CHILD DEATHS DUE TO MALTREATMENT

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

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CHILD DEATHS DUE TO MALTREATMENT

TUESDAY, JULY 12, 2011

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

The Subcommittee met, pursuant to notice, at 10:02 a.m., in Room B–318, Rayburn House Office Building, Hon. Geoff Davis [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
Tuesday, July 5, 2011
HR–5

CONTACT: (202) 225–1721

Chairman Davis Announces a Hearing on Child Deaths Due to Maltreatment

Congressman Geoff Davis (R–KY), Chairman of the Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on child deaths due to maltreatment. **The hearing will take place at 10:00 a.m. on Tuesday, July 12, 2011, in room B–318 of the Rayburn House Office Building.**

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

BACKGROUND:

According to State reports, over 1,700 children died nationally in FY 2009 due to maltreatment. However, research has shown that these reports may substantially understate the number of child victims each year. To gain a clearer understanding of this issue, the Government Accountability Office (GAO) has reviewed what is known about the circumstances of child deaths and near deaths due to maltreatment, State approaches to gathering and reporting this information, and what the Department of Health and Human Services (HHS) is doing to support the collection and accurate reporting of this information. GAO will testify about the findings of their review at the hearing.

There are currently several sources of data about child deaths due to maltreatment. First, since the 1970s, States have participated in a voluntary national data collection system reporting data on investigations of maltreatment and information on abused children. This system, called the National Child Abuse and Neglect Data System (NCANDS), is used by HHS to prepare annual reports on child maltreatment. Second, the nongovernmental National Center for Child Death Review (NCCDR) acts as a resource center for State and local teams that review cases of child deaths. These teams collect and report information on child fatalities from all causes, and 37 States currently report data to the national database. The NCCDR uses this data to focus attention on child fatality risks and to develop strategies to prevent fatalities in the future. Third, States also have data on child fatalities from sources such as law enforcement reports, death certificates, or medical records.

In announcing the hearing, Chairman Davis stated, **"Any child's death is tragic, but the death of a child from abuse and neglect is especially troubling. Current data on the number of child deaths from maltreatment appear incomplete, and the difficulty in even compiling complete information undermines States' ability to develop effective strategies to prevent these tragedies from repeating. I look forward to hearing from GAO on the findings of their report as well as other experts on how we can improve our understanding of both how many children die from maltreatment and more importantly how we can use this information to do a better job preventing such tragedies in the future."**

FOCUS OF THE HEARING:

The hearing will review data on child deaths due to maltreatment, determine how to improve the accuracy of this data, and review how improving the accuracy of this data may help prevent future fatalities.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to submit, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. Attach your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Tuesday, July 26, 2011**. Finally, please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721 or (202) 225–3625.

FORMATTING REQUIREMENTS:

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

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

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

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

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

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

Chairman DAVIS. The hearing will now come to order. But before we begin, I would like to yield to the Chairman of the Ways and Means Committee, Dave Camp, who asked that the report from GAO that is the basis of our hearing be commissioned in the first place. He has long been a champion of these issues regarding children. And with that, I would like to yield to the distinguished Chairman, Mr. Camp.

Chairman CAMP. Well, thank you very much, Chairman Davis. I wanted to thank our witnesses for being here today, and also a

special thanks to GAO for completing this report on abuse and neglect and maltreatment of children. And having gotten a little bit of what the report may say, I understand that the reality is even more dramatic than the official estimates that we are getting.

The purpose of this hearing, obviously, is to focus on child deaths due to maltreatment or abuse, neglect, however you want to describe it, and what government policies might be able to try to deal with this very critical issue.

I want to thank all of our witnesses here, and Tamara, especially you, for highlighting this issue in a very public way and a very positive way, so we can hopefully make some progress on this.

And I won't delay the hearing any longer, but appreciate the hard work that you and Mr. Doggett are going to be doing today. So thank you very much. Thanks a lot.

Chairman DAVIS. Thank you, Mr. Chairman. With that, we will return to regular order. I thank the distinguished gentleman from Minnesota for yielding his chair to the Chairman, too.

This is somewhat of a historic hearing in a couple of ways. One, I think the topic is certainly important. But for those of us that grew up in the era of black and white cathode ray TV tubes, this is the first Ways and Means Subcommittee hearing done in high definition.

[Laughter.]

Chairman DAVIS. I was told I had a great face for radio by my first media consultant. So some of us are going to have a particularly challenging experience here today.

But with that, I appreciate all of the witnesses who have come, those concerned citizens, advocates from many different streams of thought with one common concern.

When children die from maltreatment, it makes international headlines, as in the Caylee Anthony case that drew the focus of millions around the world in recent months. Unfortunately, the transience of the hype and passing interest of the population belies a much deeper challenge.

And sometimes the death of a child from maltreatment gains attention due to the shocking details of the treatment while alive. That is what happened in the case of 13-year-old Christian Choate, an Indiana boy killed in 2009 after years of abuse, including being allegedly locked in a 3-foot-high dog cage.

After his death, police found letters he had written about how he wondered when anyone would check on him or give him food or water. Christian asked why nobody liked him and how he just wanted to be liked by his family. It is hard to fully comprehend the death or the sadness this boy must have experienced during his too-short life.

And sometimes the death of a child from maltreatment does not make headlines at all, possibly because it is not recorded as a death from maltreatment for a variety of reasons we will learn more about today.

It is hard to know which child deaths are more tragic, those we know about or those we do not. But our job today is to make sure that all deaths of children due to maltreatment are recorded, so we can learn from all of them and use that knowledge to work with

State and local partners to prevent more of these tragedies from occurring in the future.

Our role here today is to be a voice for the voiceless, especially those children whose deaths are missing from official data today. The Federal Government estimates that 1,770 children died due to maltreatment in 2009, the most recent year of data we have. But as we will learn today in today's hearing, that official data understates the total number of children who die due to maltreatment each year for numerous reasons. This undercount could be significant.

GAO indicates that 24 States only report the deaths of children who had previous contact with a child welfare agency. Another study found child welfare agency records undercounted deaths by 55 to 76 percent. The bottom line is States are not reporting each child maltreatment death, and that makes it harder to prevent these deaths in the future.

We welcome a range of experts today to help us understand how we currently count the number of children who die each year due to maltreatment, as well as to discuss flaws in the current system. These experts will also help us to determine how these systems can be improved, and how better information can help us better protect children, which is our ultimate goal.

I want to commend Chairman Camp, who last year asked GAO to review and report on these issues, based on his concern that we are unfortunately not getting it right today. That GAO report is being released today, and is the backstop of GAO's testimony this morning.

We also welcome experts from the broader community who have worked for years to prevent child deaths due to maltreatment. Our panel today includes Tamara Tunie, the spokesperson for the National Coalition to End Child Deaths, who has worked to raise the profile on this issue and better protect children. We look forward to all of our witnesses' comments, and thank them for their commitment to better protecting children from abuse and neglect.

And I would say in the time that we have worked together on the Subcommittee, Ranking Member Doggett and I have had a commitment to correcting broken information processes, to be able to integrate sources, to remove obstacles and silos. And we are continuing to hold hearings like this to identify constraints that prevent the service providers, the caregivers, from doing their very, very critical job.

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

And now I would like to yield to my friend and distinguished Ranking Member from Texas, Mr. Doggett, for an opening statement.

Mr. DOGGETT. Thank you, Mr. Chairman. Thank you for your commitment to this issue. Each weekend that my wife and I are back in Texas, we try to devote a little time to our three preschool granddaughters. The joy of being with them, their growth, their learning, their creativity, and also their innocence and vulnerability are in such contrast in homes where they are surrounded

by love, with what we see played out in national TV with the abuse and death of too many young children.

And so, today we conduct a bipartisan exploration of what we can do about the gap between those children, the many children in our country that are surrounded by loving and supporting families, and those who are not. And I think we recognize that the death of even one child due to abuse or neglect is just too many.

We are aware that there are so many, many children across the country who lose their lives or are permanently scarred by abuse or neglect from a caretaker. We know that there are many reasons why this happens. But the goal of today's hearing must be to improve our understanding of these causes, and what we can do to prevent this kind of maltreatment of children. Certainly poverty, teenage parenting, substance abuse, and mental health challenges are among the considerations.

We must ensure that we don't make matters worse than they are today by slashing services that are important to assure child protection, even though there are many gaps in those services. Nor can we afford to slash the wider safety net for our families.

As my neighbor in Austin, Dr. Jane Burstain, eloquently states in a written testimony, "To cut programs that support struggling families in tough economic times is the very definition of penny wise and pound foolish, and is a choice that our children could pay for with their lives."

Regrettably, the lives of children have not always gotten top priority. They are not necessarily, despite the full house today and the many effective advocates who are here, they are not necessarily the best lobbied force in the country. In my home State of Texas, the legislature just concluded with a 40 percent cut, actually more than 40 percent, in certain child abuse prevention programs, even though my home State of Texas has one of the highest rates of child abuse and neglect deaths in the country.

Here in Washington, I have concern about the proposal here in the House, the House Republican Budget Resolution, to eliminate the Social Services Block Grant program, which provides some funding that is very important in child protective services.

And I am also concerned that the child welfare programs that we studied in our last Committee hearings, as well the TANF program, which is important in so many States for providing assistance to low-income families—those programs are about to expire. And we hopefully, as a result of the work of this Committee, can come up with bipartisan legislation to continue them, and learn from the experience.

I have just recently filed legislation concerning the TANF supplemental grants, which were part of the original 1996 law that are very important in Texas and 15 other States in providing services.

