psychology, College of Liberal Arts, Penn State University
Research Professor, University of Kansas

~~~

Thank you to the members of the Committee for the opportunity to speak with you today.

My name is Dr. Yo Jackson and I am a professor in Psychology as well as the Associate Director of the Child Maltreatment Solutions Network at Penn State University. I am also a research professor at the University of Kansas, and have worked for over 20 years as a board-certified clinical child psychologist and a researcher on the development of resilience for youth exposed to trauma and child maltreatment. Today, I hope to provide the members of the committee with details on the scope and gravity of child maltreatment in the United States, a view into what the data says, and a synthesis of current research in the field.

**Child Maltreatment: The scope of the problem**

Child maltreatment is a significant public health problem that includes physical abuse, sexual abuse and neglect. A national incidence study showed that 7.5 million children were referred to the protective service system in 2017, with 3.5 million children meeting the minimum threshold of risk to warrant an investigation (also known as being "screened in"). Of those, 674,000 children were determined to be victims of child maltreatment.<sup>1</sup> This translates to 1.3 children being significantly harmed every 60 seconds. The most pervasive form of child maltreatment at 74.9% is neglect (or the failure to provide basic care resulting in harm or threat of harm), followed by physical abuse at 18.3%, which is characterized as the intentional use of force resulting in or with potential to result in physical injury.<sup>1</sup> Sexual abuse accounts for 8.6%, and is characterized as the completed or attempted sexual act, sexual contact, or exploitation of a child by a caregiver.<sup>1</sup> Sadly, 1,720 children died as a result of child maltreatment in 2017, placing the United States second only to Mexico for the most intentional child fatalities in the developed world.<sup>1,2</sup>

Prevalence rates in the US indicate that 37% of children will, in some way, be involved with the child protective services before age 18<sup>3</sup> and 12.5% of children will experience

## Extended Testimony

substantiated child maltreatment.<sup>4</sup> This rate puts child maltreatment second in terms of the most prevalent childhood public health problem just after obesity and ahead of ADHD, prematurity, asthma, food allergies, cancer, and autism.<sup>4</sup> In 2015, the average lifetime public cost associated with child maltreatment is estimated to be \$830,928 per victim, coming to a total of roughly \$428 billion in costs for the number of victims over the course of just one year.<sup>5</sup>

Child maltreatment is associated with a plethora of negative and often devastating outcomes. Research consistently shows that child maltreatment (in any form or type) is related to a range of physiological, behavioral, and mental changes for children. It is important to note that most children exposed to child maltreatment are under the age of 7 years old – a time of great plasticity in the developing brain and social interaction systems.<sup>6</sup> Early childhood is a sensitive period for the development of healthy social relationships and the forming of secure attachments, something that is not possible in abusive and threatening caregiver-child relationships. Child maltreatment can be responsible for changes to the structure and chemical activity of the brain (like decreased size or connectivity in some parts of the brain) and in the emotional and behavioral functioning of the child (like over-sensitivity to stressful situations). For example, in non-maltreating caregiver-child relations, infants will babble or gesture or cry to bring reliable and healthy reactions from their caregivers. When caregivers respond positively to these efforts, the neural pathways in the brain that are attuned to social interaction and inform the child about the consistency for getting their needs met are strengthened. However, if the caretaker is abusive or neglectful, the child's brain is likely to develop a sense of hyper-alertness for danger or not fully develop. The kind of neuronal pathway that is developed – healthy/secure or hyperalert/underdeveloped will dictate how the child is later able to cope with stressors. When a child is exposed to child maltreatment, their ability to respond to later nurturing care may be limited.

Many biological processes are affected by child maltreatment. For example, research shows that in the brain, adults who were maltreated as children have reduced volume in the hippocampus, a part of the brain critical for learning and memory.<sup>7</sup> Structures like the corpus callosum, responsible for processes like emotion, arousal and complex cognitive abilities are often impaired.<sup>7</sup> The cerebellum is also affected as youth exposed to maltreatment often show decreased volume here, which helps coordinate motor behavior and executive functioning.<sup>8</sup> Finally, the prefrontal cortex, responsible for behavior and decision-making, cognition, social skills, and emotion regulation is often reduced volume in youth exposed to child maltreatment.<sup>9</sup>

Beyond the grave neurological and biological effects, child maltreatment results in a lifetime<sup>10-12</sup> of negative health behaviors and outcomes. Such behaviors include early alcohol use,<sup>13</sup> illicit drug use,<sup>14</sup> tobacco use,<sup>15</sup> as well as risky sexual behaviors,<sup>16</sup> often resulting in outcomes like teen pregnancy,<sup>17</sup> obesity,<sup>18</sup> diabetes,<sup>19</sup> lung cancer,<sup>20</sup> depression and anxiety,<sup>21</sup> cardiovascular disease,<sup>22</sup> chronic pain,<sup>23</sup> and sexually transmitted infections.<sup>24</sup> Youth exposed to maltreatment may show a persistent fear response. Perhaps a result of adaptation under abusive conditions, this threat hypervigilance puts these youth at-risk for the development of future anxiety disorders

## Extended Testimony

like post-traumatic stress disorder. Moreover, hypervigilance can result in difficulty benefiting from instruction in the classroom environment as hypervigilance can include an unrelenting need to monitor the environment for threats. As a result, the brains of child maltreatment victims are less able to interpret and respond to verbal cues, even when they are in an environment typically considered nonthreatening. Often youth exposed to child maltreatment are identified as learning disabled or as having ADHD, in part because their brains have developed in such a way that they are unable to achieve the relative mental calm necessary for learning.

Youth exposed to child maltreatment are at great risk for a range of emotional, behavioral, cognitive and social delays that some may be able to adapt to, but most will never overcome. Neglect is another good example of this process. Neglect is not only failure to meet the child's basic physical needs like for food and safety, but it also can be a failure to meet a child's cognitive, emotional, or social needs, not allowing the child to develop the systems that are necessary for adequate physical and mental health. For children to master developmental tasks, caregiver support and encouragement is a necessity. If this stimulation and care is lacking during a child's early years, the child may not achieve the usual developmental milestones.

Beyond the kinds of delays seen in early childhood, maltreatment is consistently associated with higher rates of all forms of clinical mental health diagnoses including an increased risk for self-harm as the child gets older. Youth exposed to child maltreatment who have contact with child protective services are three times more likely than their non maltreated peers to fail in school, (e.g., about 50% leave high school without a degree) be consistently unemployed, become a teen parent, experience chronic physical and mental health problems in adulthood, and are more likely to be incarcerated or homeless, or living below the poverty line as adults.<sup>25</sup> Moreover, children who experienced maltreatment in childhood are at greater risk for substance abuse disorders later in life.<sup>26-29</sup> Compared to youth in the general population, youth with formal child welfare system involvement report higher rates of lifetime marijuana use (18% vs. 14%), lifetime and current inhalant use (12% & 5% vs. 6% and 2%, respectively), and lifetime and current hard drug use (e.g., cocaine, heroin) (6% and 3% vs 4% and 2%, respectively)<sup>30</sup>.

In summary, the emotional, behavioral, and cognitive limitations common to youth exposed to maltreatment are numerous. Although this information presented here is not meant to be exhaustive, it does provide a summary of the kinds of common deficits and challenges that result from all types of child maltreatment. We also know that the negative effects of maltreatment are significantly increased with each revictimization, making what was a hard-to-treat problem much worse and increasing the odds of long-term mental and physical maladjustment due to abuse. Given that the average number of re-referrals to the child protection system for the same child is 2.98,<sup>31</sup> the impact of child maltreatment on development is likely underestimated by the research presented here.



## Extended Testimony

It is also important to note that child protective services referrals, regardless of substantiation status, increases the risk for negative health and behavioral outcomes in later life. A recent analysis using causal inference methods demonstrated that involvement with the child protective services increases a child's risk for teen motherhood, HIV infection, and substance use.<sup>32</sup>

Although child maltreatment is pervasive and too-often fatal, it is also preventable. Given the scope and grave consequences, child maltreatment requires a comprehensive prevention strategy.<sup>33</sup>

Child maltreatment has many possible causes. It is important to remember that child maltreatment is not a unitary construct, it is not one effect linearly related to one cause. Because child maltreatment has multiple forms, strategies to prevent child maltreatment must also be varied. For prevention efforts to be effective, an evidence-informed, multi-faceted approach is necessary. Child maltreatment also develops over time. That is, perpetrators who neglect, physically injure or sexually abuse a child do not do so without presenting some evident risk factors for this behavior before the abuse is perpetrated. So too then, prevention strategies must include a range of pre-abuse risk factors in the effort to prevent the dangerous behavior on the part of the caretaker.

Given the high cost of child maltreatment and sheer number of children involved in protective services, the problem of child maltreatment is in dire need of effective and sustained prevention efforts. Currently, there are several approaches to prevention. *Primary prevention*, sometimes also referred to as 'universal prevention' is a population-based strategy designed to stop maltreatment before it occurs in communities, schools, and institutions. These programs raise public awareness, provide education about how to recognize the signs of abuse, and provide practical skills and support for taking action to get help or report abuse. Other programs provide one-on-one skills training, usually to parents, focused on positive parenting practices, reducing household stressors, and larger family advocacy needs. *Targeted or indicated prevention*, on the other hand, focus on stopping maltreatment within high-risk groups, stopping maltreatment from happening again, and/or staving off or mitigating the harmful consequences of maltreatment. These programs specifically target aspects of abusive and neglectful parenting or are focused on reducing behavior problems, post-traumatic-stress symptoms, and other aspects of mental and psychosocial health in victims.

The bulk of *primary prevention* efforts currently fall under the definition of 'home visiting'—where nurses, other professionals, or paraprofessionals visit parents in their homes, some starting in the prenatal period, and focus on the wellbeing of children aged 0 to 5. Several of these primary prevention programs have been shown to reduce reports of maltreatment to social services and proxies of maltreatment such as hospitalizations. A recent paper published in 2018 reported the cost benefit of universal, primary prevention programs, ranging from \$1.73 (or \$1.73 of benefits for every \$1 of program costs) to \$6.37.<sup>34</sup>

## Extended Testimony

In general, *targeted prevention* is thought to yield more 'bang for the buck' because those who are in most need of intervention are identified and provided services. In 2017, over 3% of children were referred to protective services for a child abuse investigation. Research shows that children and families who have been referred to protective services constitute one of the highest risk populations to target for prevention given that the risk for re-referral for these children is approximately 50%,<sup>35</sup> most occurring within 6 months.<sup>36</sup> Moreover, 20% of child maltreatment victims are re-victimized within 5 years.<sup>37</sup> As a result of these findings, a host of programs are now implemented within protective services organizations in attempt to improve home environments and protect children from re-referral or another instance of maltreatment. A cost benefit analysis conducted by the independent Washington State Institute on Public Policy (WSIPP) found that two of the most widely lauded targeted prevention programs, SafeCare ®<sup>38</sup> and Parent Child Interaction Therapy (PCIT<sup>39</sup>), returned \$21.60 and \$15.97 respectively in benefit for every dollar spend on implementation.<sup>40</sup>

Given cost estimates showing that each new instance of child maltreatment results in \$830,928 in lifetime public cost for non-fatal victims and \$16.6 million for fatal victims, the cost-benefit of implementing primary or targeted prevention is an obvious worthwhile investment.<sup>5</sup> In fact, one recent analysis estimated that if these programs were implemented in all 50 states, the combined cost savings would be an approximately \$16B over the lifetime of each annual cohort of child victims.<sup>34</sup>

However, despite public health approaches to child maltreatment prevention, national rates have not fluctuated substantially over the past 15 years. In fact, the most recent reports show that the number of children investigated for child maltreatment has actually increased by 10% over the past five years and the number of substantiated child maltreatment has increased by almost 3%.<sup>41</sup>

However, we do know that prevention efforts work best when there is a community-level response and where available services are identified and disseminated in a coordinated fashion<sup>45</sup>. For example, the Positive Parenting Program (PPP)<sup>46</sup> and Family Connects Durham<sup>47</sup> are among the most effective child maltreatment prevention programs by showing reductions in actual rates of child maltreatment. These both bring together and coordinate various evidence-based prevention services within communities to promote healthy families, including reducing risk for maltreatment. While these efforts are promising, there are substantial challenges that limit the coordination of services at the community-level and only a few models that have been effective at reducing overall rates of child maltreatment.<sup>45, 46</sup>

Several recent meta-analyses of the most common primary prevention home visiting programs (Early Head Start, Healthy Families America, Nurse Family Partnership, and Parents as Teachers) find their impacts on child maltreatment rates to be modest,<sup>42</sup> with several implementation factors, including provider training, supervision, and program fidelity having a significant effect on program outcomes.<sup>43</sup> Similarly, although 1.9 million children receive targeted prevention each year<sup>1</sup>, these targeted prevention strategies have shown only small to moderate effects<sup>44,45</sup> and the extent to which these programs

## Extended Testimony

reduce rates of child maltreatment varies widely.<sup>44,45</sup> It is important to remember that none of these programs were designed to prevent child maltreatment directly, so the fact that they have any impact on child maltreatment is important and promising for programs that actually target the multi-faceted causes of child maltreatment. For example, Nurse Family Partnership was developed to target prenatal health, Parents as Teachers was designed to target child development outcomes, and Early Head Start was developed to enhance school-readiness.

Because child maltreatment is not linear, not one cause leading to one effect, the approach to prevention has to be multi-pronged and coordinated across systems of care (e.g., parents, caregivers, teachers). Because the effects of child maltreatment are not always immediate, nor are the effects of intervention, prevention programs have to be implemented and evaluated over the long-term. Currently the field is in the early stages of documenting the success of the effective programs, but much more research is needed to show long-term gains. The rates of child maltreatment have not changed in over a decade and thus there is a significant need to increase implementation of prevention programs, to create and test innovation in prevention, and provide rigorous evaluation and research on outcomes for youth and families so that the impact of child maltreatment specific prevention programs is clearer.

It should also be noted that, with very few exceptions (e.g., Triple P, SafeCare®), these large programs neither access nor track changes in actual RATES of child maltreatment. In fact, a recent U.S. Preventive Services Task Force report designated the existing research on child maltreatment prevention to be incomplete due to a failure in research methods linking intervention effects to reductions in actual cases of child maltreatment.<sup>46</sup>

Finally, the impact of primary and targeted prevention on rates of child sexual abuse is largely unknown because they are rarely reported and are often included in aggregate reporting of 'referrals to child protective services. This is likely due to the fact that the most widely disseminated home visiting and parenting programs are not designed to prevent child sexual abuse. Instead they focus mainly on targeted parenting behaviors linked to physical or psychological abuse and neglect, like reducing harsh parenting and ameliorating poor knowledge of child development. They do not target risk factors linked to child sexual abuse such as identifying grooming behaviors and recognizing the emotional and physical signs of sexual abuse.<sup>47</sup>

While the situation is dire for the state of child maltreatment, the reauthorization of the Child Abuse Prevention & Treatment Act (CAPTA) is an opportunity to better support the systems that protect children from maltreatment.

Through CAPTA, we can seek to better coordinate our efforts across the patchwork system of federal, state and local agencies and services, in order to seek out efficiencies and best practices that are supported by a strong evidence-base. To do this, we need to invest in data-driven approaches that are scalable and transferable across populations. Improved data sharing standards aimed at promoting collaboration across

Extended Testimony

the system are vitally needed. We also need to seek and lift up innovative solutions to foster coordinated efforts that facilitate the feasible and sustainable involvement of schools, parents, adults, government agencies, and service providers.

Coordination. Data-focus. Innovation. These frames are vitally important, because what we know is that our current efforts have shown little to modest impacts to stem the tide of child maltreatment.

Thank you.

## Extended Testimony

## References

1. U.S. Department of Health & Human Services. *Child Maltreatment 2017*. <http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment2019>.
2. Unicef. *A league table of child maltreatment deaths in rich nations*. UN; 2003.
3. Kim H, Wildeman C, Jonson-Reid M, Drake B. Lifetime prevalence of investigating child maltreatment among US children. *American journal of public health*. 2017;107(2):274-280.
4. Wildeman C, Emanuel N, Leventhal JM, Putnam-Hornstein E, Waldfogel J, Lee H. The prevalence of confirmed maltreatment among US children, 2004 to 2011. *JAMA pediatrics*. 2014;168(8):706-713.
5. Peterson, C., Florence, C., & Klevens, J. The economic burden of child maltreatment in the United States, 2015. *Child abuse & neglect*. 2018;86:178-183.
6. Healy J. *Your child's growing mind: Brain development and learning from birth to adolescence*. Harmony; 2011.
7. Wilson KR, Hansen DJ, Li M. The traumatic stress response in child maltreatment and resultant neuropsychological effects. *Aggression and Violent Behavior*. 2011;16(2):87-97.
8. McCrory E, De Brito SA, Viding E. Research review: the neurobiology and genetics of maltreatment and adversity. *Journal of child psychology and psychiatry*. 2010;51(10):1079-1095.
9. Child NSCotD. The science of neglect: The persistent absence of responsive care disrupts the developing brain. *Working Paper 12*. 2012.
10. Anda RF, Felitti VJ, Bremner JD, et al. The enduring effects of abuse and related adverse experiences in childhood. *European archives of psychiatry and clinical neuroscience*. 2006;256(3):174-186.
11. Corso PS, Edwards VJ, Fang X, Mercy JA. Health-related quality of life among adults who experienced maltreatment during childhood. *American journal of public health*. 2008;98(6):1094-1100.
12. Felitti VJ, Anda RF, Nordenberg D, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American journal of preventive medicine*. 1998;14(4):245-258.
13. Rothman EF, Edwards EM, Heeren T, Hingson RW. Adverse childhood experiences predict earlier age of drinking onset: results from a representative US sample of current or former drinkers. *Pediatrics*. 2008;122(2):e298-e304.
14. Dube SR, Felitti VJ, Dong M, Chapman DP, Giles WH, Anda RF. Childhood abuse, neglect, and household dysfunction and the risk of illicit drug use: the adverse childhood experiences study. *Pediatrics*. 2003;111(3):564-572.
15. Ford ES, Anda RF, Edwards VJ, et al. Adverse childhood experiences and smoking status in five states. *Preventive medicine*. 2011;53(3):188-193.
16. Wilson HW, Widom CS. An examination of risky sexual behavior and HIV in victims of child abuse and neglect: a 30-year follow-up. *Health Psychology*. 2008;27(2):149.
17. Noll JG, Shenk CE. Teen birth rates in sexually abused and neglected females. *Pediatrics*. 2013;131(4):e1181-e1187.

## Extended Testimony

18. Noll JG, Zeller MH, Trickett PK, Putnam FW. Obesity risk for female victims of childhood sexual abuse: a prospective study. *Pediatrics*. 2007;120(1):e61-e67.
19. Thomas C, Hyppönen E, Power C. Obesity and type 2 diabetes risk in midadult life: the role of childhood adversity. *Pediatrics*. 2008;121(5):e1240-e1249.
20. Brown DW, Anda RF, Felitti VJ, et al. Adverse childhood experiences are associated with the risk of lung cancer: a prospective cohort study. *BMC public health*. 2010;10(1):20.
21. Kaplow JB, Widom CS. Age of onset of child maltreatment predicts long-term mental health outcomes. *Journal of abnormal Psychology*. 2007;116(1):176.
22. Dong M, Giles WH, Felitti VJ, et al. Insights into causal pathways for ischemic heart disease: adverse childhood experiences study. *Circulation*. 2004;110(13):1761-1766.
23. Irish L, Kobayashi I, Delahanty DL. Long-term physical health consequences of childhood sexual abuse: A meta-analytic review. *Journal of pediatric psychology*. 2009;35(5):450-461.
24. Hillis SD, Anda RF, Felitti VJ, Marchbanks PA. Adverse childhood experiences and sexual risk behaviors in women: a retrospective cohort study. *Family planning perspectives*. 2001;206-211.
25. Courtney ME, Dworsky AL, Brown A, Cary C, Love K, Vorhies V. *Midwest evaluation of the adult functioning of former foster youth: Outcomes at age 26*. Chapin Hall at the University of Chicago Chicago; 2011.
26. Bennett EM, Kemper KJ. Is abuse during childhood a risk factor for developing substance abuse problems as an adult? *Journal of Developmental and Behavioral Pediatrics*. 1994.
27. Aarons GA, Hazen AL, Leslie LK, et al. Substance involvement among youths in child welfare: The role of common and unique risk factors. *American Journal of Orthopsychiatry*. 2008;78(3):340-349.
28. Hussey JM, Chang JJ, Kotch JB. Child maltreatment in the United States: prevalence, risk factors, and adolescent health consequences. *Pediatrics*. 2006;118(3):933-942.
29. Pilowsky DJ, Wu L-T. Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved with foster care. *Journal of Adolescent Health*. 2006;38(4):351-358.
30. Fettes DL, Aarons GA, Green AE. Higher rates of adolescent substance use in child welfare versus community populations in the United States. *Journal of studies on alcohol and drugs*. 2013;74(6):825-834.
31. Fuller T, Nieto M. Child welfare services and risk of child maltreatment rereports: do services ameliorate initial risk? *Children and Youth Services Review*. 2014;47:46-54.
32. Kugler KC, Guastaferro K, Shenk CE, Beal SJ, Zadzora KM, Noll JG. The effect of substantiated and unsubstantiated investigations of child maltreatment and subsequent adolescent health. *Child abuse & neglect*. 2019;87:112-119.
33. Herrenkohl TI, Leeb RT, Higgins D. The public health model of child maltreatment prevention. In: Sage Publications Sage CA: Los Angeles, CA; 2016.
34. Peterson C, Florence C, Thomas R, Klevens J. Cost-benefit analysis of two child abuse and neglect primary prevention programs for US states. *Prevention science*. 2017:1-11.
35. Proctor LJ, Aarons GA, Dubowitz H, et al. Trajectories of maltreatment re-reports from ages 4 to 12: Evidence for persistent risk after early exposure. *Child maltreatment*. 2012;17(3):207-217.

## Extended Testimony

36. Connell CM, Bergeron N, Katz KH, Saunders L, Tebes JK. Re-referral to child protective services: The influence of child, family, and case characteristics on risk status. *Child Abuse & Neglect*. 2007;31(5):573-588.
37. English DJ, Marshall DB, Brummel S, Orme M. Characteristics of repeated referrals to child protective services in Washington State. *Child Maltreatment*. 1999;4(4):297-307.
38. Chaffin M, Hecht D, Bard D, Silovsky JF, Beasley WH. A statewide trial of the SafeCare home-based services model with parents in Child Protective Services. *Pediatrics*. 2012;129(3):509-515.
39. Chaffin M, Funderburk B, Bard D, Valle LA, Gurwitsch R. A combined motivation and parent-child interaction therapy package reduces child welfare recidivism in a randomized dismantling field trial. *Journal of consulting and clinical psychology*. 2011;79(1):84.
40. WSIPP. Benefit-cost technical documentation. December 2018; [http://www.wsipp.wa.gov/BenefitCost/Pdf/3/WSIPP\\_BenefitCost\\_Child-Welfare](http://www.wsipp.wa.gov/BenefitCost/Pdf/3/WSIPP_BenefitCost_Child-Welfare).