So, I hope that out of today's hearing we can gain more insight from our expert witnesses, and out of this can come together with effective legislation to try to respond to some of these matters that concern all of us so deeply.

Thank you, Mr. Chairman.

Chairman DAVIS. Thank you very much, Mr. Doggett. Before we move on to our testimony, I would like to remind all of our witnesses to limit their oral statements to 5 minutes. All of your state-

ments will be entered into the record, and we will allow more time for discussion and for question.

On our panel this morning we will be hearing from: Kay Brown, Director of Education, Work force, and Income Security, the U.S. Government Accountability Office; Tamara Tunie, actor from Law and Order: Special Victims Unit, and spokesperson for the National Coalition to End Child Abuse Deaths; Theresa Covington, the Director of the National Center for Child Death Review; Michael Petit, President and Founder of Every Child Matters Education Fund; Carole Jenny, M.D., Director of the Child Protection Program at Hasbro Children's Hospital in Providence, Rhode Island; and Jane Burstain, Senior Policy Analyst at the Center for Public Policy Priorities in Austin, Texas.

Ms. Brown, please proceed with your opening statement.

STATEMENT OF KAY E. BROWN, DIRECTOR, EDUCATION, WORKFORCE, AND INCOME SECURITY, U.S. GOVERNMENT ACCOUNTABILITY OFFICE

Ms. BROWN. Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee, thank you for inviting me here today to discuss our work on this very important topic of child deaths due to maltreatment. My remarks are based on a GAO report that is also released today. I plan to cover three issues: the number of children who die from maltreatment; State reporting challenges; and HHS assistance to States.

First, on the number of child deaths. Every year, children in the United States die after being physically abused, severely neglected, or otherwise maltreated, frequently at the hands of their parents or other trusted care givers. Unfortunately, we don't know for sure how many have died. Based on data reported by State child welfare agencies to the National Child Abuse and Neglect Data System, or NCANDS, we know that there were at least 1,770 deaths in fiscal year 2009.

But this is likely an undercount. Almost half of these State agencies reported only those cases that were already known to them. Yet these agencies don't necessarily know about all children who die from maltreatment. Some children may not have been previously maltreated, or their earlier maltreatment may not have been reported.

However, these deaths may be known to other sources, such as law enforcement agencies, medical examiners, coroners, or health departments. To illustrate this point, studies in a few States have combined information from several of these sources, and found that using the State child welfare records alone undercounted known fatalities by from 55 to 76 percent. Further, a national sample of 122 counties across the country—again, using multiple sources—estimated 2,400 child deaths from maltreatment.

Understanding the numbers and circumstances surrounding child fatalities from maltreatment can help inform prevention efforts. HHS prepares annual reports on the NCANDS data, which include a wealth of information on the children who have died, the perpetrators, and many other factors. However, we found that HHS does not include all of the potentially useful information it collects in its reports.

In addition to NCANDS, State and local multidisciplinary child death review teams assess the causes of child fatalities, with an eye to improving investigations, services, and prevention. These teams, found in all but one State, don't review every death, but their reviews can provide more and richer detail on each case. Many States are now submitting data from these reports to the HHS-funded National Child Death Review Center, and the Center is beginning to analyze the data specific to fatalities from maltreatment.

For my second point, States face multiple challenges that make it difficult to collect and report these data. For example, without definitive evidence, it can be difficult to determine that a child's death was, in fact, caused by maltreatment, rather than by natural causes. Further, resources are limited for autopsies and other tests, which can be expensive. Officials investigating fatalities may have differing skills, training, and experience, and coordination and data sharing across various agencies and jurisdictions may be hindered by concerns about privacy or confidentiality requirements, or by differing goals and cultures.

On my third point, HHS provides a variety of technical assistance to States to help improve the data that they report to NCANDS. However, in our survey, State officials asked for additional assistance on collecting child fatality data, using it for prevention, and collaborating across agencies. We have made recommendations to HHS related to these and other issues.

In conclusion, any child's death from maltreatment is especially distressing, because it involves a failure on the part of the adults responsible for protecting them. Policymakers and practitioners rely on data to understand the numbers and circumstances of these tragic deaths, and to learn from them to prevent other deaths. Without improving upon and better sharing these data, we lose precious opportunities to protect our children.

This concludes my prepared statement. I am happy to answer any questions.

[The prepared statement of Ms. Brown follows:]

United States Government Accountability Office

GAO

Testimony

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

For Release on Delivery
Expected at 10:00 a.m. EDT
Tuesday, July 12, 2011

CHILD FATALITIES FROM MALTREATMENT

National Data Could Be Strengthened

Statement of Kay E. Brown, Director
Education, Workforce, and Income Security

GAO-11-811T

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

Thank you for the opportunity to participate in today's discussion of child fatalities from maltreatment. Every year, children in the United States die after being physically abused, severely neglected, or otherwise maltreated, frequently at the hands of their parents or others who are entrusted with their care. Infants and toddlers are the most vulnerable to such abuse and neglect. According to estimates by the National Child Abuse and Neglect Data System (NCANDS), 1,770 children in the United States died from physical abuse or other forms of maltreatment in fiscal year 2009.[1] Some experts believe that more children have died from maltreatment than are captured in this estimate and that there are inconsistencies and limitations in the data that states collect and report to NCANDS. In addition, many more children are severely harmed and may nearly die from maltreatment, but NCANDS does not collect data specifically on near-fatalities. The Department of Health and Human Services (HHS) maintains NCANDS, which is a voluntary state data-reporting system.[2] HHS provides oversight of state child welfare systems, and in all states, child protective services (CPS) is part of the child welfare system. When state CPS investigators determine that a child's death is considered maltreatment under state laws or policies, CPS documents the case, and the state's child welfare department reports it to NCANDS.

My testimony today is based on our July 2011 report, which is being publicly released today and addresses three issues: (1) the extent to which HHS collects and reports comprehensive information on child fatalities from maltreatment; (2) the challenges states face in collecting and reporting information on child fatalities from maltreatment to HHS; and (3) the assistance HHS provides to states in collecting and reporting data on child fatalities from maltreatment.[3] To address these questions,

[1] In this testimony, we use the term "maltreatment" to refer to both abuse and neglect.

[2] The 1988 amendments to the Child Abuse Prevention and Treatment Act (CAPTA) required HHS to establish a national data collection and analysis program for child maltreatment data. Child Abuse Prevention, Adoption, and Family Services Act of 1988, Pub. L. No. 100-294, sec. 101, § 6(b)(1), 102 Stat. 102, 107.

[3] GAO, *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention,* GAO-11-599 (Washington, D.C.: July 7, 2011).

we assessed the methodology of published research on the number of child fatalities; analyzed fiscal year 2009 NCANDS data; and interviewed HHS officials responsible for NCANDS child maltreatment data, child welfare practitioners, and other experts. We also conducted a nationwide Web-based survey of state child welfare administrators in 50 states, the District of Columbia, and Puerto Rico; and conducted site visits to California, Michigan, and Pennsylvania. Finally, we reviewed HHS documents on child maltreatment fatalities and near-fatalities as well as CAPTA and related laws, including pertinent state laws. We conducted our work from April 2010 through July 2011 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions in this product.

The following summarizes our findings on each of the three issues discussed in our report:

- *National estimate of the number of children who likely have died from maltreatment*. More children have likely died from maltreatment than are reflected in the national estimate of 1,770 child fatalities for fiscal year 2009. Undercounting is likely due to nearly half the states reporting to NCANDS data only on children already known to CPS agencies—yet not all children who die from maltreatment were previously brought to the attention of CPS.[4] HHS encourages states to obtain information on child maltreatment fatalities from other non-CPS sources of information, but 24 states reported in our survey that their 2009 NCANDS data did not include child fatality information from any non-CPS sources.[5] Synthesizing information about child fatalities from multiple sources—such as death certificates, state child welfare agency records, or law enforcement reports—can produce a more comprehensive picture of the extent of child deaths than sole reliance

[4]NCANDS collects information on all children who were referred or reported to CPS because of alleged maltreatment and whose maltreatment was investigated or otherwise assessed.

[5]Since NCANDS is a voluntary data-reporting system, state CPS agencies cannot be required to obtain information from other state agencies, according to HHS officials.

on CPS data. For example, one peer-reviewed study[6] found that more than 90 percent of the child fatality cases could be identified by linking any two of the data sources.[7] Furthermore, inconsistent state definitions of maltreatment, differing state legal standards for substantiating maltreatment, and missing state data can complicate the ability to obtain comprehensive information on child fatalities from maltreatment across states or over time. In addition to collecting the number of child fatality deaths, NCANDS collects data on the circumstances surrounding these deaths, which could be useful for prevention, but not all of this information is synthesized or published in HHS's annual *Child Maltreatment* report. For example, for children who had died from maltreatment, HHS's 2009 report did not provide data on child risk factors and caregiver risk factors. When we analyzed unpublished fiscal year 2009 state data reported to NCANDS on children's deaths from maltreatment, we found that 16 percent of perpetrators of fatal child maltreatment were previously involved in an incident of child maltreatment.

- *Challenges to collecting and reporting child maltreatment fatality data to NCANDS*. Local child death investigators, such as law enforcement officials, coroners and medical examiners, and CPS staff, face several challenges in determining whether a child's death was caused by maltreatment. One challenge is that without definitive medical evidence, it can be difficult to determine that a child's death was caused by abuse or neglect rather than natural causes. In our survey, 43 states indicated that medical issues were a challenge in determining child maltreatment. For example, investigators in California told us that determining the cause of death in cases such as sudden unexplained infant death is challenging because the child may have been intentionally suffocated, but external injuries are not readily visible. State and local resource constraints can also limit

[6]P. G. Schnitzer et al, "Public Health Surveillance of Fatal Child Maltreatment: Analysis of 3 State Programs," *American Journal of Public Health*, February 2008, Vol. 98, No. 2.