41. Chen M, Chan KL. Effects of parenting programs on child maltreatment prevention: A meta-analysis. *Trauma, Violence, & Abuse*. 2016;17(1):88-104.
42. Casillas KL, Fauchier A, Derkash BT, Garrido EF. Implementation of evidence-based home visiting programs aimed at reducing child maltreatment: A meta-analytic review. *Child abuse & neglect*. 2016;53:64-80.
43. Michalopoulos C, Crowne SS, Portilla XA, et al. *A summary of results from the MIHOPE and MIHOPE-Strong Start studies of evidence-based home visiting*. Mathematica Policy Research;2019.
44. Guastaferro K, Lutzker JR. Getting the most juice for the squeeze: Where SafeCare® and other evidence-based programs need to evolve to better protect children. In: *Parenting and family processes in child maltreatment and intervention*. Springer; 2017:141-163.
45. Guastaferro KM, Lutzker JR, Graham ML, Shanley JR, Whitaker DJ. SafeCare®: Historical perspective and dynamic development of an evidence-based scaled-up model for the prevention of child maltreatment. *Psychosocial Intervention*. 2012;21(2):171-180.
46. Viswanathan M, Fraser JG, Pan H, et al. Primary care interventions to prevent child maltreatment: updated evidence report and systematic review for the US Preventive Services Task Force. *Jama*. 2018;320(20):2129-2140.
47. Black DA, Heyman RE, Slep AMS. Risk factors for child sexual abuse. *Aggression and violent behavior*. 2001;6(2-3):203-229.

Chairwoman BONAMICI. Thank you for your testimony, Professor Jackson.

I now recognize Ms. King for your testimony.

**STATEMENT OF JUDY KING, MSW, DIRECTOR, FAMILY SUPPORT PROGRAMS, WASHINGTON STATE DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES, OLYMPIA, WASHINGTON**

Ms. KING. Good afternoon, Chair Bonamici, Ranking Member Comer, and members of the subcommittee. I appreciate the opportunity to speak to you today about community-based child abuse prevention or CBCAP. I serve as the Director of Family Support Programs at Washington State's new Department of Children, Youth, and Families, and I am the CBCAP State lead in Washington.

Thanks to CBCAP, Washington State served 1,698 parents and 2,153 children with family support services in 12 out of 39 counties last year. We still have a long way to go in reaching all of the children and families who could benefit from CBCAP services and systems building efforts, but that task would be difficult and less effective without CBCAP funding.

Brain science tells us that laying a strong foundation early in life critically impacts healthy development. Science also tells us that addressing trauma at the individual, family, and community levels allows us to prevent bad things from happening, promotes strength in children and families, and intervene early. In our everyday work, this means we notice the important things. We identify the tremendous stress, pressure, and uncertainty that leaves parents feeling alone, unconnected, and ashamed.

CBCAP is designed to create environments where families get the support they need before harm occurs. This supports children on a positive trajectory to reach their full potential in school and life. This work includes parental skills building, voluntary home visiting programs, self-help programs, coordination and connection with mental health, and substance use services and other family supports.

Prevention requires a highly integrated, multi-systemic public health approach. Just as we don't wait for someone to show signs of the flu before we encourage them to get a flu shot, we shouldn't wait for warning signs that a family needs support before making sure they have that support.

In 2018, Washington's newest state agency formed combining the strengths of an early learning department and child welfare services into one unified agency. A two-generation approach informed by brain science leverages CBCAP funding for families receiving TANF benefits to offer home visiting services and parenting education. Experiencing success in education, employment, and parenting can break the intergenerational cycle of poverty. We offer specific programs shown to be effective with tribal populations and are working extensively to build pathways for new moms to get the support that they need while experiencing perinatal mental health challenges like postpartum depression.

These are a few examples of how my state uses its CBCAP funding. As a chapter of Prevent Child Abuse America and member of a National Alliance of Children's Trust Funds, I have a front row



seat to witness the extraordinary work being done by my colleagues around the country and in each of your own states.

The flexibility in CBCAP provides options for communities to implement evidence-based, evidence-informed, and promising practices. CBCAP awardees can tailor their programs to serve the needs of their communities while evaluating programs, measuring outcomes, meeting fidelity, and adhering to implementation science principles to achieve the positive child and family outcomes. States have said they need flexibility to use federal funds to help families sooner, before serious danger arises or harm occurs.

As far as resources, CBCAP represents the main federal investment in primary prevention for the entire country with an investment of \$39 million over all 50 states in 2018. This funds prevention at \$0.53 per child per year resulting in a great deal of unmet need. The current funding in Washington State allows 10 to 12 local organizations to offer small-scale programs with more than 90 percent of qualified applicants turned away. DCYF, my agency, recently identified 23 small locales with highest rates of abuse or neglect that we are not able to serve due to funding constraints. With more funding for prevention, we would work within each community to build community-driven interventions using a targeted universalism approach to increase services available in communities at known risk. This is prevention at its best and it requires resources. The pursuit of the goal of strengthening families is through primary prevention, strong and responsive communities, and collaborative efforts among public health, early learning, and child welfare.

Every parent wants to be a good parent. They just need the tools and supports to get them there. Families describe this work as raising their children with opportunities to achieve their hopes and dreams. I say it helps families live their best lives.

I appreciate your time and attention this afternoon, and I would be happy to answer any questions you may have. Thank you.

[The statement of Ms. King follows:]

**Testimony of  
Judy King, MSW, Director of Family Support Programs  
Washington State Department of Children, Youth, and Families  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

**U.S. House of Representatives  
Committee on Education and Labor  
Subcommittee on Civil Rights and Human Services  
March 26, 2019**

**Introduction**

Good afternoon, Civil Rights and Human Services Subcommittee Chair Bonamici, Ranking Member Comer, and members of the Subcommittee. Thank you for the opportunity to testify on "Strengthening Prevention and Treatment of Child Abuse and Neglect."

I serve as the Director of the Family Support Programs Division for Washington state's newest agency, the Department of Children, Youth and Families. My Division leads our state's child abuse prevention strategy, home visiting system development, early intervention, therapeutic and trauma-informed child care, health, and early childhood mental health.

I also serve as the Community-Based Child Abuse Prevention (CBCAP) Washington State Lead, the Executive Director of the Washington State Chapter of Prevent Child Abuse America, and sit on the Board of Directors of the National Alliance for Children's Trust and Prevention Funds.

Thanks to CBCAP, Washington state served 1,698 parents and 2,153 children in FY 2018 with family support services in 12 out of 39 counties. We still have a long way to go in reaching all of the children and families who could benefit from CBCAP services and systems-building efforts, but that task would be significantly more difficult and less effective without CBCAP funding.

CBCAP grants provide critical support for locally-driven services that are essential to building healthy and thriving communities and strong families. CBCAP also supports key systems work focused on policy and practice development across the many state and local partners in prevention.

In 2017, the federal government funded CBCAP at \$39 million across the 50 states engaged in primary and secondary prevention work. The average funding received by states is 53 cents per child per year. Historically, CBCAP is the main federal investment in primary prevention for the entire country.

**Why Prevention Matters**

According to research from the Centers for Disease Control and Prevention (CDC), in the United States, at least one in seven children experience child abuse and/or neglect annually.<sup>1</sup> Studies show that the *total lifetime economic burden associated with child maltreatment is approximately \$2 trillion.*<sup>2</sup> This economic burden rivals the cost of high-profile public health epidemics such as strokes and type 2 diabetes.

---

<sup>1</sup>Fortson B, Klevens J, Merrick M, Gilbert L, Alexander S. (2016). Preventing Child Abuse and Neglect: A Technical Package for Policy, Norm, and Programmatic Activities. Atlanta, GA: National Center for Injury Prevention and Control Centers for Disease Control and Prevention (CDC)  
<sup>2</sup>Cora Peterson, Curtis Florence, Joanne Klevens. "The Economic Burden of Child Maltreatment in the United States." Child Abuse & Neglect The International Journal 86 (2018): 178-183. The National Center for Injury Prevention and Control Centers for Disease Control and Prevention (CDC).

These costs include childhood health care costs, adult medical costs, loss of productivity, child welfare costs, criminal justice costs, and special education costs. When we fail to prevent abuse and neglect from occurring in the first place, it has tremendous consequences for the child, the family, our communities, and our nation. Greater focus on prevention now yields significant cost reduction later, saving taxpayers from long-term, costly interventions while simultaneously improving outcomes for children and families.

Healthy child development is a foundation for community and economic development, as capable children become the foundation of a prosperous and sustainable society. We know that when we support parents in their critical responsibilities to help their children become healthy, successful citizens, these are the most effective decisions we can make.

#### **What is Prevention?**

To prevent child maltreatment, we must put science into action. Maltreatment and other adverse childhood experiences are linked to adult illness and early preventable death—such as cancer, cardiovascular disease, lung disease, and diabetes. The mechanisms between childhood trauma and adult disease are believed to lie in the increased rate of mental and behavioral health challenges that can impact health—depression, anxiety, serious mental illness, smoking, and substance abuse. At a population level, we see chronic health effects and serious psychosocial effects present in communities and these effects may be observed decades later, according to researchers in epigenetics and resiliency. We also know we can protect or buffer children from abuse and neglect by building protective factors in families and communities. Protective factors are conditions in families and communities that, when present, increase the health and well-being of children and families. We must strive to create environments where families get the support they need before the harm occurs, which supports children on a positive trajectory to reach their full potential in school and in life.

This is where CBCAP comes in. To be effective in supporting children and families, communities identify collaborative opportunities among the organizations that touch families' lives. Prevention requires a highly-integrated, multi-systemic public health approach.

As Associate Commissioner of the Children's Bureau and Acting Commissioner for the Administration on Children, Youth and Families Jerry Milner said:

Our challenge and opportunities lie in working across systems, be that the medical system, the mental health and substance abuse treatment provider systems, our schools, law enforcement, community organizations and all other stakeholders that come in contact with vulnerable families and providing them the support they need to stay healthy and strong. A community-based approach requires a few things. It's important to understand what life is like for families in their specific communities. What are they struggling with? What resources are available? Are there cultural practices or norms that are unique? These are all things that are known at the local level and can make a key difference in the effectiveness of interventions. The aim is to become a system to which people turn for help, not seek to avoid. There's also good reason to believe that if services were offered in more accessible, less threatening ways, by people and in places that may be familiar, such as through the auspices of a community center or a church, parents may be more likely to seek help on their own and benefit from the supports available to them. We need to resolve the problems that lead to the increased need for foster care placement.<sup>3</sup>

<sup>3</sup> "Trump's Top Child Welfare Official Speaks" The Chronicle of Social Change, November 6, 2017.

### **What is Community-Based Child Abuse Prevention (CBCAP)?**

CBCAP grants, which are authorized under Title II of the Child Abuse Prevention and Treatment Act (CAPTA) provide critical supports and strategic system-building efforts to change the context in which families live and provide the right supports at the right time. This includes parental skills-building, voluntary home visiting programs, self-help programs, coordination and connection with mental health and substance use services, and other family support services. CBCAP grants, which are structured to leverage local and private funds, are currently funded at only \$39 million per year—half of the federal authorization cap of \$80 million for all 50 states. The average funding states receive is **53 cents per child**—falling short of the funding necessary to prevent child abuse before it occurs.

### **CBCAP in Washington**

Washington state's newest cabinet-level agency, the Department of Children, Youth, and Families (DCYF), was established as a result of recommendations from a Blue Ribbon Commission focused on creating a system to better support children and families, leveraging science and community capacity with a relentless focus on preventing child abuse and neglect. Combining the strengths of an early learning department and child welfare services into one unified agency offers an opportunity for a laser focus on children growing up safe and healthy—thriving physically, emotionally, and educationally, nurtured by family and community. Launched in July 2018, DCYF is poised to accomplish this by partnering with state and local agencies, tribes, and other organizations in communities committed to these outcomes.

Brain science tells us that laying a strong foundation early in life critically impacts healthy development. Science also tells us that addressing trauma at the individual, family, and community levels allows us to prevent bad things from happening, promote strengths in children and families, and intervene early.

Within DCYF, the Strengthening Families Washington team (SFWA) serves as the child abuse prevention arm and leads all CBCAP work. CBCAP is designed to support primary and secondary prevention programs and system initiatives that reduce the incidence of child abuse and neglect, ensure optimal child health and development, and increase protective factors in families and communities. These attributes serve as buffers to Adverse Childhood Experiences (ACEs), helping parents find resources, support, or coping strategies that allow them to parent effectively, even under stress.

In our everyday work, we notice important factors affecting children and families. We identify the tremendous stress, pressure, and uncertainty that leaves parents feeling alone, unconnected, and ashamed. We focus on building capacity and connections in communities so families have access to supports that help them be strong. We provide ready access to services and support networks to meet their most pressing needs and instill hope for a bright future for their children. This is what we want for all of our children: that all children, irrespective of race or income, have the opportunity for success in school and in life.

### **Local Services to Strengthen Families**

In 2018, DCYF provided CBCAP funding to communities with a focus on quality, capacity-building, and sustainability for local prevention programs. Eleven local programs provided direct services to families, meeting a fraction of the need among Washington state communities with total funding of \$290,991. This represents only 6 to 9 percent of the annual applications received to provide evidence-based and evidence-informed programs made up of small grants of up to \$30,000 per program.

Programs funded in Washington state are typical of programs funded by CBCAP in other states throughout the country. DCYF funds programs where parenting coaches work with families to develop effective positive discipline approaches that are matched to child needs and developmental stages. Parents help their children understand and express emotions, set clear expectations, and improve family communication. This helps to strengthen parenting competencies and promote effective strategies for managing children's challenging behaviors. One of Washington state's funded sites offers classes in Spanish, which was an identified gap in their community. For families that have struggled with prior trauma related to violence, chronic stress, or homelessness, we fund an evidence-based intervention that helps families heal by fostering strong parent-child attachment, building skills to better regulate emotions and decreasing fear-based discipline practices. In a remote area of our state a local non-profit is adapting a model that has shown effectiveness in a large metropolitan area to support new mothers. The rural gatherings emphasize early attachment, adjusting to life with a new baby, and getting connected with other parents. This organization has intentionally provided concrete supports for families including food assistance, transportation and diapers. In the same rural community parents with toddlers or preschoolers learn about building social-emotional skills and early literacy skills in a parenting group tailored to meet their needs. With 29 federally recognized tribes in Washington state several of our funded programs are implementing curricula designed specifically for American Indian/Alaska Native families living on tribal lands or in large urban areas.

Across the various programs, parents often tell us they want to parent differently than they were parented. This takes learning, unlearning, and a great amount of practice. Services provided to new moms and expectant fathers build confidence and nurture parent-child attachment as they are rapidly adjusting to their new roles. CBCAP funding offers a unique opportunity to work with trusted community partners and implement specialized approaches that have promising results with specific populations. Washington state joins partners nationwide to build strong evaluation practices and build capacity to report how programs build protective factors with participating families.

#### **Public Awareness**

Another key prevention strategy is to build public awareness in an effort to reduce risk and create safe behaviors based on the best evidence available. Washington state has three ongoing public awareness campaigns which are widely integrated across our systems: Infant Safe Sleep, Speak Up When You're Down (Perinatal Mood Disorders/Postpartum Depression), and Have a Plan (Abusive Head Trauma Prevention). Washington state provides a statewide large-scale distribution as part of our birth registry system. 92 percent of the state's parent population (89,000 births per year) receive this information. Social workers, primary care providers, and early learning providers share safe sleep information to prevent infant fatalities related to unsafe sleep practices. We are now just days away from Child Abuse Prevention Month. In April, Prevent Child Abuse chapters, Trust and Prevention Funds, and CBCAP programs participate in a unified platform, the "Pinwheels for Prevention" campaign, to ignite and inspire everyday actions among parents, communities, and providers to ensure all children have a great childhood.

#### **Perinatal Mental Health Community Capacity Building**

Another of DCYF's specific efforts focuses on destigmatizing and reducing barriers that prevent families from seeking treatment for mental health issues. This effort includes building on the multi-systemic work to support Perinatal Mood and Anxiety Disorder (PMAD) awareness. These efforts include broad training for community members and partners on the unique characteristics of perinatal mood disorders, building resource guides and support groups. Besides creating

potentially life-threatening risks for moms, the effects of PMAD on maternal and family functioning can seriously undermine a child's healthy development if not treated properly. One mom in our state shared the important impact a support group had on her after she lost her job following the birth of her child due to lack of paid leave. These stresses caused anxiety and depression as she had to navigate the Supplemental Nutrition Assistance Program (SNAP), WIC, and other resources for the first time and she experienced challenges finding mental health service providers that would take Medicaid.

#### **CBCAP Systems of Prevention Work**

CBCAP state leaders work across systems to create conditions that better support families. In Washington state, the CBCAP partnership with the Temporary Assistance for Needy Families (TANF) program has fostered a strong two-generation approach informed by brain science to leverage funding for home visiting, parenting education, and skills-building for families receiving TANF benefits.<sup>4</sup>

Success in education and employment is coupled with support for the important role of parenting in breaking the intergenerational cycle of poverty.<sup>5</sup> Working with partners in the corrections system has shaped an innovative approach to the reintegration of incarcerated parents into their communities with support for parenting and life skills.<sup>6</sup> Current work in our new agency will help establish stronger early learning supports for families that have experienced complex trauma so that child care providers have access to wraparound supports for families and early childhood mental health consultation to support the well-being of children and their teachers.

#### **CBCAP in Other States**

This is just one example of how a state uses its CBCAP funding. Being fortunate to be part of Prevent Child Abuse America's 50-state chapter network and the National Alliance of Children's Trust and Prevention Funds, I am keenly aware of the great work being done around the country and in each of your own states.

The flexibility in CBCAP provides states with the ability to choose programs that make sense for their communities and to implement evidence-based, evidence-informed, and promising approaches. CBCAP awardees have the flexibility to tailor their program to serve the specific needs of their communities, identify target populations, and select which service delivery models best meet state and local needs.

These states are evaluating programs, measuring outcomes, meeting fidelity, and adhering to implementation science. They are working with evidence-based family life skills training programs to improve parenting skills, enhance family relationships, and increase children's social and life skills. They are working to increase resilience and reduce risk factors for substance abuse, aggression, depression, delinquency, and school failure as well as reduce child abuse and neglect by strengthening bonds between parents and children and increasing the use of positive parenting skills.

<sup>4</sup>Cross-System Collaboration to Better Support Babies in Washington: Strengthening Partnerships Between Temporary Assistance for Needy Families and Home Visiting Systems

<sup>5</sup><https://www.clasp.org/publications/report/brief/tanf-and-first-year-life-making-difference-pivotal-moment>

<sup>6</sup><https://cantasd.ad.hhs.gov/wp-content/uploads/Unlikely-Partnership-TK.pdf>

***States need the flexibility to use federal funds to help families sooner—before serious danger arises or harm occurs.*** Washington state has taken this monumental step and is seeing new opportunities in the partnership between early learning, child welfare, and juvenile rehabilitation.

Statistics show, in 29 reporting states, that only 12.2 percent of the child abuse and neglect fatalities were known to Child Protective Services (CPS) in the five years immediately preceding the deaths.<sup>7</sup> Extrapolated, that would suggest that 88.8 percent of those child abuse and neglect deaths were of children *never reported to CPS*. What this means is that we can't ensure the safety of our nation's children through monitoring after the fact. We must reform our systems placing value and emphasis on primary prevention strategies.

As Associate Commissioner Milner noted:

Tweaking what we have in place won't solve the problems... We need to change the focus of child welfare to primary prevention of maltreatment and unnecessary removal of children from their families. We can only break the cycle of family disruption and maltreatment by addressing the root causes of those situations.<sup>8</sup>

It is our belief that all parents can use support across the ever-changing periods of development, especially during the perinatal period when children are at the highest risk for maltreatment.

Research shows that the protective factors are linked to a lower incidence of child abuse and neglect and build family strengths and a family environment that promotes optimal child and youth development—this work is being done by CBCAP grantees successfully across the nation.

Reforms in the child welfare system need to include a primary prevention approach to child abuse and neglect. Those elements include reducing poverty, expanding parenting support services, addressing disparities, implementing coordinated multi-disciplinary efforts, and building evaluation capacity. If the current approach is modified by including preventative strategies, a deliberate reduction of child abuse and neglect becomes attainable. Efforts at the federal, state, and local levels need to address quality with the same emphasis as availability and accessibility. However, there are barriers to this success.

#### **Unmet Need**

Washington state receives more than \$1 million in requests we cannot meet each year. In FY 2017, we received 54 funding requests for community prevention programming, but we were only able to fund four new programs. Washington state is fortunate that our leaders have worked together to create efficiencies and to stretch these valuable dollars. However, as you have heard in my testimony, creating a robust community system of support for all families, service delivery, coordination, and prioritization of prevention is the only way to reduce the number of families who reach the point of needing the attention of the public child welfare and protection services.

In a recent analysis, we identified 23 small locales with the highest rates of abuse or neglect. In a strong system of prevention, we would work closely with each community and build community-driven interventions. This targeted universalism approach, where we can work to

<sup>7</sup>Children's Bureau, Administration for Children & Families, DHHS. "Child Maltreatment Report 2014." Published January 25, 2016.  
<sup>8</sup> "Trump's Top Child Welfare Official Speaks" The Chronicle of Social Change, November 6, 2017.

enrich the services available in communities at known risk, is prevention at its best, and it requires resources.

#### **State Awards Vary Greatly**

Utah has a population of approximately 3.2 million with a population-based allocation of CBCAP dollars of \$293,277 (2017). This amounts to *9 cents per person* in the state for family strengthening/prevention-based services through CBCAP/CAPTA.

South Dakota has a population of approximately 850,000 with a population-based allocation of CBCAP dollars of \$200,000 (the minimum amount any state receives). This amounts to *24 cents per person* in the state.

Funding can be used to improve the safety and stability of families by enhancing the capacity of communities to offer broad-based family and parental supports; continually improving systems through data analysis, aligning strategies across sectors to address barriers and create efficiencies; implementing and supporting strategic collaborations with traditional family-serving agencies and non-traditional partners; and engaging in multidisciplinary coordinating, monitoring, and reporting on strategies and outcomes.

#### **Building Systems and Capacity, Evaluation, Evidence-Based (EB) and Evidence-Informed Approaches, Interdisciplinary Strategies, Implementation Science**

The current approach for CBCAP funding allows states and communities to build new cross-system partnerships to advance policy and practice based on community experiences, local and state level data, and well-established and emerging research on child abuse and neglect prevention. CBCAP serves as a catalyst for—and an important supplement to—other related policy areas, including early childhood development, broad parenting supports, health care, mental health, substance abuse, jobs, and upward mobility, among many others.

By creating integrated networks of child and family services, communities have the resources to invest in infrastructure that link at all levels. Establishing these connections can help create the framework for the Family First Prevention Services Act (FFPSA), the SUPPORT Act, and other existing federal policies.

Programs in Washington state as well as across the country include a range of evidence-based and evidence-informed programming. In concert with the CBCAP requirements, states utilize CBCAP funds to both build capacity in communities and to implement rigorous programs and understand its impact on the families served. Flexibility in funding allows for continuing with these critical functions and continuing to innovate to meet the ever-changing needs of populations in the communities we partner with.

#### **Conclusion**

As you think about CAPTA reauthorization, picture this: it hasn't been reauthorized since 2010. I urge you to think about the children and think about what science tells us and what we know.

#### **What Will it Take to Get There?**

The involvement of health care and public health agencies and professionals is vital to safety for children. Well-coordinated interagency efforts are essential. We must change our current system so that it strengthens the resiliency of families as our primary intervention and gives children what they need to thrive.



The pursuit of the goal of strengthening families is through primary prevention, strong and responsive communities, collaborative efforts among organizations and groups whose work affects outcomes in child welfare, and increasing the well-being of children and families.

Every parent wants to be a good parent, they just need the tools to help get them there. Families describe this work as raising their children with opportunities to achieve their hopes and dreams. I say it helps families live their best lives. I appreciate Congress placing a high value on the importance of families.

Thank you for the opportunity to appear before you today. I appreciate your time and attention and I look forward to addressing any questions you may have.

Chairwoman BONAMICI. Thank you for your testimony.  
I now recognize Mr. Thomas for 5 minutes for your testimony.

**STATEMENT OF BRADLEY THOMAS, CEO, TRIPLE P, POSITIVE PARENTING PROGRAM, COLUMBIA, SOUTH CAROLINA**

Mr. THOMAS. Chairwoman Bonamici, Ranking Member Comer, and members of the subcommittee, my name is Brad Thomas, and for 8 years I have served as the CEO of Triple P America. I thank the committee for the opportunity to share my experience with the Positive Parenting Program which takes a primary prevention approach to child abuse and neglect.

In the four decades since CAPTA was first authorized, the U.S. has built a foundation of child welfare and safety based upon best practices, evidence, and lessons learned. Systems can always strive to improve, and we are now in a position to build upon that foundation. We believe that the current system is under significant stress because it is designed primarily to provide intervention rather than focus on the prevention of abuse and neglect before it occurs.

Costly systems have been built to deal with the conveyor belt of maltreatment, and therefore, avoidable abuse and neglect of children occurs. The child welfare system is overwhelmed, and the taxpayer is faced with the resultant cost. There is a better way, primary prevention that targets the broader population.

Notwithstanding the immediate and tragic impact of child maltreatment, it can also have long-term effects on health and well-being if not addressed. The treatment of child abuse and neglect after it occurs is significantly more expensive than the prevention of it. A study conducted by the Perryman Group estimated the lifetime impact of first time child maltreatment occurring in 2014 as costing the U.S. 5.9 trillion.

Conversely, evidenced-based models for primary prevention catch parents well ahead of adverse experiences for children. They normalize parents asking questions and ensure quick, reliable, and actionable information. Oftentimes, this can be the difference between equipping parents with the confidence to problem solve daily stresses or allowing stressful and challenging behaviors, left unchecked, to escalate for both parent and child.

The challenge, however, is building systems that can scale and achieve reductions in child maltreatment at a county or state level. There are some essential elements that make programs like Triple P work to achieve population level change. One, program design. Two, evidence based. Three, use of an existing work force. And four, cost effectiveness. Let me explain.

The most impactful programs to achieve population level effects are designed to make services available for delivery in an array of settings that suit the parent's preferences and allow parents to receive help according to their needs, not taking a one-size-fits-all approach.

Next, it is essential that programs and services are evidence-based. As an example, Triple P is the most researched parenting program in the world with over 300 evaluation papers involving more than 400 academic institutions worldwide. One such evaluation was a landmark randomized control trial funded by the CDC in 18 counties in South Carolina in 2005. During the period stud-

ied, child maltreatment rates increased by 7.9 percent in the nine controlled counties and decreased by 23.5 percent in the nine counties where Triple P was implemented. Similar patterns were found for out-of-home placements and hospital-treated child maltreatment injuries.

Training a community's existing work force to deliver parenting supports dramatically increases the speed at which a program is able to scale and leverages existing trusted relationships between parents and providers. In turn, systems that only provide supports to the extent needed and utilize a work force that is already in place saves money and resources. Independent research undertaken by the Washington State Institute for Public Policy on a range of program supports these savings. By way of example, the research demonstrates that for every dollar invested in the Triple P system upstream, there is a resultant \$10.05 in benefits downstream. In spite of proven outcomes, evidence-based models that align with primary prevention have been limited in their ability to scale due to a lack of available funding for prevention programs.

CAPTA is the main federal legislation providing population level primary prevention capacity building, so appropriate funding is absolutely critical. We applaud Congress for examining CAPTA and the prevention of child abuse and neglect generally. As Congress looks to reauthorize CAPTA, we encourage you to consider the following:

First, a focus on primary prevention designed to reach the broad population or provide both monetary savings and reduce the human toll taken on children and families exposed to abuse and maltreatment.

Second, the designation of appropriate lead agencies for CBCAP that have a demonstrated commitment to broad community prevention work such as children trust chapters, prevent child abuse chapters, and health departments may help to unfurl the streams of funding and have a more significant impact on communities.

Finally, ensuring funding is allocated to evidence-based holistic primary prevention will thereby invert and shrink the funding pyramid over time and reduce the incidence of and costs associated with child maltreatment.

I appreciate and welcome your committee's dedication to this important endeavor and stand ready to be of assistance in any and all ways possible.

[The statement of Mr. Thomas follows:]

**Statement of**

**Brad Thomas  
Chief Executive Officer  
Triple P America, Inc.**

**Before the**

**Subcommittee on Civil Rights and Human Services  
Committee on Education and Labor  
U.S. House of Representatives**

**"Strengthening Prevention and Treatment of Child Abuse and Neglect"**

**March 26, 2019**

Chairwoman Bonamici, Ranking Member Comer, and members of the Subcommittee, my name is Brad Thomas and for 8 years I have served as the CEO of Triple P America. I thank the Committee for the opportunity to share my experience with the Positive Parenting Program - Triple P, which has created better outcomes for children, teenagers and families at an individual, family and community level through a broad population-based approach to primary prevention.

In the four decades since the *Child Abuse Prevention and Treatment Act* (CAPTA) was first authorized, the U.S. has built a foundation of child welfare and safety based upon best practices, evidence and lessons learned. Systems can always strive to improve and we are now in a position to build upon that foundation. We have learned, however, from our work across the country that state and local systems addressing child abuse and neglect, and the workforce in those systems, are under significant stress. We believe that a large contributor to this stress is that the current system is designed more to provide intervention than focus on population-level primary prevention - the prevention of abuse and neglect *before* it occurs. Costly systems have been built to deal with the "conveyor belt" of abuse and neglect, instead of its prevention, creating reactive systems, designed to treat the symptoms of the issue but not the cause. By not focusing on

prevention, avoidable abuse and neglect of children occurs, the child welfare system is overwhelmed, and the taxpayer is faced with the resultant cost. There is a better way: primary prevention through a community-wide approach that targets the broader population.

#### *Importance of primary prevention*

We know the damage that child abuse and neglect can have on children. Notwithstanding the immediate and tragic impact of child maltreatment, it can also have long-term effects on health and wellbeing if not addressed (for example, it may manifest in substance abuse, delayed brain development, lower educational attainment, and limited employment opportunities). According to numerous studies the cumulative cost of child maltreatment is significant. For example, a study conducted by the Perryman Group<sup>1</sup> estimated the lifetime impact of first-time child maltreatment occurring in 2014 as costing the U.S. \$5.9 trillion. The treatment of child abuse and neglect *after* it occurs is significantly more expensive than the prevention of it.

Conversely, evidence-based models for primary prevention catch parents well ahead of adverse experiences for children. They normalize parents asking questions and ensure quick, reliable and actionable information, and often times are the difference between equipping parents with the confidence to problem-solve daily stressors or allowing stressful and challenging behaviors left unchecked to escalate for both parent and child. Over 7 million children were involved in maltreatment investigations in the U.S. in 2017 - primary prevention has been demonstrated to drastically reduce abuse and neglect and can be implemented and begin to take effect quickly. More of a focus on primary prevention can remove the unnecessary trauma

---

<sup>1</sup> The Perryman Group. (2014). *Suffer the little children: An assessment of the economic cost of child maltreatment*. Retrieved from [https://www.perrymangroup.com/wp-content/uploads/Perryman\\_Child\\_Maltreatment\\_Report.pdf](https://www.perrymangroup.com/wp-content/uploads/Perryman_Child_Maltreatment_Report.pdf)

experienced by our children - and the long-term effects of maltreatment - while also providing significant savings to our systems and the taxpayer.

*Designing effective systems*

While the importance and benefits of primary prevention are understood and supported by research, the challenge is building systems that can scale and achieve reductions in child maltreatment at a county or state level.

The most impactful programs to achieve population level effects are designed to provide a range of parenting supports to the general population, tailored to the needs of the community, to work with all kinds of families and cultures. In our experience, services that are primarily focused on child abuse and neglect prevention, but that may also be tailored for both prevention and intervention, such as Triple P, achieve the most positive population level results. When creating a system, it must be built with those that it is serving in mind to be effective, and should be designed to overcome the many barriers that exist to providing quality parenting support, and in turn reducing child maltreatment:

1. Provision of support: Not all parents are alike and differ in their preferences for parenting supports. It is important to make services available for delivery in an array of settings that suit the parent e.g. in-person (individual or in a group setting) or 24 hour online supports.
2. Intensity of support: Parents should receive help according to their needs and their stated desire to receive it. The majority of parents need what we call “light-touch” low-intensity support. Some need more. A one-size fits all approach does not work for the broader population. For example, Triple P is designed to provide the level of support needed by

the parent – not too much, not too little. Importantly, our program requires the parent to take ownership of the goals for their family and trained providers give them the tools to achieve those goals.

With research indicating child maltreatment may be more than 40 times higher than official records, large scale parent engagement is essential to achieving population level reductions in child abuse and neglect. Therefore, the importance of a program's design to have community-wide reach cannot be overstated. Parents are unlikely to engage with a program that doesn't fit into their lifestyle or preferences. It is counterproductive to invest in programs that may contain good content but do not resonate with their intended audience.

#### *Evidence-based*

Another essential component for the reduction of child abuse and neglect is ensuring that programs and services that receive federal funding to achieve this goal are evidence-based. Children, parents and communities need services that have been proven to work. Available financial resources cannot be spent on programs that have not been demonstrated to work.

As an example, Triple P is the most researched parenting program in the world. There are over 150 randomized-controlled trials, 300 evaluation papers, involving more than 400 academic research/institutions worldwide. Triple P is also recognized in the Child Welfare Information Gateway as a successful primary prevention strategy. It is one of only two parenting programs identified by the World Health Organization (WHO) as being supported by the strongest evidence for a parenting program's ability to prevent child maltreatment.<sup>2</sup> It is because of this research and

---

<sup>2</sup> World Health Organization (2009). *Preventing violence through the development of safe, stable and nurturing relationships between children and their parents and caregivers. Series of briefings on violence prevention: The evidence*. Geneva, Switzerland: WHO

evaluation that we are able to accurately assess what is working and what is not, and implement only those services that demonstrate positive outcomes.

One such evaluation was a landmark randomized control trial funded by the Centers for Disease Control and Prevention (CDC) in 18 counties in South Carolina in 2005, which demonstrated county-wide reductions in child-maltreatment prevalence rates.<sup>3</sup> During the period studied, child maltreatment rates *increased* by 7.9% in the 9 control counties and *decreased* by 23.5% in the 9 counties where Triple P was implemented.<sup>4</sup> Similar patterns were found for out-of-home placements and hospital-treated child maltreatment injuries. Astoundingly, population-level changes were observed within two years of Triple P being implemented. To combat child maltreatment effectively, only programs and services that have the evidence to prove that they work should be employed.

#### *Existing workforce*

An important design factor that our model incorporates and that we suggest might be considered, is training a community's existing workforce to deliver parenting supports, for example, primary care providers, school guidance counsellors and social workers. This dramatically increases the speed at which a program is able to scale, and leverages existing trusted relationships between parents and providers.

---

<sup>3</sup> Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2009). *Population-based prevention of child maltreatment: The U.S. Triple P system population trial*. *Prevention Science*, 10(1), 1–12. doi: 10.1007/s11121-009-0123-3

<sup>4</sup> Prinz, R. J., Sanders, M. R., Shapiro, C. J., Whitaker, D. J., & Lutzker, J. R. (2016). *Addendum to "Population-based prevention of child maltreatment: The U.S. Triple P system population trial"*. *Prevention Science*, 17, 1-7



*Cost effective*

To this end, systems that only provide support to the extent needed and utilize a workforce that is already in place, save considerable amounts in salaries that are often associated with “traditional programs.” Independent research undertaken by the Washington State Institute for Public Policy on a range of programs supports these savings. By way of example, the research, demonstrates that for every dollar invested in the Triple P system upstream, there is a resultant \$10.05 savings downstream.<sup>5</sup>

*Scaling and CAPTA*

In spite of proven outcomes, evidence-based models that align with primary prevention have been limited in their ability to scale due to a lack of available funding for prevention programs. CAPTA is the only federal legislation providing population-level primary prevention capacity building, so appropriate funding is absolutely critical. Funding to date has largely come from siloed systems designed to focus on treatment over prevention.

We applaud Congress for examining CAPTA and the prevention of child abuse and neglect generally. As noted by the Associate Commissioner of the Children’s Bureau at HHS, Jerry Milner: “Tweaking what we have in place won’t solve the problems....we need to change the focus of child welfare to primary prevention of maltreatment and unnecessary removal of children from their families. We can only break the cycle of family disruption and maltreatment by addressing the root causes of those situations.”<sup>6</sup> As Congress looks to reauthorize CAPTA we encourage you to consider the following:

---

<sup>5</sup> Washington State Institute for Public Policy. (2018). *Benefit-cost results*. Retrieved December 2018, from <http://www.wsipp.wa.gov>

<sup>6</sup> “Trump’s Top Child Welfare Official Speaks” *The Chronicle of Social Change*. November 6, 2017

1. Focus on a primary prevention approach designed to reach the broad population

Certain situations (for example, poverty and substance misuse) can increase the risk of child maltreatment; however, even well-resourced families need effective parenting support as they are not immune to stressors that can lead to maltreatment. An approach that reaches a broader section of the population is therefore needed. Limiting support to just the home setting, although effective and an important piece of the puzzle, is a barrier to providing supports to the full population because many parents are hesitant to receive services in their home, and broad parent reach cannot be achieved due to the cost of home visiting. The blended approach and flexible use of destigmatizing communications campaigns, individual support, seminars, group support, online programs, and providing services where parents interact, such as the primary care provider's office, schools and place of worship achieves extensive community reach.

2. Designate appropriate lead agencies for CB-CAP

To ensure that the goals of this important legislation are achieved in practice, consideration should be given to legislative mechanisms that require funds to flow to lead agencies that have a core focus, understanding, and demonstrated commitment to broad community primary prevention work such as Children's Trust chapters, Prevent Child Abuse chapters, and/or Health Departments. To accomplish this, we suggest that Title II instructs the lead agency to utilize the funds in a way that focuses on evidenced-based primary prevention work at a community level.

3. Ensure funding is allocated to evidence-based primary prevention

Data supports the cost-savings that flow from investment in primary prevention. From a budgetary perspective though, the short-term challenge is how to invest in primary prevention while continuing to fund services for families in need. There is an urgent need for system reform, creating smarter systems. Funding for treatment programs that are not evidence-based or not delivering results should be diverted to evidence-based prevention. Systems need to be reformed and better coordinated. This approach may go some way to addressing the funding gap, but the data also supports that even if there is a short-term overall increase in the funding of prevention and treatment, in the medium term, costs will reduce if programs like Triple P are implemented. This is because results flow quickly and generate cost savings. The goal would be to invert and shrink the funding pyramid overtime, so that broad population primary prevention strategies are appropriately funded to substantially reduce the incidence of, and costs associated with treatment of child abuse and neglect.

I appreciate and welcome your Committee's dedication to this important endeavor and stand ready to be of assistance in any and all ways possible.

Chairwoman BONAMICI. Thank you for your testimony.

And finally, Mrs. Rose, thank you so much for being here. I recognize you for 5 minutes for your testimony.

**STATEMENT OF LACRISHA ROSE, FACILITATOR OF THE WEST VIRGINIA CIRCLE OF PARENTS NETWORK, TEAM FOR WEST VIRGINIA CHILDREN, MIAMI WEST VIRGINIA**

Mrs. ROSE. Thank you. Good afternoon, Madam Chair Bonamici, Ranking Member Comer, and members of the committee. Thank you for the invitation to be here today.

My name is LaCrisha Rose, and I live in Cabin Creek with my husband and three children. I am employed by TEAM for West Virginia Children where I facilitate a program with mutual self-help groups on the state level using the Circle of Parents model. And today I would like to talk to you about why the reauthorization of the Child Abuse Prevention Treatment Act is important for families like mine.

Have you ever found yourself wondering or wishing that someone would sit down with you and help you be a better parent? That is exactly how I felt when my husband and I found ourselves facing the same challenges that our parents had before us. And just like most first-time parents, you use the methods that were used on you as a child. But that didn't work for us. So the more I spanked my child, the worse his behavior became.

One day I joined a local play group at the Sharon Dawes Elementary School through the Starting Points Family Resource Center, right by our home. Talking with other parents made me feel like I wasn't alone, and I really enjoyed learning about my child's brain development. Eventually I signed up for other programs at the Starting Point Center such as the home visitation program with Parents as Teachers, and it was through building a trusting relationship with my home visitor that allowed me to reach out for help with my concerns surrounding discipline.

My home visitor was wonderful. She provided me with tons of positive parenting solutions such as time in versus time out, getting down to my son's level and looking him in the eye. She encouraged me to look at these tools like tools in a toolbox. And some of the concepts were so simple, but yet, they never crossed my mind. Maybe that is because the only tool I ever had in my toolbox was a hammer, so everything looked like a nail.

A couple months later I was at a group exercise for the Circle of Parents, and I had to play the role of a parent who lost her child due to harsh physical punishment. And this hit me like a ton of bricks because the only difference between that parent's outcome and my own was prevention.

This sparked a fire inside of me and made me realize that I needed to pay it forward, and so I started to climb the parent leadership ladder. I became a home visitor for the Parents as Teachers program in my local community, and then I started to facilitate the Circle of Parents groups at a state level. Then I was invited to become the co-chair of the Alliance National Parent Partnership Council.

But my favorite achievement on my journey was becoming certified to deliver the same program that saved my life, the Strength-

ening Families Protective Factor Framework of bringing the framework to life and your work. Sorry. This snowball effect has led me here today.

Growing up, my parents worked very hard but yet struggled to provide my brother and I with the best life that they could. And today families continue to struggle, but local prevention programs help families like mine succeed. Prevention matters, and it can be used in all families, so here are my hopes.

I hope that something I have said here today helps you recognize the importance of increasing the resources that are available to families. Currently Congress invests about \$0.53 per child annually across the Nation. We can do so much better. It would be great if we could increase that to \$0.53 per child per month versus annually.

I hope that you hear more testimoneys in the future with happy endings like mine due to the efforts of prevention that you have created and supported. And I hope that 1 day my children will be able to stand here in front of you and thank you for listening to their mother's story and tell you about the lives of their children and how much richer they are because of the decisions you make in the next coming days.

Thank you for your time here today and letting me tell you what I believe helps build strong families; yours, mine, and all the families across the Nation.

[The statement of Ms. Rose follows:]

**Testimony of  
LaCrisha Rose, Parent  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

**U.S. House of Representatives  
Committee on Education and Labor  
Subcommittee on Civil Rights and Human Services  
March 26, 2019**

Good afternoon, Madam Chair Bonamici, Ranking Member Comer, and members of the committee. Thank you for the invitation to be here today. My name is LaCrisha Rose. I currently reside in Cabin Creek WV with my husband and three children Remington, Sawyer and Meadow. I work for TEAM for WV Children facilitating a network of peer to peer mutual self help groups using the Circle of Parents model. I would like to share a glimpse of my story in hopes for helping you understand what the re-authorization of the Child Abuse Prevention and Treatment Act means for families like mine.

I want to start by asking you a few questions. Have you ever felt overwhelmed? Have you ever wished that someone would sit down with you and help you to be a better parent? That is exactly what I wished for when I became a parent and found myself walking down the same path that my parents, and many of you, have walked down. Growing up my family struggled. My parents worked hard to provide us with the best life that they could, with the resources they had. Life for my family was good until one day my father came home from the mine and handed my mother a pink slip and at the very same time she handed him a positive pregnancy test. With no job and a baby on the way, things became tough. The instability of employment of the mining industry caused a roller coaster effect on our lives.

The more challenges we had, the more responsibility I took on as a big sister. I helped wipe away my little brother's tears and looked after him, but over the years keeping him safe took on new meaning. Sometimes keeping him safe meant taking the blame for something that he did or didn't do, so I would take a whipping instead of both of us. Other times keeping him safe meant us crawling out my bedroom window and visiting my grandparents' house next door, so that he wouldn't hear all the yelling in the next room. No matter what, keeping my little brother safe was my top priority. Life was hard for us, but my parents loved us and did the best they could with the tools they had.

Today families continue to struggle with various challenges, but community based programming helps families to have options so making positive parenting choices becomes easier when facing adversity.

In August 2008 my now husband and I were about to welcome the first great grandchild from my generation into our family. Life was good for our little family until my husband brought home a pink slip from the mines, and I was headed down the same path my parents had walked down before. With no income and a baby at home, we struggled. Like many other families, when it came to disciplining our son I repeated the same technique that my parents used to discipline me. The more I spanked my son, the worse his behavior became. As I laid in the bed at night crying, I finally understood from a parent's perspective what my father meant when he would say "This is going hurt to me more than it hurts you." I felt so alone.

One day I saw an ad in the newspaper advertising a playgroup at The Starting Points Family Resource center at our local elementary school. I really enjoyed learning about my son's healthy brain development. The director of the center extended an invitation for me to participate in the Parents as Teachers Home Visitation Program, and I politely declined. I didn't know her that well and I wasn't fond of the idea of someone coming into my personal space and being judgmental. In addition to attending playgroups, I started attending a peer group on Fridays. This helped my child with separation and attachment and allowed me to discuss the challenges and successes surrounding parenting over a cup of coffee. Once again, I was encouraged to participate in the Parents as Teachers Program from my peers and decided to give it a try. I polished my home from top to bottom in preparation for my home visitor's arrival. Our first visit mirrored playgroup, but was tailored to the individual needs of our family. Building a trusting relationship with my home visitor over time gave me the confidence to reach out for help with my concerns surrounding the discipline of our son. I knew there was a chance that my home visitor may have to call Child Protective Services but I was scared, alone and willing to take the chance for help. I know now that I was nowhere near a Child Protective Services call, but I was afraid at the time.