[7]HHS's most recent National Incidence Study of Child Abuse and Neglect (NIS-4)—issued in January 2010—estimated 2,400 child deaths from maltreatment in the study year spanning portions of 2005 and 2006. The NIS is a congressionally mandated, periodic effort of HHS to estimate the incidence of child abuse and neglect in the United States. 42 U.S.C. § 5105(a)(2). Unlike NCANDS, which relies primarily on CPS data reported by states, the NIS-4 relies on multiple sources of child death information. The small number of fatalities in the sample size limits the reliability of the NIS estimate for child fatalities from maltreatment. Because the sample size is small, the estimate has a large standard error.

investigators' ability to conduct testing, such as autopsies, to determine how a child died. Another challenge in determining cause of death is that the level of skill and training for coroners and medical examiners can vary greatly, according to the National Academy of Sciences.[8] Child death investigators can also differ in their interpretation and application of maltreatment definitions, which can lead to inconsistent determinations of the cause of death. For example, law enforcement officials and coroners sometimes disagree on the manner or cause of death when the death is suspected to be from natural causes but there is some indication of abuse or neglect, according to California law enforcement officials we interviewed. Finally, states reported challenges coordinating among geographic jurisdictions and with other state agencies, such as health departments, to obtain information on child fatalities from maltreatment. For example, counties face challenges obtaining medical records and death certificates from jurisdictions in another state when children are taken across state borders to the nearest trauma center, according to Michigan officials.

- *Assistance by HHS to help states report on child maltreatment.* HHS provides ongoing assistance to states for reporting child maltreatment fatality data through an NCANDS technical assistance team that hosts an annual technical assistance meeting, provides Web-based resources, and uses an NCANDS Listserve to share information with states and facilitate peer-to-peer assistance. States can obtain individualized NCANDS technical assistance upon request from an assigned NCANDS technical team liaison, and an NCANDS State Advisory Group meets annually to review and update NCANDS collection and reporting processes. In addition, HHS provides assistance to states' child death review teams through the National Center for Child Death Review (NCCDR), which helps states share information by publishing their child death review teams' contact information, data, and annual reports on its Web site.[9] The NCCDR Web site also offers best practices for preventing the leading causes

[8]Committee on Identifying the Needs of the Forensic Sciences Community, National Research Council. *Strengthening Forensic Science in the United States: A Path Forward.* A special report prepared at the request of the Department of Justice. Washington, D. C.: August 2009.

[9]NCCDR is a nongovernmental organization funded by HHS that provides resources to state child death review teams. These multidisciplinary teams review cases of child deaths for follow-up and prevention.

of children's injury and death and other information. NCCDR and NCANDS officials acknowledged that, to date, they have not routinely coordinated on child maltreatment fatality data or prevention strategies. In responding to our survey, state officials indicated a need for additional assistance collecting data on child fatalities and near-fatalities from maltreatment and using this information for prevention efforts. For example, several states mentioned that assistance with multidisciplinary coordination could help them overcome difficulties such as obtaining death certificates from medical examiners' or coroner's offices. States also reported wanting assistance to collect and use information on near fatalities, which CAPTA defines as "an act that, as certified by a physician, places the child in serious or critical condition," but NCANDS does not collect near fatality data.[10] HHS officials believe that such cases are most likely reported generally under maltreatment, but are not specifically identified as near fatalities, because NCANDS does not have a data field identifying the case as a near fatality from maltreatment. In comments on a draft of this report, HHS stated that it is considering adding a field to identify these specific cases.

In the report we released today, we recommended, as summarized here, that the Secretary of HHS take steps to

- further strengthen data quality, such as by identifying and sharing states' best practices and helping address differences in state definitions and interpretation of maltreatment;
- expand available information on the circumstances surrounding child fatalities from maltreatment;
- improve information sharing on the circumstances surrounding child fatalities from maltreatment; and
- estimate the costs and benefits of collecting national data on near fatalities.

We provided a draft of the report we drew on for this testimony to HHS for its review, and copies of HHS's written responses can be found in appendix IV of that report.[11] In its comments, HHS agreed with our

[10]42 U.S.C. § 5106a(b)(4)(A).

[11]We provided a copy of the draft report to the Department of Justice (DOJ) and pertinent excerpts to NCCDR. DOJ and NCCDR provided technical comments which we incorporated as appropriate.

recommendations to improve the comprehensiveness and quality of national data on child fatalities from maltreatment and pointed out activities under way that are consistent with our recommendations. However, more can be done to address these issues, such as by using stronger mechanisms to routinely share information and expertise on child fatalities from maltreatment.

Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee, this concludes my statement. I would be pleased to respond to any questions you or other Members of the Subcommittee may have.

GAO Contacts and Acknowledgments

If you or your staff have any questions about this report, please contact me at (202) 512-7215 or brownke@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals who made key contributions to this testimony include Katherine C. Berman, Lorraine R. Ettaro, Brett S. Fallavollita, Julian P. Klazkin, Sheila R. McCoy, Deborah A. Signer, Kate van Gelder, and Monique B. Williams. Almeta J. Spencer provided administrative assistance.

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Chairman DAVIS. Thank you very much, Ms. Brown.

Ms. Tunie, if you could, give your testimony.

STATEMENT OF TAMARA TUNIE, ACTOR, "LAW AND ORDER: SVU," AND SPOKESPERSON, NATIONAL COALITION TO END CHILD ABUSE DEATHS

Ms. TUNIE. Good morning, Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee. My name is Tamara Tunie. Many people know me in my role as Dr. Melinda Warner, the medical examiner on "Law and Order: Special Victims Unit."

However, I am here today in my role as a concerned citizen, and as the spokesperson for the National Coalition to End Child Abuse Deaths. The Coalition is made up of five national organizations that came together over a common concern for the growing number of child abuse and neglect deaths in the United States. Those organizations are: The National Association of Social Workers; National Children's Alliance; National District Attorney's Association; Every Child Matters Education Fund; and the National Center for Child Death Review.

I am honored to be able to speak to you today. On "Law and Order," we investigate fictionalized crimes, and often have to deal with difficult story lines. But nothing compares to the real and tragic cases that we hear about with increasing regularity in the national headlines: Caylee Anthony in Florida; Marcella Pierce, from my home State of New York; and the gruesome story of Nubia Barahona, also in Florida.

The unfortunate truths about these deaths is how common they are. Since becoming the Coalition spokesperson, I have learned about the thousands of American children dying at the hands of those who are supposed to love and protect them, and I am here to say that the need for action is critical.

Unfortunately, the most startling truth about death from child abuse is how common it is. As we have heard and will hear today from the experts in this field, an estimated 2,500 children die each year from abuse and neglect; that is 7 children a day.

It is not enough to feel saddened when hearing about the loss of innocent lives. We have an obligation, as adults and citizens, to protect those who have no power to protect themselves, who have no voice to address the powers that be, and obligation to prevent these fatalities.

The first step in ending child abuse and neglect deaths is awareness of the problem, including the accurate collection of data regarding the number and circumstances of child deaths from maltreatment. We are all here today because Chairman David Camp, Chairman Geoff Davis, and Ranking Member Doggett, and the Members of the Subcommittee on Human Resources believe that this important issue deserves attention.

On behalf of the Coalition, I want to thank you for holding a hearing on child abuse and neglect fatalities, and for your efforts to bring an end to the preventable deaths of children like Caylee, Marcella, and Nubia in the United States.

Thank you so much for hearing my testimony.

[The prepared statement of Ms. Tunie follows:]

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
***** TUESDAY, JULY 12, 2011 AT 10:00 A.M. *****

TESTIMONY OF TAMARA TUNIE, SPOKESPERSON
NATIONAL COALITION TO END CHILD ABUSE DEATHS
before the
COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HUMAN RESOURCES US HOUSE OF REPRESENTATIVES
Hearing on "Child Deaths Due to Maltreatment"
July 12, 2011

Good morning, Chairman Davis, Ranking Member Doggett and Members of the Subcommittee. My name is Tamara Tunie. Many people know me in my role as Dr. Melinda Warner, the Medical Examiner, on Law and Order Special Victims Unit. However, I am here today in my role as a concerned citizen and as the spokesperson for the National Coalition to End Child Abuse Deaths. The Coalition is made up of five national organizations that came together over a common concern for the growing number of child abuse and neglect deaths in the United States. Those organizations are: National Association of Social Workers, National Children's Alliance, National District Attorneys Association, Every Child Matters Education Fund and the National Center for Child Death Review.

I am honored to be able to speak to you today. On Law and Order, we investigate fictionalized crimes and often have to deal with difficult story-lines, but nothing compares to the real and tragic cases that we hear about with increasing regularity in the national headlines. Caylee Anthony in Florida, Marchella Pierce from my home in New York City, and the gruesome story of Nubia Barahona, also in Florida. The unfortunate truth about these deaths is how common they are. Since becoming the Coalition's spokesperson, I have learned about the list of American children dying at the hands of those who are supposed to love and protect them, and I am here to say that the need for action is critical.

Unfortunately, the most startling truth about death from child abuse is how common it is. As we have heard today, an estimated 2,500 children die each year from abuse and neglect, that's 7 children a day.