My experience with my home visitor was nothing less than phenomenal. The way my home visitor responded was everything I could have hoped for and more. It was as if I had asked a neighbor for a cup of sugar. She armed me with dozens of positive discipline options. She encouraged "time in" versus "time out", connection instead of correction, and how to use a positive rewards chart to point out his strengths. It was so simple, yet it had never occurred to me. She explained it to me as if it were like a toolbox. Not all tools were universal and I would have to try different tools depending on the situation or behavior. She also helped me understand how my temperament could influence the effect of outcomes. My parents and in-laws participated in home visits as well. It was nice seeing the grandparent toolbox come to life. I continued to fill my toolbox with all the possible tools that I might need to use in the

future. As I started to dig deeper, I learned that the Strengthening Families Protective Factor Framework was at the root of every tool in my toolbox and all the community based programs that had helped our family. It was nice focus on strengths for a change. This sparked a fire inside of me.

In 2012 the director of the Starting Points Family Resource Center asked me to accompany her to a workshop to pilot a program called “Circle of Parents.” The Circle of Parents was much like the peer group that I attended Fridays. During a group exercise, I was asked to play the role of a parent who had lost custody of her child due to using harsh physical punishment as a means of discipline. It was then that I came face to face with what could have been my life had I not chosen to reach out for help. It hit me like a ton of bricks. The only difference in the outcome of my former self and the role play parent was PREVENTION. (Community Based Programming using the Strengthening Families Protective Factor Framework to prevent child abuse and neglect.)

After that experience I decided it was time to pay it forward. I realized that society as a whole had a responsibility to help other parents like me, and I wanted to be part of that. One year after that workshop, I became a home visitor for the Parents as Teachers Program. I started taking on bigger roles to help shape policies affecting local families. I began taking evidence-based training in programs such as Triple P (*Positive Parenting Program*) and in 2015 I was asked to facilitate the West Virginia Circle of Parents State Network. My favorite personal achievement was becoming certified in the national training of *Bringing the Strengthening Families Protective Factors Framework to Life in Your Work*, after being nominated to join the Alliance National Parent Partnership Council. Being a part of the council has helped me understand the bigger picture of prevention and how policy can affect change for the future of our nation’s children. I currently serve as a co-chair of the council and have a seat as a board member for the National Alliance of Children’s Trust and Prevention Funds. This snowball effect has led me here today.

Although I wish I were a perfect parent, I feel comfortable saying that I am a much better parent today than I was in 2008. I have to work on building the protective factors every day. There are several instances throughout my life when throwing in the towel might have been easier. I can definitely understand why some folks are drawn to the dark side to sometimes make poor decisions. One of the hardest times for our family was the loss of our daughter, Liberty. Tragically, she passed in utero due to medical complications before we ever had the chance to know her. It would have been very easy to let that kind of pain tear our family apart and possibly make me neglect our family. Instead we chose to completely rebuild resilience,



rely on concrete supports, social connections and talk about feelings with our children to make our family stronger.

**Some of the things I have learned since reaching out for help are...**

- ... If the only tool in your toolbox is a hammer, everything looks like a nail!
- ... The Strengthening Families Protective Factors Framework saved my life.
- ... When faced with the exact same challenge as my parents with pink slip from the mines while awaiting the birth of our second child, I had support and toolbox full of resources.
- ... PREVENTION MATTERS and it can benefit all families
- ... Currently, Congress invests about \$.53 per child<sup>1</sup> in prevention supports each year for my children and others across the country. This is wonderful, but we can do better so that other children and families can gain the benefits that my family achieved.

**My hopes for action upon my departure here today are that...**

- ... Something I have said here today sticks with you in recognizing the importance in considering increasing the resources available to all families throughout the country.
- ... In the future you hear more testimonies with happy endings because of prevention efforts that you have helped create and support.
- ... That one day, my children will stand before you thanking you for listening to their mother's story and share how much richer the lives of their children are because of the decisions that you made in the next coming days.

Thank you so much for the opportunity to speak to you today about what I believe helps build strong families-yours, mine and all the families across the nation!

---

<sup>1</sup> This calculation is based on US Census Bureau estimates that there are 73,939,840 children in the United States. Meanwhile, the total CBCAP appropriation for last year was \$39 million. This equates to \$0.53 per child across the nation. Source: <https://www.census.gov/quickfacts/fact/table/US#>

Chairwoman BONAMICI. Thank you very much for your testimony. What a wonderful example of how you can break the cycle, and we really appreciate your being here and sharing your own personal story.

Under committee rule 8(a), we will now question witnesses under the 5-minute rule. As chair, I will start and be followed by the ranking member, and then we will alternate between the parties.

Ms. King, thank you for discussing the importance of the federal community-based child abuse prevention grants and your agency's prevention work in Washington State, my neighbor to the north. We know that child abuse and neglect is preventable, and yet, as you mentioned in your testimony, the grants are currently funded at half of the federal authorization cap.

In my home state of Oregon, the CBCAP grants are critical to supporting key prevention activities. In the Fiscal Year 2018, we got \$280,000. That is it. That is not nearly enough to meet the needs. So can you talk about how increased federal investment in the CBCAP grants would benefit your state's work and the work of other states on prevention?

Ms. KING. Sure. Thank you. It is an interesting experience for us because we provide very small grants for small scale programs with our CBCAP funding, approximately \$30,000 to \$40,000 per program that is involved for a 3-year cycle. We end up only funding three to four new programs per year with usually asks coming in from communities for between \$800,000 and a million dollars. So just the nature of communities that are ready to be implementing services needs in their communities have models are going to work, we see a tremendous need.

I also discussed briefly that we have identified 23 locales. Think about neighbor—a little larger than a neighborhood but not as large as a subcounty that really have some of the highest risk, and what we would like to do in the future is figure out how to embed more programs and services, not just prevention but early learning and other types of support services in those communities driven by the community, and that something to do that deeper work we can't do with current funding as well.

So I would say we have a lot of unmet needs and a lot of communities ready to take action.

Chairwoman BONAMICI. Indeed, thank you so much. I mentioned in my opening statement, the opioid crisis, and I am very concerned about the increase in the rate of child abuse and neglect, and some of it, you know, we have in conjunction with conversations about the opioid crisis.

I remember in Oregon, listening to the story of a woman who became addicted to opioids—well, they were prescribed to her following a C-section, and then when she ran out of her prescription, went to the streets, lost her kids for a while. And it was hard work to get them back. And I have seen—so we hear tragic stories like that across the country, but I have seen promising programs to support these families, for example, Health Share of Oregon, a coordinated care organization in Portland, provides integrated care for mothers with addiction and their children, some of whom are born with withdrawal symptoms.

And another project—program called Project Nurture that supports families during their pregnancy for a year, and then after the child is born, they receive substance abuse treatment, mental health services, and parenting resources. And the majority of mothers who have participated in the program are now parenting successfully.

So what more can be done at the federal level to address this increase in child abuse and neglect that is exacerbated by the opioid crisis and support those families? I think I will start with Professor Jackson, if you have thoughts on that?

Ms. JACKSON. I think it is really important to remember that this an issue that has multi sides to it, that child abuse and neglect is not caused by one thing. There is not one situation that we can point to, that will tell us every time what is going to happen next, and so we have to be vigilant about what the data tells us.

So I think what I would encourage you to think about is really the multifaceted nature of the factors that contribute ultimately to this happening and then—and part of why we have to think about prevention in a multipronged way as well.

Chairwoman BONAMICI. Thank you.

Does anybody else have thoughts on the—especially the mothers keeping them with their kids, what is the best way to address that?

Ms. King?

Ms. KING. I would agree with Professor Jackson. I think it is a very complex problem, and it requires a complex set of solutions across those many partners. Your suggestion of the work in Oregon with really embedded-in, coordinated care on the health side, also being really supported through where dollars flow for substance use and mental health treatment. And child welfare and early learning, all having a response to this. What we know is that some of our youngest children, infants in our state—and I know many other states—are the highest percentage of children coming into the child-welfare system with a high degree of those children coming in due to substance use. And we have to look at how we can work together across the system to provide more opportunities for families.

I have had a story shared relatively recently about a family who was receiving home visiting services, had been using—hadn't screened in the questionnaire for using substances, and got to the point in her comfort level with a home visitor to say, I am afraid that my baby will be affected when it is born, and that home visitor then was able to work with that mom to do some planning, let go of some of the shame and guilt and try to help her be successful.

Chairwoman BONAMICI. Thank you. I don't mean to cut you off, but I want to set a good example because I am over time. I yield back. Thank you.

I right now recognize Representative Stefanik from New York for her questions.

Ms. STEFANIK. Thank you, Chairwoman Bonamici. I also want to thank all of the witnesses for your very important and compelling testimony today.

I wanted to particularly highlight your testimony, Mrs. Rose. Thank you so much for being here. Your statement was incredibly powerful to hear from you as a mom, and you are an example for

so many parents across this country. So thanks for your courage today and for telling your story.

I wanted to ask the panel as a whole—and anyone can answer—the data shows that neglect is the most prominent form of abuse cases. Can you talk about the different ways children are neglected that may not be obvious to viewers today or people at this hearing. And then specifically how we can structure programs to help prevent these cases of neglect.

So first the indicators of neglect, descriptions of examples of neglect, and then broadly, how we prevent neglect.

Professor Jackson, I will start with you.

Ms. JACKSON. Sure. So there is a couple different ways we think about neglect. That actually covers several different things. So it includes things like personal hygiene, physical hygiene. It includes health, so taking your child to the doctor when they need to go to the doctor. It also includes things like educational neglect, which is making sure your child goes to school. So there is a variety of different things.

Some of them are very clear from the outside. So kids who show up to school who haven't changed clothes, for example. But sometimes things are harder to see, right, so in terms of the neglect in the home environment, right, sometimes those are basic needs, kinds of things, is there enough food, right, things that a case-worker maybe could easily spot.

But there is other types of neglect that are, I think to your point, more challenging to see because they are not so obvious and physical, right? So that might be more things like emotional neglect, right, where you are not providing support—emotional support, praises, and encouragements to your child for the things that they do. Children need that. That is not extra. Children need your support. They need your praise.

And so what prevention efforts do in terms of addressing some of those harder-to-see, everyday things, is, they provide parents with education. They provide them with support of their own, so that they have the capacity to be able to support their children emotionally and socially as they move forward.

Ms. STEFANIK. Thank you.

Mr. Thomas, did you want to comment on how your program invests in preventative measures when it comes to preventing neglect?

Mr. THOMAS. Sure. And I think Professor Jackson handled that really nicely in terms of the answer. I think the emotional neglect is certainly one that is not as obvious. And a large part of what Triple P does is simply to get a parent to enjoy parenting again, and to build a stronger relationship with their child.

And there are strategies such as praise that Professor Jackson mentioned, and getting involved in activities with the child, to have that relationship and build that relationship with the child.

Ms. STEFANIK. One followup, and this may fall under the educational focus that you talked about, Professor Jackson. One of the challenges we have in the 21st century is screen time. Can you talk about whether we have invested in parenting classes or information on how technology specifically regarding the regular use of

screen time to keep kids occupied can potentially lead to harm down the road?

Professor Jackson?

Ms. JACKSON. So the short answer is yes. There is a whole area of burgeoning research on what screen time is doing and how that operates in the growing, developing brain of children, what ages children should have screens, when they shouldn't have screens, appreciating, too, that they have screens in schools, right? So that is actually—there is a good side of this, right? You see kindergartners learning faster. You see kids who demonstrate symptoms of autism able to communicate better, right? So there are—we talk about screen time, we are not always talking about video games, I think which is what a lot of times that means, when children are sort of babysat by the screen, right?

But suffice it to say, there is a growing area of research clearly pointing out what the negative effects can be in terms of the reduced capacity to pay attention, reduced capacity to be frustrated, challenges with listening and being able to follow complex commands. But this is a growing area, because clearly screens are everywhere. They are not, you know, something that we see in just the home or maybe just as a toy or an activity.

Ms. STEFANIK. And just in my remaining 30 seconds, I think it is important, when we talk about educational tools for parents, that we provide information about screen time and potential long-term negative impacts of too much screen time at an early age. So thank you very much again for the testimony and for answering my questions.

Chairwoman BONAMICI. Thank you. I now recognize Representative Trone from Maryland for 5 minutes for your questions.

Mr. TRONE. All right, good afternoon and thank you again for your testimony, Mrs. Rose. That was really important, and—so the numbers are very sobering, there is no question about it. The enactment of the Protect Our Kids Act, in January 2013, established the commission to eliminate child abuse and neglect fatalities and called on the commission to produce a national strategy and recommendations for eliminating fatalities across the country.

Chairwoman Bonamici, I would like to submit the final report, Within Our Reach, A National Strategy to Eliminate Child Abuse and Neglect Fatalities—

Chairwoman BONAMICI. Without objection.

[The information referred to follows:]LINK#2 (TRONE)

Within Our Reach: <https://www.govinfo.gov/content/pkg/CPRT-116HPRT37765/pdf/CPRT-116HPRT37765.pdf>

Mr. TRONE [continuing]. for your approval into the record. Thank you.

Dr. Jackson, the commission recommended the Federal Government create national, uniform definitions for counting child abuse and neglect fatalities and life-threatening injuries. In my state of Maryland, we recognize the value of comprehensive data and have integrated steps into our system, such as working with child fatality review teams, office of chief medical examiners, et cetera. Can you talk and speak a little bit about the importance of standardized data nationally?

Ms. JACKSON. So as a researcher, that is something that is really important to me. So I think the simplest way to explain it is that you can't further knowledge if we don't all agree on what the definition of "it" is, right? And so we all have to agree on what it is, and then we can move forward with studying it, right, and whatever that might be.

In this case, a very, very serious topic, a critical topic, to better understand the rates, prevalence incidence rates of child fatalities in the country, especially those related to child maltreatment.

So that seems almost without question to be a critically important next step for folks, to have a universal definition. If you don't have a universal definition, if we don't all agree on what that is, then we can't further our knowledge. Moreover, we can't understand why these things happen, we don't know what leads up to them, because there is a myriad of things included in the pool.

So it is important for us, if we actually want to create interventions, right, or prevention interventions, that speak to reducing those numbers, that everyone be operating out of the same definition.

Mr. TRONE. Thank you.

Last year, Congress dedicated an entire section in the SUPPORT For Patients and Communities Act to trauma-informed care. This section affirmed the importance of preventing opioid addiction. In my district the other day, over 25 percent of the babies born had opioids or alcohol in their bloodstream. Four percent were born addicted. It is mind-boggling.

So this importance of preventing this—this report will address a key element that often underlies substance abuse and the harm caused by childhood trauma. This week, we are sending a letter to the bipartisan coalition of members to the Appropriations Committee to support funding for these provisions. I hope we can continue to invest in tools to identify, understand, address, and mitigate the effects of trauma on children and families.

Ms. King, in your written testimony, you mentioned, to prevent childhood maltreatment, you must put science into action. Research tells us by the age of 3, 80 percent of the brain is done developing. So laying a strong foundation early in life is important. Could you address the importance of addressing trauma in individual family and community levels and how we have to have family serving systems be trauma-informed?

Ms. KING. Yes, I can. I think for us, especially on the early learning side of the spectrum, again during that critical time of brain development—and the critical time where children learn that their needs can be met by a caregiver—that we look at all of the places that those children and family interact with and make sure we have standards for what that looks like, to both be trauma-informed and also healing-focused. We like to look at what our settings and environments are doing to promote healing among parents and children.

One of the key strategies that has been used and is being implemented in a lot of states is building trauma-informed care in childcare and early learning settings. So we have childcare providers that understand when a child comes in and is struggling and having a hard day, that it is not aimed at the teacher, it is not

aimed at the childcare provider. It is the child working on trying to regulate their emotions and deal with some things that are happening with them.

It helps us with thinking about how we can build that capacity in our full system so that the places that those children are during the day, they get that positive experience, and build relationships with trusting adults.

Mr. TRONE. Thank you.

Chairwoman BONAMICI. Thank you.

I now recognize the ranking member of the full committee, Dr. Foxx from North Carolina, for 5 minutes for your questions.

Ms. FOXX. Thank you, Chairwoman Bonamici. And I want to thank our panelists for being here today.

Mr. Thomas, when you talk about saving \$10 on the back end for every \$1 spent on the front end, are those real dollars? And is it the federal, local, or state Government that is reaping the benefit?

Mr. THOMAS. Because the—the issue of child maltreatment cuts across so many different agencies, the benefits that flow from the investment of evidence-based programs cut across local, state, and federal funding streams.

You also see in those benefits, some of those benefits also go to the participants as well, and also the taxpayer. But it is spread across all of those different systems, such as child welfare, justice, and education, as some examples.

Ms. FOXX. Thank you. Mr. Thomas, why is it important for state and local governments to think about where these kinds of programs are housed within their systems?

Mr. THOMAS. In the case of programs like Triple P, that are focused on primary prevention, it is critical to have a fit within an agency that has, as its mandate, a focus on the broader population, and so it is important when assessing the best fit for these programs as to what is the best agency to actually deliver—or at least oversee the delivery of these programs into the community, to make sure that they can scale up effectively, and reach the broad population.

Ms. FOXX. Thank you. Pardon me. I have another question. Mr. Thomas, I believe collaboration across stakeholders is critical if any program is going to be successful in addressing the issue attempting to be solved. What kind of collaboration do you do in your program to know you understand the key triggers of abuse?

Mr. THOMAS. You are absolutely right, collaboration amongst the various stakeholders within a state's system is—or a county system, is critical. That if you were going to scale up a program at a population level, you need to have all of the—the entities involved with parents involved in that process. And so we actually spend a lot of time, when we go into a community, identifying what systems are in place, and making sure that we bring those people along, to participate in the process of bringing the program to all those various systems and to the general population.

Ms. FOXX. Thank you. I want to say to the panelists that some of us were going in and out, and I apologize for that, but we had another committee down the hall that was having votes, and, unfortunately, we had to run down and vote and then come back.

So I apologize for having been out of the hearing for some time, but that was the problem. Thank you again for being here.

Chairwoman BONAMICI. Thank you.

I now recognize Representative Hayes from Connecticut for 5 minutes for your questions.

Mrs. HAYES. Thank you, Madam Chair, and also thank you, Representative Foxx, for just the explanation that the committee—I apologize for coming in late. And I also want to thank the witnesses for being here and for your tireless work on this very issue of child abuse and neglect.

I spent the majority of my adult life as a teacher. In fact, before coming to Congress, I was a classroom teacher, a mandated reporter, so I know exactly what you are talking about. And as some of my colleagues have expressed, I also recognize that abuse is not always blatant, you know, for me it was, neglect was more of a factor, you know, and understanding and recognizing what that meant and what that looked like.

In my community, in the city of Waterbury, where I taught, generally, that was associated with addiction, and trauma from addiction that really reverberated out into the entire family. In Waterbury, Connecticut, where I was a teacher, last year, we had 85 opioid-related deaths, and in most of those families there are children who are coming to school, and they don't have a label that says, you know, my mom is an addict, or no one at home is feeding me, or my dad is in prison. And so a lot of this—it was up to the educator to have an appreciation and understanding of what they were seeing and, you know, what their responsibility was in that.

This is something that was very important to me because I was one of those kids. I grew up in a home like that. And I guess what I want to make sure—and, Ms. Jackson, my question is for you—being that we know that poverty is a risk for many of these young people, addiction is a risk, when we are responding to referrals for child maltreatment, how can we assure that we are addressing the underlying issues and not simply separating parents from children because they are poor or they don't have the—the background or the information they need?

Ms. JACKSON. Right. So I think that is a really important question, because a lot of research that has been done through the years, especially in the early years of identifying child maltreatment, looked for correlates, right, things that seem to be associated with abuse. What do these abused children and these abusive families have in common? Science has evolved tremendously since those early days, but some of the early findings are still with us, right, in terms of trying to clarify really what the active factors are.

So to be clear, we are much better now in our place and our science of knowing what are the causal factors for child maltreatment. We are very clear about those things. What we notice about those families is that they have several things in common with each other. They are not always identical, but they have several things in common. There usually is a significant difficulty in support in those families, maybe some challenges with mental illness in the parents, maybe a tremendous amount of stress in the family, maybe there is a tremendous amount of conflict in the family, lots



of different things that we could point to that are active, causal factors for child maltreatment.

Poverty is not one of them. Okay? So I get that that is where in the beginning the thing that seemed to tie a lot of people together. Right? But that actually isn't a factor that is an active ingredient in risk for child maltreatment. It is really the host of many other things that we know very well that contribute.

So what prevention does, is, it speaks to those things, it speaks to the things that the science tells us actually make a difference, right? Those things that are actually important in effecting change. The anecdotes we see a lot of still, to this very day. But as a scientist, what I am most interested in are the efforts that the prevention makes to tie to what we know actually makes a difference. So prevention will tie to things like education and conflict resolution and giving support and resources to those families, regardless of economic background.

Mrs. HAYES. Thank you. I so appreciate you saying that.

Ms. King, my next question is for you. Based on what we are talking about, how can we better prepare teachers and mandated reporters to ensure that bias is not a contributing factor when they are looking for signs and symptoms of abuse or neglect? I have seen many young people who come from families who didn't—not have a lot of money, you know, who lived in poverty, but there was an abundance of love, and parents were doing the best they could. And someone from the outside looking in at that might not see the same thing that I saw or be able to identify that this was a caring and supportive family.

So how do we ensure that our teachers, our mandated reporters, the people on the receiving end of this information, don't let their own biases get in the way?

Ms. KING. Well, I think you nailed it very carefully about the disproportionality that we see in our system, and I think that is an ongoing struggle. It is an ongoing struggle in education for teachers. It is an ongoing struggle in early learning, and in reality it is an ongoing struggle in child welfare, as well. I picked up on your comment at the beginning, thank goodness children aren't wearing a label about what they have going on at home, because we want our educators, the trusted adults that work with children, to see the strength, see their resiliency, and we want our network of the multidisciplinary approach to child well-being to respond looking at strengths.

That is the important piece, and I think that is where I see a paradigm shift happening in prevention, is, we are looking at strengths to build strong families. We have to focus on harm when it has occurred, but if we are looking upstream, we are looking at building strengths in families.

Mrs. HAYES. Thank you so much.

Chairwoman BONAMICI. Thank you. I now recognize the Ranking Member, Mr. Comer, from Kentucky for 5 minutes for your questions.

Mr. COMER. Thank you.

Mr. Thomas, I appreciated your testimony about the insight, about the principles that guide your organization. What are some

key aspects of your program that could be used by other entities to attain the success that you have seen?

Mr. THOMAS. I think the—some of the discussion previous to this focuses on that. And it is this—you don't know where child abuse is necessarily and you can't make assumptions. And so one of the elements that makes Triple P successful is that it reaches the broad population, and that way you know that you are covering families that need the services. But also using an existing work force enables us to scale up very quickly, and also it leverages off that trusted relationship that is already there, say, with a primary-care provider or a schoolteacher, and enables that advice to be given in a trusted relationship.