It is not enough to feel saddened when hearing about the loss of innocent lives. We have an obligation as adults and citizens, to protect those who have no power to protect themselves and no voice to address the powers that be, to prevent these fatalities. The first step in ending child abuse and neglect deaths is awareness of

the problem, including the accurate collection of data regarding the number and circumstances of child deaths from maltreatment. We are here today, because Chairman Dave Camp, Chairman Geoff Davis, Ranking member Doggett and the members of the Subcommittee on Human Resources, believe that this important issue deserves attention. On behalf of the Coalition, I want to thank you for holding a hearing on child abuse and neglect fatalities, and for your efforts to bring an end to the preventable deaths of children like Caylee, Marchella and Nubia in the United States.

Thank you for hearing my testimony.

Chairman DAVIS. Thank you, Ms. Tunie.
Ms. Covington.

STATEMENT OF THERESA COVINGTON, M.P.H., DIRECTOR, THE NATIONAL CENTER FOR CHILD DEATH REVIEW

Ms. COVINGTON. Thank you, Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee, for providing me with this opportunity to speak to you. I serve as the director of the National Center for Child Death Review, with funding from the maternal and child health bureau at HRSA, HHS. We assist States in improving their child death review processes.

CDR is a process in which profess—in which professionals from many agencies come together to share case records, look at the facts in the deaths, and decide what they will do to prevent these deaths in the future. Every State, except Idaho, tries to review all child abuse and neglect deaths at the State or community level.

As described by the GAO, our center built and now maintains the national CDR case reporting system, which 39 States are using and submitting reports on all of the child deaths that they review. This allows for the collection of comprehensive information on child deaths, because it is a compilation of the information shared by all the agencies at a review meeting.

The system collects data on the child, their care givers, the supervisors, the perpetrators, the investigation, the circumstances in the death, and actions taken to prevent other deaths. The report tool has over 1,800 data elements, and as of today we have 94,473 deaths in the system, of which 8.3 percent were due to child abuse and neglect, which is 7,894 little children like Casey Anthony's.

And the GAO report is right. We know that more children die from abuse and neglect than is reported through NCANDS, from vital records, or law enforcement databases alone. The CDC had funded a child maltreatment surveillance project in seven States, and I was the PI in Michigan. In an average year, Michigan had reported 16 child abuse deaths through death certificates, law enforcement records, 26, child protective services, 40 deaths. When child death review synthesized these multiple sources of data, the actual number was at least 100 deaths a year.

And we just did a quick count of child abuse and neglect deaths reported through State child death review annual reports, and compared them to the NCANDS data for those same years: 15 States reported 1,029 states [sic], compared with 516 in the NCANDS report.

I agree with the GAO findings on some of the reasons for the under-reporting. Deaths due to neglect are especially under-reported, and most deaths from neglect happen when care givers egregiously fail to protect a child from hazards: toddlers drowning in bath tubs, children dying in-house fires when left alone, children left in cars on hot days, infants suffocated while sleeping with their intoxicated parents.

And different States have different definitions of abuse and neglect. What Mississippi might call abuse, Connecticut might call a bad accident, or vice versa. And States even differ on who makes the call, whether it is a CPS worker, the coroner, law enforcement, the prosecutor. And States have different criteria for how they

count the deaths into NCANDS, into our system, and into other systems. There is also wide variation in the quality of child death investigations across the country, so that when the deaths aren't well investigated, we don't really know what happened.

On a positive note, we know that when we count deaths right and do reviews well, prevention happens. That is why it is so important that we investigate, count, and review all of these deaths. I could spend all day here describing efforts implemented across the United States through child death review. Some specific to your States include: Kentucky implementing new fire safety education for families, because of deaths in which children died and adults survived. Georgia, Louisiana, Michigan, Minnesota, New York, North Dakota, and Washington implemented major public awareness campaigns on shaken baby prevention and safe infant sleep. North Dakota improved death reporting policies to CPS. Tennessee developed evidence-based home visiting programs. Texas is training all CPS workers in infant death investigation. A number of States have changed mandatory reporting policies to CPS, for example, requiring reports even if there are no survival siblings [sic].

And I agree with the GAO recommendations to improve comprehensiveness, the quality, and the use of national data on maltreatment deaths. And I look forward to being part of the solution, working with ACF, NCANDS and others, to identify how we can share and use all of our data to prevent these deaths.

I also ask that you require national standards and child maltreatment definitions and in reporting. And I ask that you call for a national commission to further study this issue.

But our States also need additional resources. States certainly need emergency help now, as—for child protection, as their resource are dwindling while child abuse and neglect is increasing. We should not be a nation that fixes its budget at the expense of abused and neglected children. Other than the $600,000 in funds allocated for our resource center, there is no dedicated funding to States for child death review or for the reporting system. Fortunately for us, a private company based near Goddard recently offered to build our new software for us.

Chairman David, Mr. Doggett, and those of you on this Committee, later tonight please think about the 7 or 8 or maybe even 10 children who will have died today because someone who is supposed to tuck them in at night killed them instead. And then tomorrow, begin work on your Committee to take action to keep our children alive. Thank you.

[The prepared statement of Ms. Covington follows:]

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
***** TUESDAY, JULY 12, 2011 AT 10:00 A.M. *****

TESTIMONY OF THERESA M. COVINGTON
NATIONAL CENTER FOR THE REVIEW AND PREVENTION OF CHILD DEATHS
Before the
COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HUMAN RESOURCES
US HOUSE OF REPRESENTATIVES
Hearing on "Child Deaths Due to Maltreatment"
July 12, 2011

Thank you Chairman Davis, Ranking Member Doggett and Members of the Subcommittee for providing me with this opportunity to speak to you about the tragedy of fatal child abuse.

I serve as the Director of the National Center for the Review and Prevention of Child Deaths, formerly known as the National Center for Child Death Review. We are based at the Michigan Public Health Institute. We are a resource center beginning our tenth year, funded through a cooperative agreement with the Maternal and Child Health Bureau within the Health Resources and Services Administration at HHS. Our center provides training and technical assistance to states as they work to conduct comprehensive and multidisciplinary case reviews of child deaths. Child Death Review (CDR) expanded to most states in the late 1990s, through training support from the Administration on Children and Families and OJJDP at the Department of Justice. In 2003, HRSA established funds for our national resource center, to encourage the focus on the prevention of deaths through the reviews. Today every state and Washington DC, with the exception of Idaho, has a CDR program in place but states vary greatly in their CDR structures, administrative homes, funding levels, and timing of reviews. Forty-four states have legislation requiring reviews and there is no national legislation requiring or supporting CDR. CAPTA legislation does however encourage death reviews of children known to the child welfare system through the citizen review process. Thirty-seven states support reviews at the county level with a state level advisory board that reviews these local findings to improve state policy and practice. Twelve states only have state-level review teams. Most states review deaths from a wide variety of causes including diseases, accidents, homicides and suicides-but all states review deaths from child abuse and neglect. All states review deaths from birth to

age 18. There are two U. S. Healthy People 2020 Objectives especially related to CDR: *all states and the District of Columbia will review 100% of all sudden and unexpected infant deaths and all deaths from external causes*-this would include child maltreatment.

Even those many states do not require participation on CDR, thousands of professionals regularly participate at CDR meetings to share case records from law enforcement, death investigators, social services, health care, public health, the courts, education, mental health and others in order to better understand why a child died and then to use that understanding to develop programs, policies and services to prevent future deaths. Most states review deaths from a wide variety of causes including diseases, accidents, homicides and suicides-but all states review deaths from child abuse and neglect. All states review deaths from birth to age 18.

As described in the just released GAO report to you, in 2005 our Center also built and now maintains the National Child Death Review Case Reporting System. The data is stored at the Michigan Public Health Institute. Thirty-nine states are now voluntarily enrolled in this on-line system-submitting comprehensive case reports on all of the deaths they review. This reporting tool allows for the collection of much more comprehensive information on child deaths than is available from any other single source-because it is a compilation of the information provided by many agencies at a review meeting, including vital records, and reports from medical examiners, law enforcement and child protective services. We have information on the child, their caregivers, supervisors, perpetrators, quality of the investigation, and the actual circumstances based on the cause of death and team recommendations for improvements to prevent other deaths. The report tool has over 1,800 data elements that can be answered by a team. We have also added additional questions for the seven states funded by the CDC Division of Reproductive Health's pilot of a national case registry for sudden and unexpected infant deaths (SUID). SUID deaths include those from SIDS, suffocation and undetermined causes and these can be almost impossible to distinguish at autopsy from a homicide caused by asphyxiation. The funded states include Colorado, Georgia, New Hampshire, Michigan, Minnesota, New Jersey and New Mexico. The CDC is contracting with our Center to assist

states in improving their child death investigations and reporting on these mostly sleep-related infant deaths so that we can better understand and prevent them. With the CDC we are actively encouraging the use of the CDC's standard infant death investigation protocol. This protocol was developed by national experts through the leadership of the Division of Reproductive Health at the CDC, and they provided five training academies across the United States to build a cadre of trainers in states. You might be interested to know that we built the software for this system at the Michigan Public Health Institute, using funds from our core center grant of $450,000. We have continued to maintain the website, manage several thousand users, the data base and data storage all within these core funds-which are also used for all of our other Center activities. Our small staff of 3 people supports the center and the reporting system. States and local teams use the data for their own purposes and most states prepare annual reports. Data submitted into the reporting system is the property of states and we do not provide case identified data to anyone. We are just beginning to analyze national level data but have yet to extensively analyze the maltreatment data.