Mr. COMER. This next question will be for all four members of the panel. What is working now with CAPTA and what is not, briefly?

Mr. Thomas, you want to start?

Mr. THOMAS. Yes. I think there is—it is sometimes difficult for agencies that have a mandate to provide services to a specific population, to also then juggle primary prevention which takes it outside of the narrow population that they are serving and requires a focus on the general population. So where we have seen it work very well is where CBCAP moneys have flowed to children's trust, for example, in South Carolina, where they have used CBCAP money there to expand on some Triple P work and other things as well. And because they have that broader population-level focus, that is where we have seen it work exceptionally well.

Mr. COMER. Ms. King, would you like to add anything?

Ms. KING. Yes, I will add. I think, I appreciate Mr. Thomas' comments on that because I think what we have to do, is, get out of the space where we are only thinking about direct services to that more coordinated system, and the systemic efforts that we really need to have to build relationships with existing providers, existing partners that work with families, to have that message carried out in all kinds of ways.

We know that one message alone typically isn't enough. Things like safe-sleep practices, that we are working really hard on across states because we want to prevent fatalities related to unsafe sleep. We know that message needs to be embedded by lots of folks, many times, different ways, to be able to ensure that we—we have children sleeping in a safe way. So we will use that with primary care. We use it with child-welfare staff. We use it with social network messaging among families, sharing that information. Because those are the ways that we—we embed it in more of a system. So moving from individual programs to more of a system would be one of my recommendations.

Mr. COMER. Thank you.

Professor Jackson?

Ms. JACKSON. I would agree with that as well. What we really need is this integration. I think that it is the patchwork that we struggle with so much day to day, from one state to the other or one agency to the other, within the same sort of community. There is not a great deal of communication about these things. So that is another part of the frustration is that when there are things that work well, it is actually very difficult to let a large proportion of

folks who would be interested know about that in a way that they can receive it. So that is one of my recommendations as well, as we think about integration coordination and making sure we have a vehicle, a mechanism, that is an easy vehicle, a mechanism for communication.

Mr. COMER. Thank you.

Ms. Rose?

Ms. ROSE. So like they have said, as well as relationships, and not only building relationship with the family, but treating the entire family, because children grow up in families and families grow up in communities. And so to treat the whole family, and I mean from one generation to the next, you know, treating that as a whole and providing that consistent messaging that children are exposed to.

For example, my in-laws and my parents being able to sit in on our home visits and learn the same language and the same methods, ensures that no matter what environment my children are in, they have the same language, they have the same methods. And the same with our local schools and, you know, you can just go, build, build, build, build, but—so I think the consistent messaging and relationships as a whole, treat the whole family.

Mr. COMER. Thank you all very much. And I yield back.

Chairwoman BONAMICI. Thank you.

I now recognize Dr. Schrier from Washington for 5 minutes with your questions.

Ms. SCHRIER. Thank you, Madam Chairwoman.

First, Mrs. Rose, I just want to thank you so much for sharing your story, because you have personalized your story for all of us. I think—I am a pediatrician, and I still found parenting to be a challenge, and so I think we all understand how important the job is, and how little training we get for it. And it is the most important job of our lives, so thank you.

Ms. King, I am sorry I was not here to introduce you. My question is for you. As the lead CBCAP entity in Washington, you are the primary funder of child abuse and neglect prevention programs in our state. And in your testimony, you talked about a coaching program for parents. You also mentioned a two-generation approach, and I was wondering if you could talk about this coaching program for positive discipline and what the interaction looks like between the coach and the parent, between the parents and the children. Then we will see if I have time for another question.

Ms. KING. Thank you. Yes, we like to use the word parent coaching because sometimes if we use the word parent visitor or parent educator, people view it as a top-down messaging, and really coaching the parent has to do with the interaction between the parent and child that someone is helping to support. So, yes, there is pieces that have to do with knowledge, but it is actually a lot about attitudes, skills, and behavior.

So if you were working with a program that focuses on infants, you would expect that coach to work a lot on attachment issues. That serve and return, tennis term about, you know, a child making—making some communication and a parent being able to respond, starting that very early brain development.

For toddlers, I would say one of the most typical things we see with parent coaches is trying to understand what is expected of a toddler, where they are developmentally. You know, they just can't share right away. And working with toddlers on, again, regulating emotions, being able to have words for feelings, and for parents not to get triggered. So developing that capacity in parents just to be calm and be able to address what is going on with their child.

So the coaching really is about side-by-side work, noticing the strengths and building on those.

Ms. SCHRIER. Does the coach in these interactions—I am imagining them at a family's home, watching the interaction between the parents—do they model it at the same time? Do they check in afterwards and say, here is what I observed, try this next time? All of the above?

Ms. KING. Yes, I think they can. I think a lot of our programs are really trying to focus on seeing what the parent is already doing and helps the parent notice that. Again, with that notion that looking at strengths, but there is lots of side-by-side coaching because a parent, you know, wants a do-over. They got worked up and it was hard for them to deal with something with the child and to be able to say, that is okay, you know, let's think about how you could try that the next time.

So I think we get some of both, but again sort of scaffolding, sometimes it is about how a parent's experiencing their child, and sometimes it is actually about skills and behaviors that a parent needs to practice, to work with a particular age.

Ms. SCHRIER. Have you seen even maybe within a family, a difference in outcomes, kindergarten readiness, later success in life, between say the first or second child where the parent didn't have this kind of coaching and then subsequent children where they did have this kind of coaching and what that meant for a family long-term?

Ms. KING. I probably can't speak to research on that. I do know what we hear from families where they say, wow, if I only had known this with the first child—because they may not have found that trusted partner or that appropriate service when they had their first child, and the second child comes around, and there is this notion of, wow, it would have been a lot easier if only I had known.

I don't actually know if we have any research or data that is showing different outcomes by—

Ms. SCHRIER. I have another question that you might have an easier answer to. You said you have only been able to serve 12 out of 39 counties. And I was wondering if you had more resources, can you tell me where—where you would put them, either which counties or which sorts of programs expanding to different areas?

Ms. KING. Well, it is interesting. We are sort of in a unique place. I think there is a commitment to evidence-based models, and there is also really a commitment to working in communities with changing demographics, and building evidence for things that have been shown to be effective in a community. So we have 23 we have identified in this analysis, and we would really like to begin that work, planning with those communities with the solutions that they want to best meet the needs of their families. Not us choosing

the model or approach, but really having the community look at what is available to match for their needs.

Ms. SCHRIER. Thank you very much.

Chairwoman BONAMICI. Thank you. I now recognize Representative Johnson from South Dakota for 5 minutes for your questions.

Mr. JOHNSON. Thank you very much, Madam Chair.

Mr. Thomas, for almost a decade I was on the board of directors at Abbott House, which is a home for abused and neglected girls in my hometown of Mitchell. And I have seen the cost in human terms, as well as dollars and cents, in dealing—in providing a therapeutic-based approach. And so I was connected very deeply with your conversation about the importance of prevention as opposed to just treatment.

And I thought the outcomes, the data from your program, was really impressive, some of the things you mentioned. You mentioned that it was widespread deployment. I mean, give me some sense of how widespread?

Mr. THOMAS. You mean in terms of—throughout the U.S.?

Mr. JOHNSON. Yes.

Mr. THOMAS. Yes. So we have trained in over 38 states in the U.S., and one of the states that I like to highlight in terms of really scaling up within the state is North Carolina, where there is, at the moment, services being delivered in—between 40 and 50 counties with plans to scale up to the full 100 counties within the next year or two. And so programs like Triple P are built and designed to scale.

Mr. JOHNSON. You mentioned in your testimony having some—you know, a flexible and tailored approach. I would think that would make it more difficult to scale up. That's Not the case?

Mr. THOMAS. No. It is—the planning of it is the critical part. And so when you go into a community, you need to work out where the—because there are a variety of approaches from light-touch intervention through to more intensive services. You need to identify where the parents are that are likely to need to receive those services, and then you engage with those groups and train those people.

So we have invested heavily in implementation science to understand how best to roll out an evidence-based program. The trial data always shows that a program works. The next challenge you have got then, is, how do you then take that and make that work within a community. And that is where the field of implementation science has taught valuable lessons in terms of how to scale up.

Mr. JOHNSON. And you talked about using existing labor, existing professionals, which I agree, seems like it would make it much easier to scale up. When I talk to these people out in the real world, they all, without an exception, describe how full their jobs already are, how complete the demands of their profession are. I mean, how do you clear space for those people to deploy yet another intervention?

Mr. THOMAS. Often it is a case of—it is not adding on to what they do. It is a case of—particularly, I will use the example of a pediatrician. They will quite often get asked questions that are not health-related. They will get asked questions that are behavioral-related or developmental-related. And so a lot of the time they

struggle to know how to actually answer that question in an evidence-based manner. And so it is not adding to the job, but it is giving them the tools to do their job in a better way.

Mr. JOHNSON. And I don't know a lot about your curriculum or your approach, although what you described in your written testimony and verbally made a ton of sense to me. I mean, having parents engaged and, you know, playing with and experiencing things with their children, when I do that as a father, I feel far more connected with my children. I think I would assume that is a message that needs to be reinforced on a regular basis with parents so that is really sticks. You know, is that demanding too much of someone like a pediatrician?

Mr. THOMAS. No. Because when you roll out a program like Triple P, the idea is to have multiple touch points within a community—I think that was mentioned before—that the more the message is heard, the more the messages are reinforced. So if you embed a program like Triple P within a community, you will be getting similar messaging from a teacher, from a pediatrician, or a place of worship. And so when the parent is consistently exposed to that—part of what we also do is a communications strategy, and that is a large part of the program where there are messages either on the internet or radio, TV, posters, flyers, that really destigmatize the need for parenting supports, and normalize that process for asking for assistance, and also is another touch point for providing assistance.

Mr. JOHNSON. So the data suggests that what you are describing works well. Is there anything within CAPTA or other federal regulations or programs that makes it more difficult for your program to scale up and help more people?

Mr. THOMAS. No. I think the evidence we have seen is that—that the CBCAP moneys that are flowing to the agencies that have rolled out Triple P, it has worked well in that regard.

Mr. JOHNSON. Thank you very much.

Thank you, Madam Chair.

Chairwoman BONAMICI. Thank you. And I now recognize the chairman of the full committee, Representative Scott from Virginia, for 5 minutes for your questions.

Mr. SCOTT. Thank you, Madam Chair.

Mr. Thomas, you were asked about real numbers on prevention, and one of the problems with prevention generally is that the person funding the prevention program isn't going to be the one reaping the benefits. If the city could fund a nice summer program, intensive enrichment program in a community, the benefits are going to be reduced incarceration and social services, to some other agencies down the way. That is just the way it is.

But if a case goes bad and it costs a million dollars, it seems to me that somewhere along the lines, we should have figured out how to prevent it if we could.

You talked about the community—primary community prevention generally as opposed to trying to target the prevention to a small group. Can you—you just said a little bit about it. Can you say why it is important to be community-wide and not try to target it?

Mr. THOMAS. Sure. First, it is thought that there is more—it is likely there is 40 times more abuse occurring than is actually reported. And so even if you tried a targeted approach, you don't know where that abuse is occurring. And so a broader approach is critical for that reason. But also, even what you would consider typically well-resourced parents are also susceptible to abuse. And there can be triggers within any household that can lead to that abuse and neglect.

And so the other issue with targeting specific populations, you start to stigmatize those families and the program as well, when you target families in that fashion, when you are having a primary prevention focus. And so the idea is to make it widely available in order to really address child maltreatment rates.

Mr. SCOTT. Thank you.

And, Dr. Jackson, I guess one question people would have is, does prevention actually work? Are you familiar with the Nurse-Family Partnership program?

Ms. JACKSON. Yes, I am.

Mr. SCOTT. Has that been studied, and can you say a word about the results of those studies?

Ms. JACKSON. Sure. The Nurse-Family program is probably one of the oldest programs, one of the first ideas, was to have a pair of professionals or have nurses or have other types of professionals come in the house, come meet with the family and help you in the house, really starting prenatally in lots of cases, right, so with pregnant, what might be considered high-risk families, and to prepare that family for the arrival of the child and then to work with them after they left.

It has the most evidence perhaps because it has been around the longest. It has also been evaluated tremendously, but we find that that is considered to be an evidence-based program at the highest level of rigor that we have a metric for evidence.

Mr. SCOTT. And what is it? Does it reduce child abuse?

Ms. JACKSON. Well, it reduces child abuse reports. The evidence also speaks to fewer hospitalizations. Bearing in mind, too, that child abuse is several different kinds of things. Primarily what we find—

Mr. SCOTT. Does it reduce prison? Long-term, does it reduce prisons?

Ms. JACKSON. Well, I think that—that is a hard connection to make, for anything, long-term, at reducing time in prison. What we find more immediately is fewer juvenile-justice problems, right, fewer conflicts in the homes.

Mr. SCOTT. Currently each state uses its own child abuse and neglect registry to collect information, which means that if somebody has a problem in Oregon and moves to Virginia, Virginia may not know. Would creating a mechanism that allows states to share data of their child abuse and neglect registries help other states avoid problems? Ms. Jackson?

Ms. JACKSON. So—so this is a vital next step, that states be able to speak to each other. It may surprise some members of the committee to understand that actually every state has its own system and that they don't necessarily speak to each other. And they

don't—not only do they not speak to each other, they often are adversarial, in terms of sharing information.

Where we see positive indication of this, there are some, if you will, rather informal agreements, between states. They are almost always states, though, that are close to each other, on the map. And around cities that sit around a state line, right, where it makes sense to share in Kansas City between Kansas and Missouri, and more informally, right, because you have a very fluid place like that.

But it is absolutely critical, perhaps most importantly, because what we know is that being victimized, especially having a substantiated case of child maltreatment puts you at tremendous, exponential risk for another incidence of child maltreatment, right? So it doesn't go away because you move, right? The change of scenery doesn't do anything for your risk factors. In fact, it probably increases them because you are now in a place with fewer resources, fewer people you know, fewer programs that you are involved with. And it doesn't allow that new state to know what worked for you before, what services did you get before, what made a difference, what didn't work, right? So without sharing that information we set ourselves backward in terms of helping children in the country.

Mr. SCOTT. And a quick followup on the Nurse-Family Partnerships, do you have a cost-benefit ratio?

Ms. JACKSON. I believe I provided one in my written testimony.

Mr. SCOTT. Okay. Thank you.

Chairwoman BONAMICI. Thank you.

I now Representative Thompson from Pennsylvania for 5 minutes for your questions.

Mr. THOMPSON. Chairwoman, thank you so much. Thanks for this hearing, and thank you to all members of the panel here for your testimony, your experiences you bring.

Dr. Jackson, as on behalf of all my Penn State alumni, welcome to Happy Valley. We are sure glad to have you there. Welcome to the Penn State family. In your written testimony, you state that despite public health approaches—and certainly the emphasis that we have all had to child maltreatment prevention—that national rates have not fluctuated substantially over the past 15 years.

You also mentioned that the most recent report shows that the number of children investigated for child maltreatment has actually increased by 10 percent over the past 5 years, and that the number of proven child-maltreatment cases has increased by almost 3 percent.

Just—I wanted to drill down a little bit and get your impressions of why that is. Are we just more aware of these issues than we were in years past, or we really didn't have a good benchmark in the past—an accurate benchmark in the past? Or is it reflected with some of your most immediate conversations of, you know, we are not all reporting the same way? What are your thoughts on that, why that is occurring?

Ms. JACKSON. Right. So why do rates stay the same, or why do they change? It is a really great question, because it speaks to, I think, ultimately a question we want to ask about, is what we are



doing making a difference, and can that be reflected in the prevalence and incidence rates that we see reported.

So we do know a couple of things. One, the public is much more informed about child maltreatment than it ever was before, to be sure. There is many, many ways we are getting more information. Public service information within our school systems, right, so we get more information about the types of child abuse, the types of child maltreatment, so we are aware of those things.

To my knowledge, though, the number of things like the mandated reporters haven't increased, like, so we don't have more people reporting, but we do have more people who are aware, and I know particularly in the state of Pennsylvania, where lights—when lights get shone on a situation, where they are concerned about a particular incidence of child abuse—Penn State, of course, experienced this several years ago—it tends to increase the knowledge base in that particular state. So we see rates of reporting in child maltreatment in the state of Pennsylvania skyrocket, particularly. So there is some sense that that is based on education, based on information that you have given them some encouragement to share that.

But also to be clear, the risk factors for abusing your children, whether those are neglect, physical abuse, or sexual abuse, have also increased. The amount of stress that families are feeling, the amount of conflict that is present in the home, the amount of mental illness that parents are reporting, the amount of addiction that is present in this country are also contributing to those rates. And so as a clinical child psychologist those are usually the things that I am paying attention to, are those sort of active factors that speak to risk in the family, even if reports are also increasing.

Mr. THOMPSON. Thank you.

Mrs. Rose, thank you for your testimony. Excellent testimony. You know, and obviously life can be challenging. There is no doubt about it. Adversity is kind of a part of life from time to time. It comes in different degrees and shapes. Have you ever—That said, with the experiences that you have had, how can families and parents build resilience to be able to deal with that? What are some of the—I love your lessons learned—they were excellent—that you shared in your oral testimony, written testimony, you know—you know, but what else can we do, what can parents do or a family do to build that resiliency?

Ms. ROSE. Thank you for your question. So, I think back—in my written testimony, it is there—to a time when I lost a daughter, and it was a really hard time for us. And so everything I had essentially been equipped with, with the tools in my toolbox, were just kind of out the window. And really the connection and all the work that had been laid up to that point, with my children and spending time and building relationships with the family, gave me that reason to move forward.

And so when you ask about building resilience and how we can make families do that, is just through simple, everyday actions. Pointing out family's strengths. So instead of pointing out, we are so sorry this happened to you, that is being empathetic and that is helpful, but this may have happened to you, but here is, you know, not a silver lining, but here is what you are strong at as a

parent. Here is the reason why you need to move forward. Here are some things you can build upon. So not dismissing the fact of things that they may need to work on, but really building on the strengths of things that they are good at and highlighting that.

Mr. THOMPSON. All right very good. Thank you.

Thank you, Madam Chair.

Chairwoman BONAMICI. Thank you.

And I now recognize the Representative Langevin from Rhode Island for 5 minutes for your questions.

Mr. LANGEVIN. Thank you, Madam Chair and Ranking Member Comer. I want to thank you for holding this important hearing and for allowing me to sit in and question today.

And I want to thank our panel of witnesses and thank you all for the work that you are doing to promote child welfare.

Clearly, we all have a lot that we can do, and we rely on experts, of course, like yourselves, who are on the front lines doing everything you can to make sure that we are protecting our children.

I am proud to co-chair the Foster Youth Caucus with Congresswoman Karen Bass from—and several other co-chairs. And I came to these issues years ago. When I was growing up, my parents had welcomed many foster children into our home, and today it is a priority of mine. It has really helped me to be a better policymaker on these issues, to ensure that every child has a safe and loving home.

So I would like to touch on a specific issue that I became aware of several years ago, sadly, as a result of a Reuters report. It is a frightening phenomenon known as unregulated, child-custody transfers, or UCT, also known colloquially as rehoming. And it is a practice of basically transferring custody of a child, usually an adopted child, to a stranger outside the safeguards of the child welfare system, resulting basically from a failed adoption.

And I first learned about this about 5 years ago from a Reuters published report on parents who were advertising, if you can believe that, the children on online forums, often because they couldn't handle their child's behavioral issues resulting from past trauma.

Without a system of support, these parents turned to strangers, people who hadn't been—who hadn't undergone background checks, home studies, or supervision. Some children from the report ended up in homes where they were subjected to physical, sexual, or emotional abuse, not to mention the additional trauma, instability of a new placement.

Addressing UCT, of course, requires a multi-pronged approach, including increasing support services for families so that they never reach the crisis point where they feel they need to give up their child. Again, the result of a failed adoption.

Just as important, however, is the need for uniform national standards to identify and—for identifying and responding to reports of UCT. So instinctively, we know that UCT is a form of abuse and neglect, and yet on the federal level, in the vast majority of states, the law doesn't clearly treat it as such, creating confusion for child protective services when they try to investigate cases, and sometimes leaving them uninvestigated entirely.

So I would like to start, if I could, Dr. Jackson, with you. Based on your experience, can multiple home placements cause trauma for the children, and do you agree that unregulated custody transfers, which often place children in unsafe environments are a form of child maltreatment?

Ms. JACKSON. Thank you for the question. So the first part of your question is about multiple placements causing harm. So my answer to that question is, it depends on the placement. So if you are moving someone from a dangerous placement or a risky placement or unsupportive placement to some other place that is supportive, then it is a good idea. And if that environment no longer meets the needs of the child, finding a place that does is a good idea.

Now, that said, children need stability in their lives. They need that kind of basic foundation to be able to understand routine. So we wouldn't encourage it by any means, but I wouldn't give a blanket statement to suggest that multiple placements are necessarily problematic. It is all about the quality. You know, this is true when it comes to alternative care in general. The idea of it is not bad. It is the implementation that can be problematic. It is the kind of home you get placed in, it is the supported environment that you are in now that makes a difference. And if that new place is not a better place, it doesn't meet your needs, then you will continue to have difficulty.

To answer your second question, unfortunately, I am not familiar with this phenomena that you are describing, this—if I understand it correctly, this having adopted kids and saying this is not working out, and then on your own as a family, finding another place and bypassing child protective services. Unfortunately, I am not familiar with that.

Mr. LANGEVIN. Okay. Probably my time is about to expire, and I will put this one for the record. But in your testimony you mentioned the importance of coordinating efforts across the patchwork system of federal, state, and local agencies to prevent child maltreatment. How important is it to have clarity about what constitutes child abuse and neglect to this coordination, to preventing and responding to child maltreatment?

So I know my time is expired, so I will yield back, and if you would answer that question for the record—

Chairwoman BONAMICI. Thank you, Mr. Langevin. I see no other Members to ask questions, so I want to remind my colleagues that pursuant to committee practice, materials for submission for the hearing record must be submitted to the committee clerk within 14 days following the last day of the hearing, preferably in Microsoft Word format.

The materials submitted must address the subject matter of the hearing. Only a Member of the committee or an invited witness may submit materials for inclusion in the hearing record. Documents are limited to 50 pages each. Documents longer than 50 pages will be incorporated into the record via an internet link that you must provide to the committee clerk within the required timeframe, but please recognize that years from now the link may no longer work.

And now without objection I would like to enter into the record a report from the U.S. Government Accountability Office which recommended that the Secretary of Health and Human Services strengthen the data quality of child abuse and neglect fatalities and current practices leading to incomplete counts.

And a scholarly article written by researchers at the Centers for Disease Control, showing that the total lifetime cost of substantiated cases of child abuse and neglect is \$830,928 per child, which bears a total annual cost of \$428 billion to our country.

[The information referred to follows:]

Strengthening National Data on Child Fatalities Could Aid In Prevention: <https://www.govinfo.gov/content/pkg/CPRT-116HPRT37764/pdf/CPRT-116HPRT37764.pdf>



Contents lists available at ScienceDirect

Child Abuse &amp; Neglect

journal homepage: [www.elsevier.com/locate/chiabuneg](http://www.elsevier.com/locate/chiabuneg)

## The economic burden of child maltreatment in the United States, 2015

Cora Peterson<sup>\*</sup>, Curtis Florence, Joanne Klevens

National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), Atlanta, GA, USA

### ARTICLE INFO

#### Keywords:

Child maltreatment  
Economic burden  
Lifetime consequences

### ABSTRACT

Child maltreatment incurs a high lifetime cost per victim and creates a substantial US population economic burden. This study aimed to use the most recent data and recommended methods to update previous (2008) estimates of 1) the per-victim lifetime cost, and 2) the annual US population economic burden of child maltreatment. Three ways to update the previous estimates were identified: 1) apply value per statistical life methodology to value child maltreatment mortality, 2) apply monetized quality-adjusted life years methodology to value child maltreatment morbidity, and 3) apply updated estimates of the exposed population. As with the previous estimates, the updated estimates used the societal cost perspective and lifetime horizon, but also accounted for victim and community intangible costs. Updated methods increased the estimated nonfatal child maltreatment per-victim lifetime cost from \$210,012 (2010 USD) to \$830,928 (2015 USD) and increased the fatal per-victim cost from \$1.3 to \$16.6 million. The estimated US population economic burden of child maltreatment based on 2015 *substantiated* incident cases (482,000 nonfatal and 1670 fatal victims) was \$428 billion, representing lifetime costs incurred annually. Using estimated incidence of *investigated* annual incident cases (2,368,000 nonfatal and 1670 fatal victims), the estimated economic burden was \$2 trillion. Accounting for victim and community intangible costs increased the estimated cost of child maltreatment considerably compared to previous estimates. The economic burden of child maltreatment is substantial and might off-set the cost of evidence-based interventions that reduce child maltreatment incidence.

### 1. Introduction

Child maltreatment includes neglect, physical abuse, psychological maltreatment, and sexual abuse (Leeb, Paulozzi, Melanson, Simon, & Arias, 2008). In 2015, 1670 children died nationwide due to maltreatment and another 683,000 suffered maltreatment that was substantiated by authorities (US Department of Health & Human Services, 2017). Survey data suggests child maltreatment is far more prevalent, affecting an estimated 25% of children and youth age 0–17 years old (Finkelhor, Turner, Shattuck, & Hamby, 2015).

Fang, Brown, Florence, and Mercy (2012) reported in this journal the estimated lifetime per-victim cost of nonfatal and fatal child maltreatment and the associated US population economic burden based on 2008 incidence data (Fang et al., 2012). That study estimated the lifetime per victim cost of nonfatal and fatal child maltreatment to be \$210,000 and \$1.3 million, respectively, and the annual US economic burden to be \$124 billion (all 2010 USD). Since that study, new data and the recent promotion of alternative

*Abbreviations:* QALY, quality of life years; USDHHS, US Department of Health and Human Services; VSL, value per statistical life

<sup>\*</sup> Corresponding author at: Mailstop F-62, 4770 Buford Highway, CDC National Center for Injury Prevention and Control, Atlanta, GA, 30341, United States.

E-mail address: [vsm2@cdc.gov](mailto:vsm2@cdc.gov) (C. Peterson).

<https://doi.org/10.1016/j.chiabu.2018.09.018>

Received 20 March 2018; Received in revised form 20 September 2018; Accepted 24 September 2018  
0145-2134/ Published by Elsevier Ltd.

methodologies for valuing morbidity and mortality have created an opportunity to update those estimates. This study aimed to use the most recent data and recommended methods to update previous estimates of 1) the per-victim lifetime cost, and 2) the annual US population economic burden of child maltreatment.

In this study we applied three updates to the previous study's methods and data: 1) value per statistical life (VSL) methodology replaced the previous study's human capital valuation of child maltreatment mortality, 2) monetized quality-adjusted life years (QALY) methodology replaced the previous study's human capital valuation of child maltreatment morbidity, and 3) updated estimates of the exposed population based on the most recent administrative data.

### 1.1. Cost methodology updates

The two cost methodology updates (VSL and monetized QALYs) were made in consideration of recent US Department of Health and Human Services (USDHHS) guidance on methods for economic evaluation for regulatory impact analysis (Office of the Assistant Secretary for Planning & Evaluation, 2016). That guidance recommended the use of VSL to value mortality and monetized QALYs to value morbidity where appropriate data exists to do so. VSL and monetized QALYs can replace the human capital valuation method used to value mortality and morbidity in many previous cost of illness studies, including the previous child maltreatment cost study (Fang et al., 2012). Both methods for valuing morbidity and mortality—VSL/monetized QALYs and the human capital method—use a societal cost perspective; that is, both methods aim to include all measureable costs attributable to a given health condition, not only those that incur to a particular payer (e.g., health system, employer).

There is a substantial literature on methods to estimate the cost of mortality and morbidity (Office of the Assistant Secretary for Planning & Evaluation, 2016). In brief, VSL mortality valuation and QALY morbidity valuation can be ultimately based on a person's willingness to pay for a defined change in mortality or morbidity risk, while the human capital method is based on the value of lost work and other productive activities—typically assessed at an observed earnings rate—due to mortality or morbidity. A major criticism of the human capital method is that intangible costs, such as the pain, suffering, and grief experienced by a community when a person dies, are not captured (Corso, Fang, & Mercy, 2011). VSL and QALY methods attempt to capture these intangible costs and typically include mortality and morbidity valuations that are many times greater than corresponding human capital valuations.

Owing to available data, a VSL mortality value is typically applied as a single standard value in cost of illness studies to estimate the cost of one lost life (e.g., \$9.6 million as 2014 USD in the recent USDHHS guidance) (Office of the Assistant Secretary for Planning & Evaluation, 2016). A QALY is a measure of the state of health, where 1 QALY is equal to 1 year of life in perfect health (National Institute for Health & Care Excellence, 2017); health conditions with greater impairment are therefore associated with lower number of QALYs. A monetized QALY morbidity value (or, monetized QALY) can be calculated using the number of years of life lived (usually assessed using population survival probabilities; or, a life table), a VSL value, and a condition-specific QALY measure. In other words, monetized QALYs represent the cost of reduced quality of life valued at a selected VSL rate. The VSL mortality value selected for a given study therefore has a substantial effect on the study's corresponding monetary QALY valuation.

#### 1.1.1. Child maltreatment-specific value per statistical life

VSL is higher for children than for adults, and the VSL value proposed in the recent USDHHS guidance is based on average mortality at 40 years old (Hammit & Haninger, 2010; Office of the Assistant Secretary for Planning & Evaluation, 2016). VSL also varies based on the characteristics of a given disease, although given the limited number of original studies that have measured VSL, it is relatively uncommon to be able to use a condition-specific VSL in a cost of illness study. However, for child maltreatment there exists a condition-specific VSL estimate based on an original analysis (Corso et al., 2011). In that previous study, a random sample of adults ( $n = 199$ ) in Georgia was questioned in 2008 on their willingness to pay for a 50% annual reduction in the risk of a child being killed by a parent or caregiver (or, a reduction from 2 per 100,000 to 1 per 100,000 population). Based on mean estimated willingness to pay (\$148) among the respondent sample, authors reported a child maltreatment-specific VSL of \$14.8 million (2008 USD). This VSL value is consistent with previous original studies indicating that an adult's willingness to pay for a reduced mortality risk to a child is higher than for oneself; VSL for children has been estimated at \$12–15 million compared to \$6–10 million for adults (2007 USD) (Hammit & Haninger, 2010).

#### 1.1.2. Child maltreatment-specific quality-adjusted life years

It appears just one study has reported child maltreatment preference-based health-related quality of life measures that can be used to calculate monetized QALYs from a VSL value (Corso, Edwards, Fang, & Mercy, 2008). In that study, researchers used data from the Adverse Childhood Experiences Study to assess self-reported health-related quality of life among adults who self-reported childhood maltreatment ( $n = 2812$ ) anytime during age  $\leq 18$  years old compared to adults matched on demographic and economic characteristics who did not report childhood maltreatment ( $n = 3356$ ). Respondents who reported childhood maltreatment had an average marginal disutility of 0.028 QALY per year during adulthood (age  $\geq 19$ ) compared with respondents who reported no childhood maltreatment.

## 2. Methods

This study updates the estimated lifetime per-victim cost and the associated population economic burden of child maltreatment reported in Fang et al. (2012). Updates are based on VSL and QALY valuations of mortality and morbidity that replace human capital valuations (commonly referred to as lost productivity values) applied in the previous study. The cost estimates in this study include

**Table 1**  
Estimated value of reduced quality-adjusted life years among adults who were victims of child maltreatment.

| Measure                                                                                           | Value        | Source                           |
|---------------------------------------------------------------------------------------------------|--------------|----------------------------------|
| QALY decrement per year of life lived among nonfatal child maltreatment victims, by age           | 0.28         | Corso et al. (2008)              |
| Discount rate                                                                                     | 3%           | Sanders et al. (2016)            |
| Lifetime discounted QALYs associated with full health                                             | 22.8         | Calculated                       |
| Lifetime discounted QALYs associated with child maltreatment                                      | 21.8         | Calculated                       |
| Lifetime discounted QALY decrement                                                                | 1.02         | Calculated                       |
| Value per statistical life                                                                        | \$16,600,000 | Corso et al. (2011) <sup>a</sup> |
| Value per QALY                                                                                    | \$743,000    | Calculated <sup>b</sup>          |
| Cost of reduced quality of life due to nonfatal child maltreatment (or, monetized QALY reduction) | \$760,000    | Calculated                       |

Notes. 2015 USD. QALY = quality-adjusted life year; VSL = Value per statistical life.

<sup>a</sup> 2015 USD values are authors' calculations based on reference source data and unpublished supporting data from a recent report (Office of the Assistant Secretary for Planning & Evaluation, 2016), received through personal email communication (December 2017). See Supplemental File for data and calculations.

intangible costs due to pain, suffering, and grief attributable to child maltreatment experienced among victims and communities. We used the Corso et al. (2011) child maltreatment-specific VSL of \$14.8 million (2008 USD)—updated to present value \$16.6 million (2015 USD) using methods consistent with the USDHHS guidance—to value mortality due to child maltreatment. A lifetime QALY value reduction of \$760,000 (Table 1) due to nonfatal child maltreatment was calculated from the child maltreatment-specific VSL of \$16.6 million (2015 USD; from Corso et al. (2011), a lifetime reduction of approximately 1 QALY (discounted at 3% as is recommended) due to child maltreatment as calculated from child maltreatment-specific QALY data reported in Corso et al. (2008), and the US population life table (Arias, Heron, & Xu, 2017). The associated Supplemental File demonstrates all calculations and supporting data.

In addition to cost methodology updates, we applied updated child maltreatment incidence (or, number of new victims) estimates to assess the annual US population economic burden of child maltreatment in 2015, calculated as the per-victim cost multiplied by the annual child maltreatment incidence. The annual economic burden estimate reported in this study—like the previous study—therefore represents lifetime costs for victims incurred annually across the population due to incident child maltreatment.

Updated incidence data consisted of: 1) the estimated number of victims based on 2015 incident substantiated (i.e., allegation of maltreatment or risk of maltreatment was supported or founded by state law or policy), and 2) investigated (i.e., not substantiated) nonfatal and fatal child maltreatment cases from US administrative sources (US Department of Health & Human Services, 2017). We followed the previous study's method for estimating the proportion of investigated cases that represented first-time (or, incident) child maltreatment; that is, we multiplied the proportion of incident substantiated cases among total substantiated cases—both directly reported in administrative sources—by the total number of investigated cases (Fang et al., 2012). Substantiated child maltreatment is a conservative measure of incidence and is influenced by individual states' procedures and criteria for substantiation (Fang et al., 2012; Kohl, Jonson-Reid, & Drake, 2009; US Department of Health & Human Services, 2017). Notably, previous research has shown there is no significant difference in developmental outcomes for children with substantiated CAN versus those subject to an investigation but not substantiated (Hussey et al., 2005).

All dollar values are 2015 USD unless otherwise noted. A 3% discount rate was applied to all future outcomes (i.e., VSL, QALY value, and other elements of the lifetime cost per victim) (Sanders et al., 2016). Other cost elements from Fang et al. (2012) (e.g., medical care, special education, etc.) remain applicable (i.e., have not been replaced by more recent data) and were updated to 2015 values for this analysis using standard inflation methods (see Table 1 notes for sources and Supplemental File for supporting data). Following the example of Fang et al. (2012), we present annual population economic burden estimates based on two incidence estimates: 1) substantiated child maltreatment victims, and 2) investigated child maltreatment victims.

### 3. Results

The total estimated per-victim cost of nonfatal child maltreatment increased from \$210,012 (2010 USD) as reported in Fang et al. (2012) to \$830,928 (2015 USD) (Table 2). This increase is almost entirely due to using monetized QALYs (i.e., includes intangible costs due to pain, suffering, and grief attributable to child maltreatment experienced among victims and communities) in place of the human capital-based lost productivity value applied in Fang et al. (2012). This methodology change increased the estimated cost of morbidity due to nonfatal child maltreatment from \$144,360 (2010 USD) to \$760,000 (2015 USD) (Table 2). Inflation-adjusted estimates of short- and long-term health care costs, child welfare costs, criminal justice costs, and special education costs yielded modest increases in the estimated per-victim lifetime cost of non-fatal child maltreatment in this study compared to the previous study (increase of \$5276; Table 2).

The total estimated per-victim cost of fatal child maltreatment increased from \$1,272,900 (2010 USD) as reported in Fang et al. (2012) to \$16,615,186 (2015 USD) (Table 2). This increase is almost entirely due to using VSL (\$16,600,000; 2015 USD) in place of the human capital-based lost productivity (\$1,258,800; 2010 USD) value applied in Fang et al. (2012) (Table 2). The inflation-adjusted cost of medical care for victims of fatal child maltreatment yielded a modest increase in the estimated per-victim cost of fatal child maltreatment (increase of \$1086; Table 2).

**Table 2**  
Updated per-victim lifetime cost and economic burden of child maltreatment estimates.

| Source                          | Fang et al. (2012) |                    | Update (this study) |                     | Update source                                                                                                   |                                                                  |
|---------------------------------|--------------------|--------------------|---------------------|---------------------|-----------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------|
| Estimate year                   | 2008               |                    | 2015                |                     |                                                                                                                 |                                                                  |
| Cost year USD                   | 2010               |                    | 2015                |                     |                                                                                                                 |                                                                  |
| Child maltreatment outcome      | Nonfatal           | Fatal              | Nonfatal            | Fatal               | Nonfatal                                                                                                        | Fatal                                                            |
| <b>Lifetime cost per victim</b> |                    |                    |                     |                     |                                                                                                                 |                                                                  |
| Short-term health care costs    | \$32,648           | \$14,100           | \$35,162            | \$15,186            | Florence et al. (2013) <sup>a</sup>                                                                             | Corso, Mercy, Simon, Finkelstein, and Miller (2007) <sup>b</sup> |
| Long-term health care costs     | \$10,530           | \$0                | \$11,341            | \$0                 | Bonnmü et al. (2008) <sup>a</sup>                                                                               | Assumed                                                          |
| Child welfare costs             | \$7728             | \$0                | \$8399              | \$0                 | DeVought, Allen, and Geen (2008) <sup>a</sup>                                                                   | Assumed                                                          |
| Criminal justice costs          | \$6747             | \$0                | \$7333              | \$0                 | Widom and Maxfield (2001); Reynolds et al. (2002) <sup>a</sup>                                                  | Assumed                                                          |
| Special education costs         | \$7999             | \$0                | \$8693              | \$0                 | Jonson-Reid, Drake, Kim, Porterfield, and Han (2004); Reynolds, Temple, Robertson, and Mann (2002) <sup>a</sup> | Assumed                                                          |
| Productivity losses             | \$144,360          | \$1,258,800        | \$0                 | \$0                 | Not included                                                                                                    | Not included                                                     |
| Value per statistical life      | NA                 | Not included       | \$0                 | \$16,600,000        | NA                                                                                                              | Table 1                                                          |
| QALY reduction                  | \$0                | NA                 | \$760,000           | \$0                 | Table 1                                                                                                         | N/A                                                              |
| <b>Total cost</b>               | <b>\$210,012</b>   | <b>\$1,272,900</b> | <b>\$830,928</b>    | <b>\$16,615,186</b> | <b>Calculated</b>                                                                                               | <b>Calculated</b>                                                |
| <b>Economic burden</b>          |                    |                    |                     |                     |                                                                                                                 |                                                                  |
| Incidence                       |                    |                    |                     |                     |                                                                                                                 |                                                                  |
| Fatal                           |                    | 1740               |                     | 1670                |                                                                                                                 | USDHHS (2017)                                                    |
| CPS substantiated               | 579,000            |                    | 482,000             |                     | USDHHS (2017)                                                                                                   |                                                                  |
| CPS investigated                | 2,775,000          |                    | 2,368,000           |                     | USDHHS (2017) <sup>b</sup>                                                                                      |                                                                  |
| <b>Total cost</b>               |                    |                    |                     |                     |                                                                                                                 |                                                                  |
| CPS substantiated               | \$123,811,794,000  |                    | \$428,254,493,000   |                     | Calculated                                                                                                      |                                                                  |
| CPS investigated                | \$584,998,146,000  |                    | \$1,995,384,064,000 |                     | Calculated                                                                                                      |                                                                  |

Notes. N/A = not applicable. CPS Child Protective Services; QALY quality-adjusted life year; USDHHS US Department of Health and Human Services. Future costs discounted by 3%. Health care costs inflated to 2015 USD in "Update" columns using Personal Consumption Expenditures-Medical, other costs inflated using Gross Domestic Product (bea.gov/table, Table 2.5.4, [last revision 8/17/2017] and Table 1.1.4 [last revision 10/27/2017], respectively. See Supplemental File for calculations and supporting data.

<sup>a</sup> Same as source original study (Fang et al., 2012). Cost differences represent only inflation from 2010 USD to 2015 USD values.

<sup>b</sup> Following Fang et al. (2012), incident cases based on number of investigated children estimated by multiplying the ratio of first-time cases to total cases among 2015 substantiated cases.

The estimated incidence of substantiated nonfatal child maltreatment and number of investigated victims decreased from 2008 to 2015 (substantiated: from 579,000 to 482,000 victims; investigated: 2,775,000 to 2,368,000 victims) (Fang et al., 2012; US Department of Health & Human Services, 2017) (includes authors' calculation of incident investigated cases) (Table 2). The incidence of fatal child maltreatment also decreased (from 1740 victims in 2008 to 1670 victims in 2015) (Table 2). Applying the two alternative nonfatal incidence estimates (in combination with 2015 fatalities) resulted in an estimated annual US population lifetime economic burden of \$428 billion based on the number of substantiated nonfatal victims (compared to \$124 billion [2010 USD] in the previous study) or \$2.0 trillion based on the estimated number of investigated incident nonfatal victims (compared to \$585 billion [2010 USD] in the previous study) (Table 2).

#### 4. Discussion

Using updated cost methods and data, this study estimated a much higher per-victim lifetime cost of child maltreatment for victims of nonfatal (\$831,000) and fatal (\$16.6 million) child maltreatment, and a higher estimated annual US population economic burden (\$428 billion to \$2.0 trillion, depending on data source for nonfatal child maltreatment incidence) (all 2015 USD) than reported in a previous study (Fang et al., 2012) (which reported lifetime costs for nonfatal and fatal child maltreatment of \$210,012 and \$1.3 million, respectively, and an annual population economic burden of \$124 to \$585 billion [all 2010 USD]). The number of annual substantiated and investigated nonfatal victims and fatal victims decreased between the previous cost estimate (2008 incidence data) and the current estimate (2015 incidence data) but owing to methodology updates the estimated per-victim cost assessed in this study was much higher than reported in the previous study, yielding overall a higher estimated annual US population economic burden.

The increased per-victim and economic burden estimates are almost entirely due to the use of alternative methodologies (VSL and monetized QALYs) to value child maltreatment mortality and morbidity. VSL and monetized QALYs do not represent actual payments for child maltreatment along the lines of medical costs and special education costs. Instead, VSL and monetized QALY are valuations of morbidity and mortality that aim to include intangible costs such as pain and suffering experienced not only by the affected individual but the wider community. This is particularly relevant when assessing the cost of child maltreatment, which can be a high-profile and painful topic for communities.



The problem of child maltreatment offers a rather unique opportunity to apply VSL and monetized QALY estimates because previous studies reported original analyses that directly measured child maltreatment-specific VSL and QALYs (Corso et al., 2008, 2011). Applying instead the standard VSL and QALY values from the recent USDHHS guidance document (i.e., \$9.6 million VSL and \$490,000 QALY as 2014 USD)—which, as described previously, apply to mortality at average age 40 years old and are not child maltreatment-specific—would yield lower child maltreatment per-victim lifetime non-fatal (\$571,928) and fatal (\$9.6 million) costs, as well as a lower range of economic burden estimates (\$292 billion based on 2015 substantiated cases or \$1.4 trillion based on investigated cases (data not shown).

This study's estimates are limited in a number of ways. First, this analysis relied on previous estimates of health care costs, child welfare costs, criminal justice costs, and special education costs; each of these estimates has limitations as previously described (Fang et al., 2012). Applying inflation to those previous estimates to update costs to present value likely insufficiently captures cost changes during the intervening period. However, each source study for those cost estimates remains the most rigorous original analysis for each respective cost domain required to estimate comprehensively the attributable cost of child maltreatment. Second, the survey study that estimated child maltreatment-specific VSL was based on a small and narrowly defined respondent sample (Corso et al., 2011). Third, the child maltreatment QALY estimate from the selected reference study refers to quality of life experiences among adults age 19 years and above (Corso et al., 2008). Given that child maltreatment occurs at average age 6 years, the best available QALY value therefore underestimates the cost of nonfatal child maltreatment by not including quality of life reductions that occur in childhood and adolescence (Florence, Brown, Fang, & Thompson, 2013). Fourth, debate remains over appropriate methods to value mortality and morbidity in cost of illness studies. VSL and monetized QALYs are used to quantify the community-wide impact of mortality and morbidity due to child maltreatment, although should not be confused with accounting values (i.e., money paid out in response to child maltreatment or cost-savings that would occur in the event that child maltreatment were averted through prevention efforts).

Despite limitations, this study has proposed methodology and data updates to a previous rigorous estimate of the attributable cost of child maltreatment. These updates primarily aimed to account for victim and community intangible costs such as pain and suffering due to child maltreatment. This study's results suggest child maltreatment incurs a greater societal cost than previously reported. Assessing the comprehensive cost of child maltreatment is essential to contextualize the magnitude of the problem and correctly assess the value of prevention strategies. Strategies to prevent and stop child abuse and neglect and to support survivors to lessen harms are available. The Centers for Disease Control & Prevention's technical package can help communities make use of the best available evidence to prevent child abuse and neglect (Fortson, Klevens, Merrick, Gilbert, & Alexander, 2016).