As of today, states have recorded 94,473 child deaths into the National CDR Case Reporting System. Teams reported that child abuse, child neglect or poor supervision was a factor in 7,894 or 8.3 percent of these deaths.

The GAO Report is right – significantly more children die from abuse and neglect than is reported through NCANDS, vital records or law enforcement databases alone. A number of studies have published this fact; including findings published in the American Public Health Association's Journal about the US Centers for Disease Control's child maltreatment surveillance project in seven states between 2001-2003. I was the principal investigator in Michigan. We found that in an average year, vital records reported 16 child abuse deaths; law enforcement records 26 deaths, child protective services 40 deaths. A high percentage of these deaths were only reported in one source and not another. However, after child death review and a synthesizing of all reporting sources, the number increased to over 100 deaths a year. This finding is troubling, especially considering that the GAO report found that 24 states reported to NCANDS only data from CPS. Other efforts have found similar outcomes.

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
***** TUESDAY, JULY 12, 2011 AT 10:00 A.M. *****

Our Center assisted Clark County, Nevada which includes Las Vegas, conduct intensive reviews of seventy-nine deaths thought to be associated with abuse or neglect. OF these deaths, only six were coded on death certificates as maltreatment from physical abuse. Only nine had been substantiated as maltreatment by CPS. Following the review, an additional twenty-six deaths were identified as requiring CPS substantiation. A large number of deaths were not even reported to CPS because law enforcement and coroners felt that the family had suffered enough with the death of their child; or that it was a "bad accident" or that the parents did not intend to kill their children; or because there were no surviving siblings. And when CPS did take a report, more often than not they did not investigate for the same reasons. In the few cases they did investigate they did not substantiate. And when they did open an investigation, oftentimes they did not substantiate. The one area in which investigations were more routinely conducted and actions taken were deaths from serious physical abuse. But most of the deaths were from accidental injuries, or from serious medical complications of asthma, diabetes or childbirth-with non-compliance of treatment or substance use by the caregivers. Overwhelmingly the reviews found that poor coordination during a death investigation among agencies can lead to this under-reporting and failure to address the abuse and neglect. The good news is that Clark County and the State of Nevada used the information discovered through these reviews to implement widespread improvements in their death investigation, CPS and judicial systems to better protect children.

We also have evidence of this undercounting across the nation by comparing the data available in state child death review annual reports, our child death review case reporting system data and NCANDS data. The following table includes data from available CDR state annual reports compared with data from NCANDS for the last year that state annual
CDR was available as well as data for that same year submitted to the National CDR Case Reporting System.

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	Number of Deaths by Abuse/Neglect Drawn From:			
State	NCANDS	CDR database	State annual CDR report	Comments re state annual reports to CDR
Arizona	11	23	51	For 2008
California	30	N/A	133	For 2001
Florida	156	N/A	192	2009. Not participating in CDR database
Georgia	60	22	77	2009
Iowa	6	3	7	For 2007
Kansas	10	N/A	13	For 2008. Not participating in CDR database.
Kentucky	22	N/A	28	For 2008, not participating in CDR data
Minnesota	16	N/A	19	For 2001
Missouri	39	N/A	109	2009. 33 of 109 are attributed to homicide by abuse; the 76 others are attributed to child abuse/neglect.
Nevada	17	5	37	For 2008
New Jersey	29	11	30	2008
Oklahoma	26	N/A	50	2006
Oregon	18	N/A	20	1999
Pennsylvania	40	10	98	2009. Includes death as a result of poor or absent supervision as well as death as a result of neglect
Washington	36 over the same 3 years	N/A	165 over 3 years	1999-2001: abuse/neglect "cited as a factor"

Compiled by National Center for the Review and Prevention of Child Deaths, July 2011

Deaths due to neglect are especially underreported. These include those in which a caregiver *egregiously* failed to protect a child from known hazards or to provide care. These include, for example, drownings of infants and toddlers in bathtubs, house fires wherein children were left alone overnight, children left in cars on hot days, or infants suffocated while sleeping together

with their intoxicated parent on couches or beds. Another area is medical neglect. In many cases these deaths are counted as deaths from natural, medical causes but a through case review may reveal that the caregivers failed to provide adequate care to keep the children healthy or alive. Examples include children who have manageable asthma or diabetes but caregivers fail to provide medication or to seek treatment when the child is critically ill.

I agree with the GAO findings on some of the reasons for the underreporting: lack of consistent definitions of maltreatment state to state and even within states; what Mississippi calls child abuse, Connecticut might call a sad accident or vice versa. There are inconsistencies across jurisdictions on how the determination of abuse and negle4ct is made and by whom- the CPS worker, the coroner, law enforcement, or the prosecutor? There are varying standards for criminal or civil charges of abuse or neglect. Community standards also vary widely across the U.S. influencing professional judgments. I have listened to many a CDR team member express frustration that a death will not be counted as abuse because the family has suffered enough, or "there but by the grace of God go I." Across the country I have listened to review teams describe very uncoordinated and/or incomplete investigations in child deaths-sometimes because resources are so limited for investigations and sometimes because investigators haven't been well trained. I have also been to many a review meeting in which the team members all agree that the child was killed by a caregiver but the prosecutor says he'll never get a jury to convict and thus no further action is taken.

On a positive note, we also know that by reviewing and understanding these deaths, communities and states are able to act on initiatives to prevent future deaths. That is why it is so important that we investigate, count and review these deaths accurately. I could spend all day here describing fantastic efforts implemented across the U.S. as a result of child death review. Some specific to the states you represent include: Kentucky has implemented new fire escape education for families because of deaths in which children died and adults survived. A number of states including North Dakota, Minnesota, Michigan, New York, Georgia and Lousisiana have implemented major public awareness' campaigns on shaken baby prevention and/or safe infant sleep awareness in part because of their reviews. North Dakota improved

their death reporting policies to CPS as a result of reviews. Tennessee developed new services for high risk families, including evidence-based home visitation. In Texas, their state CDR recommended that all CPS caseworkers be trained in infant death investigation-CPS there is now systematically training caseworkers across the 254 Texas counties based on these recommendations. Washington State recently trained 150 law enforcement officers on child death investigations. A number of states have changed mandatory reporting policies to CPS, for example requiring reports even if there are no surviving siblings. Michigan published the results of six years of review findings and subsequent recommendations and improvements in outcomes for children. They found a significant correlation between recommendations implemented into practice and declines in deaths associated with the problems addressed in those recommendations. In other words, when the state took action to address the systems problems associated with child maltreatment deaths, they had a drop in deaths that had those systems problems. One example is deaths of children from abuse with multiple prior but unsubstantiated CPS reports. Michigan implemented a policy requiring investigation after any three reports to CPS following a number of deaths in which children died and were found to have multiple unsubstantiated reports. Another example is children dying who had histories of presenting to the emergency department with injuries but the ED did not report these injuries to CPS. The state instituted widespread training for ED health professionals on mandatory reporting, and now the state sees few child deaths with prior non-reported ED histories.

I agree with the GAO recommendations to improve the comprehensiveness, quality and use of national data on maltreatment deaths. In particular our Center looks forward to being part of the solution-working with ACF, NCANDS and our child death review teams to identify mechanisms to share and use our data from child death review to improve our data, our understanding of these deaths and to prevent other deaths. We hope that there will be federal action to develop standard definitions for fatal maltreatment in civil and criminal jurisdictions; action to address privacy and confidentiality barriers that prevent the sharing of information when such information is needed to keep a child or surviving siblings safe; and increased efforts that focus on children with serious injuries from maltreatment that are not yet fatal.

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As a member of the National Coalition to End Child Abuse Deaths I also urge you to call for a National Commission as one part of the solution to study the complexities and offer national solutions to the issues presented in the GAO report.

But our states also need additional resources. Despite the fact that our nation is undergoing a severe budget crisis, we should not be a nation that fixes its budget crisis at the expense of abused and neglected children. Other than the $600,000 in funds allocated for *our* resource center, there is no dedicated funding to states for child death review or for the child death review case reporting system. Most states piecemeal their CDR programs together using state funds, Title V MCH block grant funds or CAPTA and Children's justice Act funds-never having enough to do justice to the children who have died. A bill was introduced in the last Congress and has been written this year but not yet introduced that will provide dedicated funding to states for child death review and improvements to child death investigations, especially those for sudden and unexplained infant deaths. And in addition to CDR, states certainly need emergency help for child protection as their resources dwindle while child abuse and neglect increases.

Our current CDR Case reporting system is rapidly becoming outdated and the software is fragile; but federal funds were not available to upgrade the software. Fortunately for our Center and the Case Reporting System's users, we have a new public-private partnership with Vantage Systems Inc., a private company known for its IT and engineering work at NASA's Goddard Space Flight Center. Vantage is donating its own staff and infrastructure to build a better version of our National CDR Case Reporting System. Vantage is doing this pro bono because in the words of their Vice President, Mike Ahan, "maybe our work can save one child's life." We anticipate receiving a complete software package from Vantage later this summer. Our Center and the technical support services at the Michigan Public Health Institute will work to launch this new version in January of 2012. It will have great improvements in functionality for states, including capacities to better link data with other sources, e.g. vital records, CPS and investigation records.

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Children have no power or say in what happens to them. It is our responsibility and duty to protect them and use our knowledge and lessons learned from a child's death to prevent another death. Having comprehensive and reliable data on child deaths and using that data to save children should be the foundation of our child protection efforts. The bottom line for me, and I know for the thousands of child death review teams members who spend their time together sharing horribly sad stories of children, is that we need to do a much better job working together at the local, state and national level to address the underlying causes of child abuse and neglect; work better to investigate, respond, count and report on the deaths, and most importantly create solutions to keep kids safe, healthy, happy and alive.

Chairman Davis, Mr. Doggett and those of you on the this committee, tonight I ask that you think about the seven and maybe even eight or nine or ten children who died today because someone who is supposed to tuck them in at night killed them instead. And then tomorrow please use your power on this committee to take action to keep our children alive.

Thank you.

Chairman DAVIS. Thank you, Ms. Covington.
Mr. Petit.

STATEMENT OF MICHAEL PETIT, PRESIDENT AND FOUNDER, EVERY CHILD MATTERS EDUCATION FUND

Mr. PETIT. Chairman Davis, Ranking Member Doggett, Members of the Subcommittee, thank you for convening this hearing and for the opportunity to testify on this issue. I am Michael Petit, president of Every Child Matters Education Fund.

I have been involved with child maltreatment fatalities for over 40 years, and I am sad to say that, despite great increases in our overall knowledge about child welfare, the situation facing these children has improved very little over that period of time. I was formerly with the Child Welfare League of America for a dozen years. I served as Maine's human services commissioner, which had responsibility for child welfare and child protection. I am also the author of a publication called, "We Can Do Better: Child Abuse Deaths in America."

I will devote my testimony to an overview of child abuse fatalities. Others will speak specifically to the data issues that are raised in the GAO report.

To start with, child abuse rates are much higher in the U.S. than in other democracies, triple Canada's rate, 11 times Italy's rate. The official tally of almost 1,800 deaths a year we believe is significantly undercounted, that there are, in fact, 2,500-plus deaths a year, about 5 times the number of U.S. soldiers killed in 2 wars since the beginning of our study.

Some 80 percent of the children killed are under the age of 4; 50 percent are under 1. Black children are nearly three times more likely to be killed. The vast majority of children are from low-income, low-education families. And of the 51 children randomly selected for our report—some of you may have seen this report; if not, we can make it available to you—there are 51 children here. In the course of our study period, going back to the start of the Afghan-Iraq wars, there were 400 children behind each one of these pictures. Of the 51 kids that we selected at random, only 1 was killed with a knife or a gun. The other 50 were principally—the principal cause of death was being beaten to death.

Our collective systems of child protection are stretched too thin. Too many troubled families, too few social workers and other staff, and too little community support. Few of the thousands of child protective units in the States are adequately equipped to deal with all the families brought to their attention. Consequently, protection for many children is a matter of geography. Where a child lives may determine whether she lives or dies. Some States appear to have a 10 times greater death rate than others. Some States appear to spend five times more than others on child protection. I say "appear," because of a lack of acceptance of standard definitions in the field. We don't really know.

Child abuse flows from extensive child maltreatment in the U.S., nearly three million reports a year, and preventable deaths are inevitable when we are drawing from such a large pool of vulnerable children.

A major factor, lack of public awareness about the scope and size of the problem, directly related to restrictive confidentiality laws, which—we hope one of the things that you will do is examine those laws and make modifications in them. They shield the press, public officials, and the public from shortcomings. And we made recommendations for—in 2009 that have been presented in this committee; 150 child protection experts met for a couple of days.

Let me say that I have had extensive personal experience in dealing with child fatalities where data interfered with the protection of a child. During my stint as Maine's commissioner of human services, we had a little girl that was presented to us by her family at 5:00 on a Friday afternoon.

Our social worker called the local mental health center and said, "Is the father of this child taking his medications? We know that he is a mentally ill individual, and he is not taking the medication." They said, "We are not going to share that information with you, there are confidentiality issues for the parent, and we are not going to give you the information."

One hour later, that child was put in an oven, the oven was turned on, and the child died in the oven. It was a very tragic incident that put our whole State of Maine in a state of shock for weeks.

And I have provided specific consultation to counties all across the country on this business of bringing together the information from law enforcement, child protection, the mental community, mental health. And I am sad to say that, in most communities, there is not a sharing of that knowledge. And, in many instances, the civil legal protection system for children is not enough. The criminal justice system also needs to be brought into play, and we need to afford more progress in that.

Let me say in my remaining moments that the adherence and development of national standards in this area is critical. Are these children Texas children first, or are they Vermont children first, or are they American children first? That is an issue, the national standards.

The support of a commission to examine these child abuse deaths is critical, it is a very complex topic. The increase in—I mentioned. And then, I think, a public education campaign is critical in this area.

I will close my remarks with that, and I have submitted more detailed testimony elsewhere.

Thank you.

[The prepared statement of Mr. Petit follows:]

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
***** TUESDAY, JULY 12, 2011 AT 10:00 A.M. *****

TESTIMONY OF MICHAEL PETIT, PRESIDENT
EVERY CHILD MATTERS EDUCATION FUND

before the

COMMITTEE ON WAYS AND MEANS SUBCOMMITTEE ON HUMAN RESOURCES US HOUSE OF REPRESENTATIVES
Hearing on "Child Deaths Due to Maltreatment"

July 12, 2011

EVERY CHILD *matters*
education fund

Chairman Davis, Ranking Member Doggett, Members of the Sub-committee, thank you for the opportunity to testify on this urgent issue. It is one in which I have been involved for 40 years, including the time that I served as Maine's health and human services commissioner, and while at the Child Welfare League of America.

According to official federal statistics, 13,856 children died from child abuse and neglect during the 2001-2009 period. Additionally, several studies have concluded there actually is significant undercounting of maltreatment deaths, and that the true number may be several thousands more than reported.

Much can be done to reduce these child abuse and neglect deaths. There exists a vast body of knowledge about healthy child growth and development, including how to prevent abuse in the first place, and how to protect children from further harm if abuse should occur. But the sheer amount of child abuse and neglect in America—already more than 20 million reports of maltreatment made to government agencies in this decade—is certain evidence that, despite the best efforts of the many who work daily to address this problem, we continue to fall far short in applying our knowledge.

While the day to day direct responsibility for the protection of at-risk children rests with thousands of local and state child protection agencies, law enforcement, and courts across the country, their efforts could be greatly strengthened by expanding federal planning, coordination, and funding aimed at reducing child deaths.

Child Abuse Deaths are Preventable. The President and Congress Must Elevate the Protection of Children to a National Priority if Children Facing Mortal Danger Are To Be Protected

The official number of children killed from abuse or neglect nationwide in 2009 is 1,770. In 2001, the total was 1,300. Three-quarters of the children are under four.The current systems of child protection are stretched too thin to protect these children.

Between 2001-2009, the official number of child abuse and neglect fatalities was 13,856. The U.S. Department of Health and Human Services has reported an increasing number and rate of fatalities. In thousands of these cases, people

reported the danger facing the child to authorities. For a variety of reasons—especially child protective agency budgets and staff capacity stretched dangerously thin in comparison to the problem—the response to these warnings failed the child. Now a harsh economy combined with a steadily weakened safety net in many states—including unprecedented slashes in child protection spending in some states— threaten to put even more children at risk.

The direct administration of protective services to children at risk of imminent harm properly rests with state and local governments. But with a long history of inadequate funding for child protection and severe budget crises at the state and local levels threatening public safety, the federal government alone possesses the authority and resources to ensure equal protection to children all across the country.

It remains a little known fact that the federal government already provides nearly half of the funds in the formal child welfare system and much of the statutory framework. The federal government is also legally obligated to evaluate each state's child protection performance and to prescribe recommendations for improvement. But, as presently constructed, neither federal funding nor federal oversights are at levels sufficient to protect all children who require it.

The Actual Number of Child Fatalities Is Unknown but Is Believed to Be Much Higher than Official Statistics

Well-documented research suggests the number of children who die from abuse and neglect is considerably higher than official government statistics. Here's how the federal government defines maltreatment deaths:

> "Fatal child abuse may involve repeated abuse over a period of time (e.g., battered child syndrome), or it may Involve a single, impulsive incident (e.g., drowning, suffocating, or shaking a baby). In cases of fatal neglect, the child's death results not from anything the caregiver does, but from a caregiver's failure to act. The neglect may be chronic (e.g., extended malnourishment) or acute (e.g., an infant who drowns after being left unsupervised in the bathtub)."

Using this definition, several peer-reviewed studies conclude that there is a significant undercount of child maltreatment deaths. This is mainly due to what

some researchers believe to be the improper classification of many maltreatment deaths as "unintentional injury death," deaths such as those caused by drowning, fire, suffocation, and poisoning. Upon examination of the circumstances underlying such deaths by forensic, medical and maltreatment experts—particularly if conducted by multi-disciplinary teams—the percentage of cases re-classified as maltreatment-related may comprise 50% or more of the unintentional injury deaths attributed to other causes on death certificates. The vast majority of these re-classified deaths are associated with inadequate supervision of children, often rising to the level of neglect.

If the research is correct about this "under-ascertainment" of maltreatment-related deaths, if it holds roughly true nationwide, then thousands of additional children should be included in the official maltreatment death toll from 2001-2009. What explains the undercount? There are a variety of reasons, including different state definitions of what constitutes a child abuse and neglect death, data collection methodologies, inconsistent record-keeping across the country, and who it is that actually determines the cause of death.

For example, a local child protective services agency opens a case involving child neglect. But because the mother agrees to treatment, the agency decides to leave the child home. However, the mother continues her drug use and one afternoon passes out in her apartment. Meanwhile, her two-year-old child plays unsupervised on a street and is struck by a car. In most states the death is recorded as a pedestrian accident, not the child neglect-related death that the federal definition would suggest it is.