#### Funding source

This research did not receive any specific grant from funding agencies in the public, commercial, or not-for-profit sectors.

#### Financial disclosures

The authors have no financial relationships of interest.

#### Conflicts of interest

The authors have no conflicts of interest.

#### Disclaimer

The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

#### Contributor statement

Cora Peterson led the study design and interpretation of results, analyzed the data, drafted and edited the manuscript, and approved the final manuscript as submitted.

Curtis Florence led the study design and interpretation of results, edited the manuscript, and approved the final manuscript as submitted.

Joanne Klevens assisted with the study design and interpretation of results, edited the manuscript, and approved the final manuscript as submitted.

#### Acknowledgements

Authors thank Amber Jessup and Daniel Lawver at Office of the Assistant Secretary for Planning and Evaluation for sharing data and calculations related to value per statistical life estimates published in: Office of the Assistant Secretary for Planning and Evaluation. (2016). Guidelines for regulatory impact analysis. Washington, DC: U.S. Department of Health and Human Services.

## Appendix A. Supplementary data

Supplementary material related to this article can be found, in the online version, at doi:<https://doi.org/10.1016/j.chiabu.2018.09.018>.

## References

- Arias, E., Heron, M., & Xu, J. (2017). United states life tables, 2014. *National Vital Statistics Reports: From the Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System*, 66(4), 1–64.
- Bonomi, A. E., Anderson, M. L., Rivara, F. P., Cannon, E. A., Fishman, P. A., Carrell, D., et al. (2008). Health care utilization and costs associated with childhood abuse. *Journal of General Internal Medicine*, 23(3), 294–299.
- Corso, P. S., Mercy, J. A., Simon, T. R., Finkelstein, E. A., & Miller, T. R. (2007). Medical costs and productivity losses due to interpersonal and self-directed violence in the United States. *American Journal of Preventive Medicine*, 32(6), 474–482.
- Corso, P. S., Edwards, V. J., Fang, X., & Mercy, J. A. (2008). Health-related quality of life among adults who experienced maltreatment during childhood. *American Journal of Public Health*, 98(6), 1094–1100.
- Corso, P. S., Fang, X., & Mercy, J. A. (2011). Benefits of preventing a death associated with child maltreatment: Evidence from willingness-to-pay survey data. *American Journal of Public Health*, 101(3), 487–490.
- DeVooght, K., Allen, T., & Geen, R. (2008). *Federal, state, and local spending to address child abuse and neglect in SFY 2006*. Baltimore: Annie E. Casey Foundation.
- Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, 36(2), 156–165.
- Finkelhor, D., Turner, H. A., Shattuck, A., & Hamby, S. L. (2015). Prevalence of childhood exposure to violence, crime, and abuse: Results from the national survey of children's exposure to violence. *JAMA Pediatrics*, 169(8), 746–754.
- Florence, C., Brown, D. S., Fang, X., & Thompson, H. F. (2013). Health care costs associated with child maltreatment: Impact on medicaid. *Pediatrics*, 132(2), 312–318.
- Fortson, B., Kleven, J., Merrick, M., Gilbert, L., & Alexander, S. (2016). *Preventing child abuse and neglect: A technical package for policy, norm, and programmatic activities*. Atlanta: US Centers for Disease Control and Prevention.
- Hannun, J., & Hasting, K. (2010). Valuing fatal risks to children and adults: Effects of disease, latency, and risk aversion. *Journal of Risk and Uncertainty*, 40(1), 57–83.
- Hussey, J. M., Marshall, J. M., English, D. J., Knight, E. D., Lau, A. S., Dubowitz, H., et al. (2005). Defining maltreatment according to substantiation: distinction without a difference? *Child Abuse & Neglect*, 29(5), 479–492.
- Jonson-Reid, M., Drake, B., Kim, J., Porterfield, S., & Han, I. (2004). A prospective analysis of the relationship between reported child maltreatment and special education eligibility among poor children. *Child Maltreatment*, 9(4), 382–394.
- Kuhl, P. L., Jonson-Reid, M., & Drake, B. (2009). Time to leave substantiation behind: Findings from a national probability study. *Child Maltreatment*, 14(1), 17–26.
- Leeb, R., Paulozzi, L., Melanson, C., Simon, T., & Arias, I. (2008). *Uniform definitions for public health and recommended data elements, version 1.0*. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control.
- National Institute for Health and Care Excellence (2017). *Glossary, Quality-adjusted life year (QALYs)*. Retrieved December 5, 2017, from <https://www.nice.org.uk/>.
- Office of the Assistant Secretary for Planning and Evaluation (2016). *Guidelines for regulatory impact analysis*. Washington, DC: U.S. Department of Health and Human Services.
- Reynolds, A. J., Temple, J. A., Robertson, B. L., & Mann, E. A. (2002). Age 21 Cost-Benefit Analysis of the Title I Chicago Child-Parent Centers. *Educational Evaluation and Policy Analysis*, 24(2), 267–303.
- Saunders, G. D., Neumann, P. J., Basu, A., Brock, D. W., Frey, D., Krahn, M., et al. (2016). Recommendations for conduct, methodological practices, and reporting of cost-effectiveness analysis: Second panel on cost-effectiveness in health and medicine. *JAMA*, 316(10), 1093–1103.
- US Department of Health and Human Services (USDHHS) (2017). *Child maltreatment 2015*. Washington, D.C. Administration for Children and Families: Children's Bureau.
- Widom, C. S., & Maxfield, M. G. (2001). *An update on the 'cycle of violence' research in brief (NCJ 184894)*. Washington, D.C.: National Institute of Justice.

Chairwoman BONAMICI. Again, I want to thank the witnesses for their participation today. What we have heard is very valuable. Members of the committee may have some additional questions for you, and we ask that you please respond to those questions in writ-

ing. The hearing record will be held open for 14 days, in order to receive those responses.

And I remind my colleagues that pursuant to committee practice, witness questions for the hearing record must be submitted to the majority committee's staff or committee clerk within 7 days, and the questions submitted must address the subject matter of the hearing.

And I now recognize the distinguished ranking member for his closing statement.

Mr. COMER. Thank you, Madam Chair, and our witnesses gave excellent testimony today on the importance of CAPTA. We know this is a critical law that helps states, local governments, and organizations save lives. We also heard that there are some improvements that can be made to improve the system and help the grantees better help families and children, changes like looking at prevention programs, focusing on ensuring local programs can serve people in a way that works for them, and collaborating with stakeholders to improve services.

I look forward to working with my colleagues on these improvements, and thank you all very much for your time.

Madam Chair, I yield back.

Chairwoman BONAMICI. Thank you, and I now recognize myself for the purpose of making a closing statement.

Thank you again to all of the witnesses for being with us. We appreciate your expertise and experiences.

Today's hearing was an important step toward strengthening our approach to child abuse and neglect. Although we have made progress in reducing some rates of child maltreatment, we cannot allow ourselves to become complacent, and we cannot allow the disturbing rise in child abuse and neglect cases to go unaddressed. This is not only a public health crisis but a threat to the future of our country.

Accordingly, Congress has the moral obligation to expand and improve the Child Abuse Prevention and Treatment Act for the new challenges facing our children, families, and communities. And we can all agree, regardless of party affiliation, that our current system needs improvement, to make sure that children are protected from immediate and long-term consequences of abuse and neglect.

And as our witnesses also reminded us today, any proposal to reauthorize CAPTA, the Child Abuse Prevention and Treatment Act, must recognize the importance of holistic solutions that prevent families and children from suffering, instead of waiting to treat children after they have been hurt.


We need to make sure that state agencies can work quickly and collaboratively with a broad range of protection and support services for all children, no matter where they are.

Everyone here knows what is on the line. We are committed to taking bipartisan steps toward a Child Abuse Prevention and Treatment Act that our children desperately need and deserve. And I look forward to working with my colleagues on both sides of the aisle to make sure that all children have a safe and healthy environment that allows them to reach their full potential. The lives and future of so many of our children and families are at stake.

With there being no further business, without objection, the committee stands adjourned.

[Additional submission by Ms. Schrier follows:]

House Committee on Education and Labor  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"  
March 26, 2019



Statement for the Record of Matthew E. Melmed, Executive Director, ZERO TO THREE

Thank you, Madame Chairwoman, Ranking Member Comer, and Members of the Subcommittee, for holding this hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect." I am Matthew Melmed, Executive Director of ZERO TO THREE. As an organization devoted to helping all babies thrive, we are particularly concerned about infants and toddlers who experience maltreatment and the utter lack of preparedness of our child welfare system to address their needs and the lack of attention to creating systems of support for families that could prevent encounters with the child welfare system in the first place. The reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA), over the years a catch-all for a broad range of ideas and requirements with little funding to carry them out, represents a chance to lay out a cohesive roadmap for changing how we do business for children and families. It could be used to create a system of family strengthening and child wellbeing, with principles that can also be used to transform the child welfare system into one that places families at the center and orients its activities accordingly. If laid out clearly, this roadmap could create community structures for more effectively implementing funding streams such as the Family First Prevention Services Act in a comprehensive way.

Most of my remarks are founded in our experience developing and implementing the ZERO TO THREE Safe Babies Court Team™ (SBCT) approach, which has worked in courts and communities from Alaska to Florida to use the science of early childhood development and the impact of trauma to transform how we work with infants, toddlers, and families in the child welfare system. Our ongoing data collection and quality improvement, combined with our firsthand experiences from this evidence-based community approach, form the basis for my recommendation as you consider the reauthorization of CAPTA: ensure the implementation of comprehensive approaches at the state and community level that channel the collective impact of systems, services, and advocacy organizations to support healthy communities, families, and young children.

We believe that a re-envisioned CAPTA could lay the groundwork for such a systemic approach to building a continuum of services for families. In concrete terms, this means that in Title I, the State grants for children entering Child Protective Services, should be focused on creating a community structure that wraps around the child and family. In Title II, often thought of as the "Prevention title," it means reframing our thinking as strengthening families and ensuring access to parenting support and other services that families need to nurture their children and promote healthy development. In terms of detailed recommendations, ZERO TO THREE is part of the National Child Abuse Coalition and had significant input to its recommendations, so we urge the Committee to consider those items. We are happy to discuss them from the perspective of infants and toddlers and our child welfare work, which I will describe next.

#### Background in Child Welfare Work

Founded more than 40 years ago, ZERO TO THREE is a national nonprofit organization whose mission is to ensure that all babies and toddlers have a strong start in life. We translate the science of early childhood development into useful knowledge and strategies for parents, practitioners, and

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

policymakers. We work to ensure that babies and toddlers benefit from the family and community connections critical to their wellbeing and healthy development. Nowhere are these connections that are so essential to early brain development more important than for babies in the child welfare system. Over the last decade, we have worked around the country to bring the science of early brain development to local child welfare agencies, courts and the communities that surround them.

ZERO TO THREE's child welfare work began out of concern that infants and toddlers entering the child welfare system rarely receive care designed to support their developmental needs which are placed at great risk by the experience of maltreatment and subsequent practices of the child welfare system. Although infants and toddlers are the age group most vulnerable to child maltreatment, the child welfare system is neither adequately funded nor oriented around the developmental needs of infants, toddlers, and families. Children under age 3 make up an alarming proportion of children who enter the system. Every year, almost 200,000 children from birth to 3 years old have contact with the child welfare system as victims of abuse or neglect.<sup>1</sup> Infants and toddlers comprise more than a quarter (28 percent) of all children who are abused or neglected and nearly three-quarters of those who die from abuse and neglect. Young children are also most likely to be removed from their homes and placed in foster care. Of the children who entered foster care in FY 2017, infants and toddlers were 33 percent of placements (infants alone were 19 percent).<sup>2</sup>

It is abundantly clear that many infants and toddlers and their families face multiple risks, but often are not identified until their problems become severe. Where families are identified, they often do not receive the supports they need to keep their children safe and healthy. Moreover, child welfare practices, such as multiple foster care placements, a lack of parental contact, and little attention to supporting early development can compound effects of maltreatment.<sup>3</sup> A survey of state child welfare policies found that few states had policies or practices differentiated to address the unique needs and rapid development of infants and toddlers.<sup>4</sup> States also have a long way to go in understanding and meeting parents' needs to help them address their own issues and become successful parents to their infants and toddlers. Fewer than half of states had policies requiring that birth parents be offered services and supports to overcome their own past trauma, as well as mental health, substance abuse, and domestic violence issues.<sup>5</sup> This points to a child welfare system that is ill-equipped to supportively respond to either the child's developmental needs or to the histories of childhood maltreatment, traumatic experiences, and lifelong serious adversity that most parents of young children in the child welfare system have suffered.

The stresses on families today are serious. The cumulative impacts of these stress factors on their children are significant and lasting -- ranging from emotional and cognitive harm that hampers success in school to adverse health consequences as adults. To promote children's well-being, we must face the daily realities for many families with young children. Our recently released *State of Babies Yearbook: 2019* chronicles many of these problems: close to half of all infants and toddlers live in low-income families, with one in four living in poverty; 16 percent of infants and toddlers live in crowded housing; 17 percent live in households experiencing low or very low food security; child care is scarce and often unaffordable; and the highest incidence of child maltreatment of any age group.<sup>6</sup> We also must address the conditions of many parents who often carry their own trauma histories, substance abuse or mental

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

illness, and even their own cognitive disabilities. When parents lack the ability to cope with and buffer their children from chronic, unrelenting stress, it can become toxic to the child's developing brain.

Support for these families is sadly lacking. The service systems for the needs of children and families who are under great stress from multiple challenges, but haven't come to the attention of the child welfare system, are inadequately integrated, underfunded, and themselves over-stressed. This leaves families struggling on their own until challenges escalate and spiral downward. In many cases, this downward plunge results in involvement with the child welfare system, often with the child removed from the home. Children who come to the attention of the child welfare system, regardless of whether maltreatment is substantiated, face similar risks for long-term developmental consequences. This vulnerability begins a new cycle of difficulties that can prove detrimental for children and families for years to come, including social-emotional and cognitive delays, challenging behaviors, lack of school and workforce-readiness, and long-term health and mental health consequences.

Because families live in communities, we cannot hope to change the lived experience of the child welfare system without changing how we as stakeholders interact with one another in those communities. ZERO TO THREE has developed a systems and capacity building framework for strengthening families and communities, with a key strategy of supporting strong family and child development, thus preventing and reducing child maltreatment, by casting a wide net to ensure that the systems and services that touch families with young children are fully integrated into a comprehensive system of care. We engage parents affected by adverse childhood experiences (ACEs) and lifelong trauma, strengthen protective factors that prevent abuse and neglect, reduce racial inequities and disparities, and mitigate the impact of maltreatment and disrupted attachment on children's development and well-being. Our reach spans numerous systems to embrace their integral role in promoting child and family well-being and interrupting the intergenerational cycle of maltreatment and early childhood trauma.

Our work is modeled in a broad system of supports that encompasses families with lower levels of stressors to those with even the highest risk, much like a pyramid with graduated levels of need and functioning among families. Our work with communities begins at the primary level of the prevention continuum, focusing on strengthening families with very young children in need of supportive community services. The emphasis is on addressing the social determinants of health through the identification of supports and opportunities for the whole family. Preventing abuse and neglect is one outcome of such an approach, but it is not the only objective.

Next, our focus shifts to the secondary level: preventing children from being placed in foster care. For this population, which has overlapping but also different needs from families whose children have already been removed from their home, services and supports shift to in-home parent education and specialized programs that specifically address the risk factors for removal. At the tertiary level, our focus is on improving outcomes for infants and toddlers who have been placed in foster care and their families. We do this by working with communities to ensure that (a) parents receive intensive services and supports, including mental health and substance use disorder treatment, that will increase the likelihood of reunification, and (b) young children receive intensive interventions that will address their developmental needs and heal the trauma of abuse, neglect, domestic violence, and separation from their caregiver and family.

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

Building a prevention system as well as transforming child welfare centers on building systems and capacity across the country to strengthen families with young children. A comprehensive, well-integrated system that comes into contact with very young children and their families even before they reach the child welfare system should:

- *Support parents' strengths and needs in a compassionate, respectful, holistic, and individualized way.* An approach to addressing the needs of young children and families should have a structure in place to focus on developing genuine relationships of concern and support with families, through which parents' inner resources and strengths can be built upon while their other needs are addressed through individualized plans with appropriate evidence-based and informed interventions and services.
- *Address service gaps and disparities using continuous quality improvement.* Data collection is critical in understanding the children and families served, monitoring program performance, responding flexibly to resource gaps, tailoring programming to community-specific needs, identifying gaps in resources, and responding in ways that improve outcomes and support practice changes.
- *Remove barriers to racial equity and social justice.* Although children of color now make up a little more than half of all young children, disparities in the income of their families and many health and educational outcomes result from a lack of access to services and historical discrimination. Children of color—including Native American and non-white Hispanic children—are disproportionately represented at all levels of the child welfare system and, once involved, experience disparate treatment and outcomes. Their families are less likely to receive family preservation services, and the children are more likely to be removed from their homes.<sup>xii</sup> To address this, a system should be set up to continuously collect data disaggregated by race and ethnicity to analyze disparities in safety, permanency, and well-being of infants and toddlers. Another important area is a workforce that represents diverse points of view and is trained in cultural competence.
- *Prioritize developmentally-appropriate evidence-based interventions for very young children.* Systems are changed as stakeholders come together to identify needed services, and particularly, to select appropriate evidence-based practices and make them more widely available and integrated within a community. At the family level, it means their needs are approached in a holistic way, starting with assessments of children and parents, and ensuring they receive evidence-based mental health, substance abuse treatment, and parenting services as part of an array of supports and services that includes support to keep the child's early development on track. This can be done through a coherent overall approach that ensures the structure is in place for assessing and addressing individual families' needs; providing guidance to communities that need assistance in selecting which evidence-based interventions to use; and avoiding situations where services are prescribed simply because funding is available, or where a less intensive service is provided because the overall framework is not in place to determine that a more intensive intervention is needed.
- *Prioritize high quality primary health and mental health services for parents, including evidence-based substance use disorder treatment.* Funding for services such as substance abuse and mental health treatment as well as parenting support will greatly enhance the ability to work



**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

with families on prevention. But to do so effectively, a structure must be in place for assessing individual families' needs; ensuring timely and comprehensive medical screening and mental health evaluation for parents; ensuring connection to services that help parents understand their child's developmental needs; and engaging in collaborative, problem-solving discussion among community stakeholders to identify areas for improvement in child welfare screening and assessment, gaps in the mental health services landscape, and providing guidance to communities that need assistance in selecting which evidence-based interventions to use.

- *Infuse a trauma-informed approach that supports children, families, and professionals across systems of care.* The process of developing trauma-informed approaches, integrating these approaches into child-serving systems, and including them in service and treatment settings is critical. To accomplish this, strategies must be in place to foster safe and genuine relationships between and among community stakeholders, service providers, and the families served. In addition to ensuring service providers, clinicians, judges, court personnel, child welfare staff, and other professionals are trauma-informed, the development of genuine relationships and opportunities for families to provide peer support.

**Using Title II of CAPTA to Build a System that Supports Strong Families**

Although the second title in CAPTA, the Community-Based Child Abuse Prevention (CBCAP) Program is one of the few federal programs focused on the front-end of the continuum of family needs. Originally conceived as promoting networks of family resource and support programs in states and communities, CBCAP's low funding level has hampered its ability to build comprehensive approaches. If reframed to support a comprehensive family strengthening approach at the state and community level and properly funded, this title could be the missing link in our nation's efforts to support families and prevent the ultimate entry of many of them into the child welfare system.

As the Committee considers how to improve and even transform Title II, we recommend that you adopt a framework of family strengthening to emphasize the positive development of protective factors that enable families to nurture their children, including those who are under great stress but whose children do not experience maltreatment. When we use only a frame of preventing abuse and neglect, we are casting all parents who need services in that light, rather than recognizing that many families need support for a variety of reasons. Moreover, a primary outcome we should be seeking is families who can support their children's development, take care of their own needs, and provide economically for family members. Strategies to prevent specific types of maltreatment, for example, shaken baby syndrome, should be embedded in the comprehensive supports for parenting and meeting community needs.

To truly create the 21st Century Child Well-Being system, we need to look at strategies that help build strong community systems oriented around positive early childhood and youth development and strengthening parents' ability to cope with their own needs. If adequate funding is available, Title II could be a vehicle for creating comprehensive systems that coordinate and link services in ways that are appropriate to the community and are readily accessible for families. The latter point may seem trivial, but it is the key to helping families bring order to their lives. Staff in our Safe Babies Court Teams, described below, as well as those in other settings frequently describe families seeking them out, wondering how to get access to services made more available to families in the child welfare system. In other words, in building a family strengthening system, we have to take care to have intake points.

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

How do we build such a system, where families do not have to have a finding of a dire shortcoming to enter? There are multiple approaches that states and communities could implement to meet their families' needs and use to identify and fill gaps. Here are a few ideas:

- Family resource centers increasingly have been embraced by states as a non-stigmatizing way to offer families needed support while creating a focal point for offering some services and connecting families to others. For example, New Jersey has a system of Family Success Centers offer both direct services to parents and children while bringing together stakeholders to address problems that threaten community and family stability.
- *Primary care-based child development services use the universal experience of well-child visits to identify and support young children and families with risk factors.* The [HealthySteps](#) program integrates child development specialists into pediatric practices to provide parenting support and child guidance. The specialist supports parents' ability to nurture healthy child development while assessing family risk/protective factors and connects families with community services.
- Home visiting programs provide voluntary parenting support, sometimes starting prenatally. In addition to building the trust that enables them to support parents in nurturing their children, home visitors identify other family needs and connect the family with services.
- *Forging community-wide connections starting at birth connects families with community services right from the start.* Family Connects, developed in North Carolina, reaches out to all families with newborns and offers home visits to support parenting and child development as well as connections to other community services. A key to success has been the mapping of available community services and collaboration to fill gaps identified.
- Hybrid models can build a continuum of services that weaves a strong fabric of support for families. One such experiment will link Family Connects with the ongoing services within a medical home that HealthySteps provides, and, for families needing in-home support, Nurse Family Partnership services.

While shifting an existing program of limited means toward such a comprehensive approach is difficult without increased resources, we urge the Committee to increase the authorization level and work with appropriators to increase support for Title II overall. Because of the difficulty changing requirements before sufficient financial support is secured, Congress could consider robust experimental funding for several states to build out state and community systems to support strong families and promote child wellbeing, thereby reducing abuse and neglect.