A promising development in determining the amount of maltreatment deaths has been the creation of state child death review teams. In virtually all states there is a team which exists to review child deaths and determine their cause, including deaths from child abuse and neglect. The information resulting from this multi-disciplinary team process provides invaluable data which can shape public health, law enforcement, and child welfare policy and practice. The teams vary in their capacity to conduct their activities. Some are well-funded and give each case the attention required; many don't have the necessary resources. The review teams agree on the need for stronger efforts to prevent child abuse and neglect deaths. In the words of one state's team manager: "For conditions that are 100% preventable, we do a very poor and extremely fragmented job at preventing child maltreatment, as well as protecting those being maltreated."

Child Abuse and Neglect Fatalities Flow from Extensive Child Maltreatment in the U.S.

Nearly 20 million annual reports of abuse and neglect have been made to official state child protection agencies in this decade. And while 'only' a third or so of these reports were initially substantiated as abuse or neglect, it is often just a matter of time before many of the unsubstantiated cases also reveal themselves to be true as new reports involving the same family continue to be made to the child protection agency. There is no evidence which suggests that intentionally false reports alleging maltreatment are a serious issue. The reality is that child abuse and neglect in our culture are common.

Furthermore, state reporting to the federal government—required by law—remains uneven: since 2001, 24 states did not report child abuse and neglect numbers for at least one of the years in the Department of Health and Human Services annual Child Maltreatment report, and some did not report at all. Even without complete state data, the official numbers of children reported abused or neglected are staggering. Additionally, incidence studies of abuse and neglect conducted for the federal government suggest that the actual occurrences of maltreatment may be three times greater than the number of reports made to state child protection agencies.

Of the 721,646 children confirmed abused and neglected in 2007:

- 60% did not receive proper food, clothing, shelter, hygiene, education, medical care or protection.
- 13% suffered from multiple maltreatments.
- 11% were physically abused.
- 8% were sexually abused.
- 4% suffered from emotional abuse.
- 1% suffered from medical neglect.
- 4% suffered from other mistreatment such as abandonment, threats, and congenital drug addiction.
- 50% or more of child abuse and neglect cases are associated with alcohol or drug abuse by parents.

Of the millions of children reported abused or neglected each year, several thousand are in life threatening situations. The present systems of child protection successfully intervene in many of these situations, and further harm to a child is prevented. But for nearly 2,000 children, whatever response may be generated is too little, too late, and children die.

Many More American Children Die from Abuse and Neglect Than Do Children in Other Advanced Countries

Among the richer democracies, the U.S. child abuse death rate is 3 times higher than Canada's, and 11 times higher than Italy's.

What accounts for the differences? Among other things, teen pregnancy, violent crime, imprisonment, and poverty rates are much lower in these countries. Further, their social policies in support of families are much greater and typically include child care, universal health insurance, paid parental leave, visiting nurses, and more—all things which together can prevent child abuse and neglect in the first place.

The U.S. invests only modestly in similar preventive measures compared to the needs of the most vulnerable families. This serious social policy lapse creates an environment where child abuse and neglect are common—where preventable maltreatment fatalities are inevitable.

It Is Largely an Accident of Geography Whether Abused or Neglected Children Receive the Full Protection They Need

As hard as they may try, no states are in full compliance with federal child welfare standards. No matter, state child protection reform efforts, often stemming from federal reviews and evaluations, have fueled many positive changes in state child protection practices in recent years.

But the combination of millions of children in harm's way and inadequate resources leaves many states stretched too thin to protect all children who need it. Accordingly, it is unlikely that states will come into compliance with all federal standards anytime soon, especially in view of severe state budget woes. But some states do protect children better than others. For example, in 2007 the child abuse and neglect fatality rate in the bottom state was 16 times that in the top state.

Although a clear correlation has not been established on how much states spend on child protective services and their child abuse and neglect death rates, states which do allocate more funds are more likely to investigate all abuse and neglect

reports, not just some, because social workers have more manageable workloads. They also are more likely to retain staff; invest heavily in training; provide timely mental health, substance abuse treatment, and other services; and to prosecute serious abusers. Some states have much less capacity to conduct such activities, and state budget problems are weakening already under-funded systems of child protection. Such huge variations in capability among the states and their thousands of child protection offices across the country can translate directly into whether children live or die.

Many Child Protection Workers Frequently Lack the Resources and Training They Need

Child protection work is labor intensive, difficult, and emotionally stressful. The consequences of the decisions that child protection workers must make can be enormous: leave a child in harm's way, for example, or exercise powerful state authority that can result in the termination of parental rights. When trained and experienced staffs have access to experienced supervisors and to timely services such as mental health, substance abuse treatment, police back-up, and emergency shelter, children are much more likely to be protected, and abusive parents are much more likely to learn how to care for their children safely.

Recruiting and retaining highly trained social workers is a must. A major factor in retention is workload size. Children inevitably fall through the cracks when child protection workers have unmanageable workloads, leaving workers frustrated. Caseload ratios in some jurisdictions are as high as 60 or more, even while national standards recommend 12 or fewer cases per worker. Another factor in recruitment is compensation. Starting salaries under $30,000 for child protection workers are not uncommon, and rarely do they rise above $50,000—modest sums in view of the important jobs they are asked to do.

Further, while child protection workers are the most prominent "first responders" to child abuse and neglect, there are many others on the front lines who also may be involved, including education, law enforcement, and health professionals. Often, these groups lack training and support for fulfilling their own obligations to report abuse and neglect and to protect children.

To protect children at high risk of life-threatening abuse and neglect, the official child protective services agencies and law enforcement must collaborate. Child

protective workers are best able to focus on the needs of the child, and law enforcement personnel are essential when confronting serious abusers. Written protocols and joint training between child protective services and law enforcement are essential for protecting children. Such collaborative efforts are much better developed in some jurisdictions than others, including those served by children's advocacy centers.

Restrictive Confidentiality Laws Shield the Press, Elected Officials and the Public from Shortcomings in the Child Protection System

Originally intended to protect living child victims from publicity, confidentiality laws have become a hindrance to a better public understanding of child abuse and neglect fatalities. Sometimes used to shield the public from the details of a child's death, confidentiality laws also interfere with journalists gathering and reporting facts about the incident. Even lawmakers are sometimes denied access to information surrounding an individual case, information that is critical to strengthening the child protection system. The withholding of such information benefits no one.

Stories about child abuse and neglect deaths are often reported in local papers, especially if a child's situation was brought to the attention of authorities. Frequently, however, these reports reveal little about how the formal child protection system performed in a fatality case. Instead they may focus on the seeming inadequacy of the child protective worker in the case, and often they prompt a call for both the worker and agency administrator to be fired. This response does little to address the underlying systemic problem.

The national press generally limits its maltreatment coverage to the most sensational child deaths. It provides virtually no press coverage of the federal government's role in the prevention of child abuse and neglect fatalities. And it is rare to see members of Congress or senior Administration officials speaking to the issue.

Stopping Child Abuse and Neglect Fatalities Requires Fighting Child Poverty

While strengthening the formal child protective services system has the highest

immediate promise for safeguarding children in dangerous situations, there are millions of children in marginal homes who are at daily risk of harm. Reducing this risk will reduce fatalities—and the need for protection in the first place. Reducing risk also poses an enormous economic challenge because, while child abuse occurs in all socioeconomic ranks, it lands hardest on children in the poorest families. In fact, poverty is the single best predictor of child abuse and neglect, and no wonder in view of the family stress often accompanying poverty. One study found that a child living in a family with an annual income of $15,000 or less was 22 times more likely to be abused than one in a family with an income of $30,000 or more.

One in five American children, over 14 million, still lives in poverty. Conditions that are still widespread in the U.S., i.e., teen parenthood, violence, mental illness, substance abuse, imprisonment, unemployment, low education, and poor housing, are all disproportionately associated with poverty and often wreak havoc on poor families and children.

Most fatality victims are very young and very poor. In 2007, 75% were four or younger, and almost half were under age one. As noted in the federal Department of Health and Human Services' report Child Abuse and Neglect Fatalities: Statistics and Interventions, "these children are the most vulnerable for many reasons, including their dependency, small size, and inability to defend themselves." Further, 70% of the fatalities involved a parent as perpetrator. And often the abuser is a poor "...young adult...without a high school diploma...depressed... [who] has experienced violence first hand."

We know a great deal about preventing abuse and neglect and stopping related fatalities. When provided with support services and appropriate supervision, the vast majority of potentially abusive and neglectful parents can learn to safely care for their children. And many abused children who get help are resilient enough to overcome their history. But for many, the outcome is predictable: when childhood goes wrong, adulthood goes wrong, and the sad story of abuse, including death, repeats itself from one generation of troubled families to the next.

Children at Grave Risk of Being Killed Require Protection from Their Government

We need a national approach for protecting children because of the heavy toll exacted from the nation caused by child abuse and neglect—thousands killed, millions of lives ruined, costs of more than $100 billion a year.

While it is too late to help the children shown in this report, we can honor their memories by vowing to protect every child in danger.

Yet even with broad public support for protecting every child from harm, the nation's present commitment of resources, laws, and policies is too little.

We can overcome inadequate funding for child protective services and wide variations in capacity among states only by enacting federal policy committed to protecting children no matter where they live.

Call to Action: Stop Child Abuse and Neglect Deaths

A National Commission to End Child Abuse and Neglect Fatalities should be created by Congress. Building upon the best of current child protection systems, it should recommend a national strategy for stopping maltreatment deaths.

• Current levels of federal spending are far below the level needed to protect all children at imminent risk of harm. $3 billion to $5 billion in additional funds are required, for example, to allow child protective workers and other frontline personnel to have smaller caseloads and better training, and to provide a wide array of public health and social services to help at risk families.

• In consideration of expanded federal spending, states should be required to adopt national standards, drawn from existing best practices and policy, for protecting children.

• Congress should modify confidentiality laws to allow policy makers, the press, and the public to understand better what protection policies and practices need to be improved in the aftermath of a child's death.

• The Department of Health and Human Services should standardize definitions and methodologies used to collect data related to maltreatment deaths and should require states to provide such data in order to receive federal funds. Further, state child death review teams should be adequately funded.

• The Department of Health and Human Services, in cooperation with state child protective and public health agencies, should conduct a public education campaign to encourage reporting of child abuse and neglect, and to enlist

communities in the protection of children.

• To better protect children at imminent risk of severe harm, the federal government, led by the Departments of Justice and Health and Human Services, and in cooperation with states, should adopt a model protocol for assuring that civil and criminal legal proceedings are closely coordinated between child protection and law enforcement agencies.

Chairman DAVIS. Thank you very much, Mr. Petit.
Dr. Jenny.

STATEMENT OF CAROLE JENNY, M.D., DIRECTOR, CHILD PROTECTION PROGRAM, HASBRO CHILDREN'S HOSPITAL

Dr. JENNY. Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee, I thank you for the opportunity to testify on child deaths due to maltreatment.

I am a professor of pediatrics at Brown Medical School, and the director of the child protection program at Hasbro Children's Hospital in Rhode Island. I have a unique perspective on this issue, because I may be the only person in this room who often has stood at the bedside in the emergency department or in the intensive care unit, and actually witnessed the deaths of infants and children from maltreatment.

When the death of a child is the result of abuse or neglect, a sad event becomes an immense tragedy. The 1,700-yearly child maltreatment deaths officially reported are just the tip of the iceberg. As the GAO report points out, counting and tracking the number of deaths from maltreatment is challenging.

Sometimes it is very difficult to distinguish between accidental and non-accidental death. For example, when a child is purposely suffocated with a pillow or a plastic bag, it can be impossible to distinguish this act from a death by natural causes.

In addition, many deaths from neglect are not counted as such. In Rhode Island, a three-year-old was told by his drunken father to go across a busy street to retrieve a discarded lamp from a neighbor's trash. He was hit by a car and killed, and his death was ruled an accident.

And what about deaths caused by the late effects of maltreatment? If a teenage survivor of horrific sexual abuse commits suicide because of her severe depression and post-traumatic stress, is that considered a child abuse death? In my opinion, the root cause of death in that case is child maltreatment.

My interest is in providing more accurate primary data to the agencies that track child maltreatment deaths. These agencies cannot perform well if the cases they review have not been adequately investigated. The pediatric profession has recently made a giant leap in improving this process. The American Board of Pediatrics has established the board-certified pediatric sub-specialty of child abuse pediatrics.

These pediatricians complete an additional 3 years of fellowship training in child maltreatment, becoming experts in the recognition, diagnosis, treatment, and prevention of child maltreatment. When a child does die from abuse or neglect, these pediatricians can help police, forensic, and social service agencies make the correct diagnosis by doing the appropriate medical work-up in the hospital, and by ruling out conditions that mimic abuse or neglect.

There are—there is currently no Federal support for training pediatric sub-specialists in child abuse pediatrics. We need to expand the availability of fellowships, to make sure that these doctors are available to all hospitals around the country that care for children. The National Association of Children's Hospitals and Related Institutions has published recommended guidelines for the establish-

ment of child protection teams at all children's hospitals, but there are not enough trained, board-certified pediatric specialists in the field to provide this expertise.

Another way to increase the accurate counting of child maltreatment deaths is to increase the resources available to medical examiners and coroners, and to support their performance of quality death investigations. Multiple studies have shown that only about half of the child maltreatment deaths are actually recognized and recorded on death certificates and in State vital statistics.

In summary, in addition to improving our method of counting child maltreatment deaths, we need to improve our ability to recognize and discern when a death is due to child maltreatment. And if we have the resources to diagnose abuse and neglect, and provide the necessary treatment and services to children and families, we can actually prevent the ultimate worst outcome, the death of a child.

It is important to note that strengthening the quality of medical and death investigations in child abuse cases adds another protective factor. That is, we will be better able to protect innocent parents from allegations of child abuse and neglect, and to preserve and promote families.

Thank you.

[The prepared statement of Dr. Jenny follows:]

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
***** TUESDAY, JULY 12, 2011 AT 10:00 A.M.*****

Testimony of Carole Jenny, MD, MBA, Committee on Ways and Means Subcommittee on Human Resources, U.S. House of Representatives, Hearing on Child Deaths Due to Maltreatment, July 12, 2011:

Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee, I thank you for the opportunity to testify on child deaths due to maltreatment. I am a Professor of Pediatrics at Brown Medical School and the Director of the Child Protection Program at Hasbro Children's Hospital in Providence, Rhode Island. I have provided medical care for abused and neglected children for over 28 years. I have a unique perspective on this issue because I believe I am the only person in this room who has often stood at the bedside in the emergency department or in the intensive care unit and actually witnessed the deaths of infants and children from maltreatment.

When the death of a child is a result of abuse or neglect, a sad event becomes an immense tragedy.[1] This was certainly seen most recently in the public outcry over the death of Kaylee Anthony, a previously healthy, happy toddler.

The 1,700 yearly child maltreatment deaths reported by the National Child Abuse and Neglect Data System are just the tip of the iceberg.[2] As the GAO report points out, counting and tracking the number of deaths from maltreatment is challenging. Sometimes it is very difficult to distinguish between accidental and non-accidental death. For example, when a child is purposely suffocated with a pillow or a plastic bag, it can be impossible to distinguish this from a death by natural causes. In addition, many deaths from neglect are not counted as such. In Rhode Island a 3-year-old was told by his drunken father to go across a busy street to retrieve a discarded lamp from a neighbor's trash. He was hit by a car and killed, and his death was ruled an accident. And what about deaths caused by the *late* effects of maltreatment? If a teenaged

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survivor of horrific sexual abuse commits suicide because of her severe depression and post-traumatic stress, is that considered a child abuse death? In my opinion the root cause of death in that case is child maltreatment.

My interest is in providing more accurate primary data to the agencies that track child maltreatment deaths. These agencies cannot perform well if the cases they review have not been adequately investigated. The pediatric profession has recently made a giant leap in improving this process. The American Board of Pediatrics has established the board certified pediatric subspecialty of Child Abuse Pediatrics.[3] These pediatricians complete an additional 3 years of fellowship training in child maltreatment, becoming experts in the recognition, diagnosis, treatment and prevention of child maltreatment. When a child does die from abuse or neglect, these pediatricians can help police, forensic, and social service agencies make the correct diagnosis by doing the appropriate medical work up in the hospital and by ruling out conditions that mimic abuse or neglect.

There is currently no Federal support for training pediatric subspecialists in Child Abuse Pediatrics. We need to expand the availability of fellowships to make sure that these doctors are available to *all* hospitals around the country that care for children. The National Association of Children's Hospitals and Related Institutions has published recommended guidelines for the establishment of Child Protection Teams at all children's hospitals,[4] but there are not enough trained, board certified pediatric specialists in the field to do provide this expertise.

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Another way to increase the accurate counting of child maltreatment deaths is to increase the resources available to medical examiners and coroners and to support their performance of quality death investigations. Multiple studies have shown that only about half of child maltreatment deaths are actually recognized and recorded on death certificates and in state vital statistics. [5-7]

In summary, in addition to improving our methods of *counting* child maltreatment deaths, we need to improve our ability to *recognize* and *discern* when a death is due to child maltreatment. And, if we have the resources to diagnose abuse and neglect and provide the necessary treatment and services to children and families, we can actually *prevent* the ultimate worst outcome, the death of a child. It is important to note that strengthening the quality of medical and death investigations in child abuse cases adds another protective factor. That is, we will be better able to protect innocent parents from allegations of child abuse and neglect, and to preserve and promote families.

This testimony represents the opinion of Dr. Carole Jenny and are not attributed to any organization.

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Title of Hearing: Child Deaths Due to Maltreatment, July 12, 2011

Chairman DAVIS. Thank you, Dr. Jenny. With that, I would like to defer to the distinguished Ranking Member to introduce the next witness.

Mr. DOGGETT. I am very pleased to have join our panel Dr. Jane Burstain. Dr. Burstain is responsible for child welfare and child protective service budget issues at the Center for Public Policy Priorities in Austin, Texas. It is located in the same neighborhood that is my home in east Austin. And CPPP is a non-profit, non-partisan think tank that has played a vital role in Texas, particularly on State legislative issues committed to improving the economic and social condition of low to moderate-income Texans.

Before she came to east Austin, Dr. Burstain served as an adjunct professor at Pepperdine, where she taught family policy classes. And she worked as an attorney representing children in the Los Angeles child welfare system. So we really have this coast-to-coast problem and insight offered by our panelists this morning.

Thank you, Doctor.

STATEMENT OF JANE MCCLURE BURSTAIN, PH.D., SENIOR POLICY ANALYST, CENTER FOR PUBLIC POLICY PRIORITIES

Dr. BURSTAIN. Thank you. Chairman Davis, Ranking Member Doggett, and