**Using CAPTA State Grants to Create a Structure for Transforming Child Welfare**

Moving along the continuum for families under stress leads us back to Title I and the state formula grants that are meant to help states improve their Child Protection Systems (CPS), with myriad requirements that must be met. It seems likely that most states add the small amount of funds they receive through these grants to general funds they use for their CPS. It would be unreasonable to expect the available funds to have an effect on the long list of requirements that increase with every reauthorization. Moreover, CAPTA is dwarfed by funding in Title IV of the Social Security Act, which funds child welfare services as well as providing an open-ended entitlement for payments for children in foster care. The Family First Prevention Services Act (FFPSA) will begin to shift these funds toward

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

preventing placement. So, the question arises of CAPTA's contribution to federal steering of child welfare policy.

We believe there could be a strong role for CAPTA in laying out a roadmap for building the community structures that promote services centered around addressing families' needs as well as more effective approaches to child protection. The services that will help address the problems that lead families into the child welfare system primarily lie outside that system. Giving states clear direction on tapping into community services while creating assessment and monitoring systems to ensure individualized plans for families would give CAPTA a valuable mission. These community structures are needed to effectively implement FFPSA, but they are not embedded in that Act. We recommend that CAPTA Title I state grants be directed at building the capacity of community protective systems to comprehensively address the needs of families who come to the attention of the child welfare system.

As evidence that such a system can be built, we offer our Safe Babies Court Teams approach. The SBCT approach with its comprehensive, community-wide structure, has a systems-level benefit that we believe speaks to the intent of the major shift in child welfare to prevention. This evidence-based approach provides specialized support for children at imminent risk of foster care or who are already in foster care, by connecting babies and their families with the support services they need to ensure healthy development and lasting permanency. SBCT sites work with families at different points in the child welfare system, including families whose children remain at home. This core components of the approach are tailored for families:

| Infants and Toddlers at Imminent Risk of Entering Foster Care                                                 | Infants and Toddlers in Foster/Kinship Care                                                                   |
|---------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------|
| 1. Judicial and Child Welfare Leadership                                                                      | 1. Judicial and Child Welfare Leadership                                                                      |
| 2. Local Community Coordinator                                                                                | 2. Local Community Coordinator                                                                                |
| 3. Active Community Stakeholder Team                                                                          | 3. Active Community Stakeholder Team                                                                          |
| 4. Meeting Parents Where They Are                                                                             | 4. Meeting Parents Where They Are                                                                             |
| 5. Preventing Removal and Concurrent Planning                                                                 | 5. Concurrent Planning and Limiting Placements                                                                |
| 6. Mentoring Between Birth Parent and Kin/Natural Supports                                                    | 6. Mentoring and Co-Parenting Between Birth and Foster Parents, Kin Caregivers                                |
| 7. Initial and Ongoing Family Team Meetings                                                                   | 7. Pre-Removal and Monthly Family Team Meetings                                                               |
| 8. Quality Family Interaction                                                                                 | 8. Frequent, Quality Family Time (Visitation)                                                                 |
| 9. Continuum of Parenting Interventions and Mental Health and Substance Use Prevention and Treatment Services | 9. Continuum of Parenting Interventions and Mental Health and Substance Use Prevention and Treatment Services |
| 10. System Commitment to Continuous Learning and Improvement                                                  | 10. System Commitment to Continuous Learning and Improvement                                                  |

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

Each SBCT works successfully with families facing multiple and severe challenges, whose children often end up in foster care because the families receive no support to address their needs. One of the keys to working successfully with birth parents, especially, is the recognition of the extensive trauma they carry with them. Data on families served by SBCT through May 2018 found that 70% of children have at least one parent who has experienced four or more ACEs.<sup>xiii</sup> Four ACEs is the tipping point at which the odds of a negative outcome, such as substance abuse or mental health problems, chronic health issues, and even early death increase exponentially. A strategic focus of the SBCT approach is understanding parents' needs through developing emotional connections and supportive relationships. Comprehensive medical and mental health assessments and evaluation of childhood trauma for all parents ensures the court teams can build on family strengths and work toward supporting reunification while simultaneously helping parents gain insight on the importance of stability for their child.

The SBCT approach works at two levels. At the direct service level, a family team made up of the parent and family members, child welfare worker, attorneys, service providers, and others supporting the child and parent meet regularly to identify and address needs of children under the court's jurisdiction and address barriers to reunification for those who have been placed in foster/kinship care. This approach ensures that decisionmakers have the most complete picture possible of the needs of the families in the community. Instead of services providers being like the spokes on a wheel, connecting individually to the hub that is the child welfare worker, our approach ensures that community teams are sharing information among its members—thus functioning as the wheel's rim, connecting their collective knowledge about the family.

At the community level, the SBCT approach brings community partners together as a stakeholder team focused on broader systems improvement to address prevention and treatment service gaps and disparities. The court teams are led by judges who place a strong emphasis on addressing the unique challenges facing infants and toddlers, while collaborating with child development specialists to cultivate community teams of child welfare and health professionals, child advocates, and community leaders who provide comprehensive services. This leadership from judicial and child welfare partners is essential to the approach, fostering a climate of collaboration, trust, and shared vision for improving outcomes for infants, toddlers, and their families involved with the child welfare system.

The community stakeholder team not only focuses on the needs of individual families, it also works across the service areas in the community to identify and problem-solve around service gaps and barriers to helping families be successful. Starting with such a coordinated community stakeholder effort, which also carries this coordinated approach down to working with individual children and families, will ensure that we can truly transform the child welfare system. Understanding these staggering risk factors, the SBCT process of guiding parents through a journey of integrated trauma and substance abuse services while promoting the unique developmental needs of infants and toddlers results in timely permanency:

- Among children in SBCT with closed cases, 84% reached permanency within 12 months, with no significant differences found by race and ethnicity. The permanency outcomes of young children in SBCT sites are double the national standard established by the Children's Bureau (41%).
- Of the children in SBCT sites, close to half (49%) were reunified with parents, about a third were adopted (32%), and 14% were placed with a relative. Although most children reached

ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"

permanency within 12 months, outcomes were significantly different based on ACE scores. Among children with a parent with the highest ACE score, 30% were reunified; Alternatively, for children with a parent with the lowest score, 56% were reunified.<sup>k</sup>

Our goal is making SBCT's wrap-around services available to all families with infants and toddlers as they enter the child welfare system and, ultimately, to move the community service structure to address families' needs before they encounter child welfare. By proactively frontloading services and supports, SBCT communities become a model of shared responsibility for improving the lives of families.

In closing, I urge the Subcommittee to consider using CAPTA as a catalyst to build state and community systems that address how best to maximize the effectiveness of services provided, the ability to transform culture and practice, and above all, to meet families' needs in a comprehensive manner that in the long run truly leads to healthier lives and thriving children. The experience of SBCT illustrates how comprehensive approaches provide a framework within which the needs of individual families are appropriately considered, services are integrated, and the community's ability to respond with the most appropriate evidence-based interventions is enhanced. However, it is important to note that enabling CAPTA to play a pivotal role in transforming how we support families, both in general and within the child welfare system, while protecting children's safety, wellbeing, and development, will only succeed if Congress makes the significant investment needed to achieve this goal.

<sup>1</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *Child Maltreatment* 2015, 2017, [www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment](https://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment)

<sup>2</sup> U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, *The AFCARS Report: Preliminary FY 2017 Estimates as of August 2018*, 2018, <https://www.acf.hhs.gov/cb/resource/afcars-report-25>

<sup>3</sup> Cohen, J., Cole, P., & Szrom, J. (2011) A call to action on behalf of maltreated infants and toddlers. Washington, DC: ZERO TO THREE, American Humane Association, Center for the Study of Social Policy, Child Welfare League of America, and Children's Defense Fund.

<sup>4</sup> Jordan, E., Szrom, J., Colvard, J., Cooper, H., & DeVooght, K. (2013). Changing the course for infants and toddlers: a survey of state child welfare policies and initiatives. Washington, DC: ZERO TO THREE and Child Trends. <https://www.zerotothree.org/resources/218changing-the-course-for-infants-and-toddlers>

<sup>5</sup> ZERO TO THREE and Child Trends. (2013) Understanding and meeting the needs of birth parents. Retrieved from <https://www.zerotothree.org/resources/1005-understanding-and-meeting-the-needs-of-birth-parents>

<sup>6</sup> Keating, K., Daily, S., Cole, P., Murphey, D., Pina, G., Ryberg, R., Moron, L., & Laurore, J. (2019). *State of Babies Yearbook: 2019*. Washington, DC: ZERO TO THREE and Bethesda MD: Child Trends.

<sup>7</sup> Quality Improvement Center for Research-Based Infant-Toddler Court Teams (2018). *Advancing Equitable Outcomes for Infants and Toddlers Involved in Child Welfare*. ZERO TO THREE. [www.qicct.org/equity](http://www.qicct.org/equity).

**ZERO TO THREE Statement for the Record  
Hearing on "Strengthening Prevention and Treatment of Child Abuse and Neglect"**

<sup>vii</sup> Casanueva, C., Smith, K., Harris, S., Carr, C., & Burfeind, C. (2018). Adverse childhood experiences, family risk factors, and child permanency outcomes of very young children involved in Safe Babies Court Team™ sites. Prepared for ZERO TO THREE, Quality Improvement Center for Research-Based Infant-Toddler Court Teams. <http://www.qicct.org/sites/default/files/ACES%20Policy%20Brief%20v4%20%28003%29.pdf>

<sup>viii</sup> Casanueva, C., Smith, K., Harris, S., Carr, C., & Burfeind, C. (2018). When Less is Better: Reducing Out-of-Home Care Placements for Young Maltreated Children. Prepared for ZERO TO THREE, Quality Improvement Center for Research-Based Infant-Toddler Court Teams.

[Questions submitted for the record and their responses follow:]

MAJORITY MEMBERS:  
ROBERT C. "BOBBY" SCOTT, VIRGINIA  
Chairman

SUSAN A. DAVIS, CALIFORNIA  
RAUL M. GRIJALVA, ARIZONA  
JOE COURTNEY, CONNECTICUT  
MARCIA L. FUDGE, OHIO  
GREGORY KILI CAMACHO SABLON,  
NORTHERN MARIANA ISLANDS  
FREDERICA S. WILSON, FLORIDA  
SUZANNE BONNIECCI, OREGON  
MARK TAKANO, CALIFORNIA  
ALMA S. ADAMS, NORTH CAROLINA  
MARK DESAULNIER, CALIFORNIA  
DONALD NORCROSS, NEW JERSEY  
PRAMILA JAYAPAL, WASHINGTON  
JOSEPH D. MORELLE, NEW YORK  
SUSAN WILD, PENNSYLVANIA  
JOHN HARDER, CALIFORNIA  
LUCY MCBEATH, GEORGIA  
KIM SCHRIER, WASHINGTON  
LAUREN UNDERWOOD, ILLINOIS  
JAHANA HAYES, CONNECTICUT  
DONNA E. SHALALA, FLORIDA  
ANDY LEVIN, MICHIGAN  
ILHAN OMAR, MINNESOTA  
DAVID J. TRONE, MARYLAND  
HALEY M. STEVENS, MICHIGAN  
SUSIE LEE, NEVADA  
LORI TRAHAN, MASSACHUSETTS  
JOAQUIN CASTRO, TEXAS



COMMITTEE ON EDUCATION  
AND LABOR  
U.S. HOUSE OF REPRESENTATIVES  
2176 RAYBURN HOUSE OFFICE BUILDING  
WASHINGTON, DC 20515-6100

June 24, 2019

MINORITY MEMBERS:  
VIRGINIA FOIX, NORTH CAROLINA,  
Ranking Member

DAVID P. ROE, TENNESSEE  
GLENN THOMPSON, PENNSYLVANIA  
TIM WALBERG, MICHIGAN  
BRETT GUTHRIE, KENTUCKY  
BRADLEY BYRNE, ALABAMA  
GLENN GROTHMAN, WISCONSIN  
ELISE M. STEFANIK, NEW YORK  
RICK W. ALLEN, GEORGIA  
FRANCIS ROONEY, FLORIDA  
LLOYD SMUCKER, PENNSYLVANIA  
JIM BANKS, INDIANA  
MARK WALKER, NORTH CAROLINA  
JAMES COMER, KENTUCKY  
BEN CLINE, VIRGINIA  
RUESS FLOCHER, IDAHO  
VAN TAYLOR, TEXAS  
STEVEN WATKINS, KANSAS  
RON WRIGHT, TEXAS  
DANIEL MEUSER, PENNSYLVANIA  
WILLIAM R. TIMMONS, IV, SOUTH CAROLINA  
DUSTY JOHNSON, SOUTH DAKOTA

Ms. Yo Jackson, Ph.D., ABPP  
Professor, Psychology Department and  
Associate Director, Child Maltreatment Solutions Network  
The Pennsylvania State University  
219 Moore Building  
State College, PA 16802

Dear Professor Jackson:

I would like to thank you for testifying at the March 26, 2019, Subcommittee on Civil Rights and Human Services hearing entitled "*Strengthening Prevention and Treatment of Child Abuse and Neglect*."

Please find enclosed additional questions submitted by Committee members following the hearing. Please provide a written response no later than Friday, June 28, 2019, for inclusion in the official hearing record. Your responses should be sent to Paula Daneri of the Committee staff. She can be contacted at 202-225-3725 should you have any questions.

I appreciate your time and continued contribution to the work of the Committee.

Sincerely,

ROBERT C. "BOBBY" SCOTT  
Chairman

Enclosure

**Civil Rights and Human Services Subcommittee Hearing**  
***“Strengthening Prevention and Treatment of Child Abuse and Neglect.”***  
 Wednesday, March 26, 2019 at 10:15 a.m.

**Chairman Bobby Scott**

- Professor Jackson, a significant amount of research has documented the overrepresentation of certain racial and ethnic populations—including African-Americans and Native Americans when compared with their representation in the general population. There are racial disparities at various decision points in the child welfare continuum such as child protection, investigation and decision making. Racial bias, implicit bias and discrimination exhibited by individuals including caseworkers, mandated and other reporters, systemic factors such as a lack of resources for families of color, and geographic context, such as the region, state, or neighborhood are all factors in this over representation.
  - How can prevention and early intervention services address this disparity? And how do we assure that services are allocated in a way that will not re-enforce the current disproportionality?
- Professor Jackson, one of the risk factors in child abuse and neglect is exposure to violence in the home. The Family Violence Prevention and Services Act, which authorizes funding for programs that provide emergency shelter and assistance to victims of domestic violence, is up for reauthorization.
  - How would strengthening services for victims of domestic violence help prevent child abuse and neglect?
- Professor Jackson, in your testimony, you mention the importance of “coordinating efforts across the patchwork system of federal, state and local agencies” to prevent child maltreatment. How important is it to have clarity around what constitutes “child abuse and neglect” to this coordination -- to preventing and responding to child maltreatment?



### Questions for the Record

Committee on Education and Labor  
 Subcommittee on Civil Rights and Human Services Hearing  
*Strengthening Prevention and Treatment of Child Abuse and Neglect*  
 March 26, 2019, 2:00pm

Dr. Jackson, a significant amount of research has documented the overrepresentation of certain racial and ethnic populations—including African-Americans and Native Americans when compared with their representation in the general population. There are racial disparities at various decision points in the child welfare continuum such as child protection, investigation and decision making. Racial bias, implicit bias and discrimination exhibited by individuals including caseworkers, mandated and other reporters, systemic factors such as a lack of resources for families of color, and geographic context, such as the region, state, or neighborhood are all factors in this over representation.

- How can prevention and early intervention services address this disparity? And how do we assure that services are allocated in a way that will not re-enforce the current disproportionality?

**Response:** Prevention services raise awareness and provide education that helps to address disparity because, when universally applied, they mitigate risk for all families and can reduce family involvement in a complex system that relies on human judgment and intuition to make case determinations. Universal prevention involves all members of a community, and thus includes all caretakers (regardless of background) and all children in the scope of its intervention. This not only eliminates bias in a service selection process, it may also reduce stigma that creates a barrier to service utilization. Moreover, prevention services create an environment where discussion and individual understanding of each family's unique needs is the norm instead of organizing individuals by demographic characteristics. This has the potential to make service delivery responsive to diverse socio-cultural backgrounds. However, the success of service delivery is inherently tied to the quality of implementation; therefore, it is critical that service process be monitored and supported with technical assistance, in addition to evaluating effectiveness in terms of programmatic outcomes for families. All parents, regardless of socio-cultural backgrounds, may benefit from support in navigating the challenging times common to parenting in early childhood. Prevention interventions include activities like learning the stages of typical development so that parents can be better informed about what behaviors may be expected, even if not always easy to manage. Child abuse prevention programs also educate service providers about maltreatment risk factors - experiences like family conflict or parental stress that are common to all families no matter the ethnic or racial background or economic status. Moreover, prevention science moves the discussion from subjectively derived risk factors to objectively determined evidence-based science, going beyond individual assumptions and bias. In sum, prevention services may have the potential to reduce disparities when the services are evidence-based and delivered universally in socio-culturally responsive ways to address risk factors that affect diverse populations.

Dr. Jackson, one of the risk factors in child abuse and neglect is exposure to violence in the home. The Family Violence Prevention and Services Act, which authorizes funding for programs that provide emergency shelter and assistance to victims of domestic violence, is up for reauthorization.

- How would strengthening services for victims of domestic violence help prevent child abuse and neglect?

**Response:** Programs that are able to effectively reduce rates of interpersonal violence (IPV), including domestic violence, may be an important part of a broader public health approach to reducing children's experiences of maltreatment and other family violence. A recent review highlighted the need for intervention strategies that provide supports to families experiencing IPV and other risks associated with child maltreatment (e.g., parental depression) as an important means to reduce child maltreatment. Research consistently demonstrates significant co-occurrence of IPV and child maltreatment within households reported to child protective services (CPS). Data from the National Survey of Child and Adolescent Well-being (NSCAW), for example demonstrated that mothers reported to CPS indicated a lifetime prevalence of IPV of 45% and past month occurrence of 29%. Others report comparable results in state-level analyses. Furthermore, IPV is associated with increased risk of a range of different types of child maltreatment. Similar rates of co-occurrence are also seen when assessing populations experiencing IPV – for example, child maltreatment was observed in 40% of households impacted by IPV in one study. Because IPV appears to increase risk of maltreatment and IPV and child maltreatment co-occur, we would expect that decreasing IPV may also prevent some cases of child maltreatment.

Prof. Jackson, in your testimony, you mention the importance of “coordinating efforts across the patchwork system of federal, state and local agencies” to prevent child maltreatment. How important is it to have clarity around what constitutes “child abuse and neglect” to this coordination -- to preventing and responding to child maltreatment?

**Response:** Coordination, particularly around common metrics and definitions, is fundamental to our success. The federal government is in a unique position to guide national efforts for preventing child abuse. For the sake of evaluation alone – to determine if interventions are actually doing what we intend them to do - common metrics and definitions are the foundation of how we determine an evidence-base rooted in rigorous evaluation of program outcomes. The patchwork- nature of our child welfare system involves fragmentation across levels of government, differences in roles and purview across jurisdictions, and includes important non-governmental players. Importantly, diverse communities vary in their definition and determination process, which makes it challenging to create a national definition of child abuse. However, the factors involved in case determination could be more uniformly defined and reported at the federal level in a way that supports the development of a more consistent indicator of maltreatment across the states. Furthermore, because prevention necessarily focuses on addressing risk and protective factors prior to the occurrence of maltreatment, more consistent data on those could inform prevention strategies and service improvement. Federal leadership is crucial in coalescing a range of stakeholders in developing uniform data systems that track conditions associated with risk and case determination.

Much work is being done to take coordination even further to improve outcomes for children. This important coordination involves both data integration and improved service delivery. The effects of child maltreatment are felt at the individual, family, community, and societal level; therefore, these effects are experienced across myriad systems including child welfare, physical and behavioral health care, juvenile and adult corrections, education, and other public systems. This complexity requires that we advance systems-focused approaches that leverage administrative data systems to explain processes leading to maltreatment exposure and its effects. Utilizing Integrated Data Systems (IDS) can provide more accurate means of detection and prediction of adverse outcomes, as well as provide a means of empirically testing the efficacy of treatment and intervention response

to maltreatment. These advances are critical to developing a more effective and evidence-based policy and intervention response, as well as investigating risks and cross-system, downstream effects associated with child maltreatment.

Systems that integrate existing administrative data would provide a foundational tool that communities could use to enhance their capacity to address complex challenges; for instance, machine learning methods and predictive analytic modeling could analyze narrative and other data to predict the likelihood of future behavior or events. IDS would also support efficient economic analyses (e.g., cost-benefit) to estimate Return on Investment (ROI) associated with patterns of risk or of service delivery. Further coordination, particularly from the federal and state-levels, can foster promising science-based problem-solving.

Enhanced service delivery can also be synergistic with IDS because an array of service providers contribute data into the system, improving the accuracy of IDS, and may use that information to coordinate services across different agencies. Bridging this coordination capacity are services designed to link families to an array of services in a service network of community agencies and public systems that coordinate health, community, and human services programs and are responsive to the multiple health and social needs of families—including issues such as parental mental health, substance and/or opioid use disorders (SUD/OD), and domestic violence that place families at increased risk for child maltreatment. Such referral systems may benefit information obtained from, as well as contribute to information entered into integrated data systems. For instance, the success of home visiting depends greatly on a well-integrated and well-resourced service networks. It is important to note, however, that although evidence-based home visiting programs provide valuable supports to vulnerable families and are designed to operate within the fabric of community health and social support services, a recent (2018) statewide evaluation of Pennsylvania's evidence-based home visiting services (Early Head Start, Healthy Families America, Nurse-Family Partnership, and Parents as Teachers) showed these programs had *no discernable impact* on child abuse prevention. Such services rely on referrals to other high-quality and effective prevention services. We can only expect such referral systems to prevent the occurrence of maltreatment when a network of effective prevention services that address various risks to maltreatment (e.g., substance use, domestic violence) are integrated in a cooperative public system connected by referral and data linkages (i.e., a system which permits a common vernacular and data integration across multiple service system to create a "prevention infrastructure").

### Key References

- Daro, D., & Dodge, K. A. (2009). Creating community responsibility for child protection: possibilities and challenges. *The Future of Children*, 19, 67-93.
- Leeb R, Paulozzi L, Melanson C, Simon T, Arias I. Child maltreatment surveillance: Uniform definitions for public health and recommended data elements, Version 1.0. Atlanta, GA: Centers for Disease Control and Prevention, National Center for Injury Prevention and Control 2008.
- Matone M, Kellom K, Griffis H, Quarshie W, Faerber J, Gierlach P, Rubin DM, Cronholm PF. A Mixed Methods Evaluation of Early Childhood Abuse Prevention within an Evidence-Based Home Visiting Program, *Maternal and Child Health Journal*. 2018 Oct;22(Suppl 1):79-91
- Putnam-Hornstein E, Needell B, Rhodes AE. Understanding risk and protective factors for child maltreatment: The value of integrated, population-based data. *Child Abuse Neglect*. 2013; 37:116-9.
- Ridings LE, Beasley LO, Silovsky JF. Consideration of risk and protective factors for families at risk for child maltreatment: An intervention approach. *J Fam Violence*. 2017; 32:179-88.

[Whereupon, at 4:23 p.m., the subcommittee was adjourned.]

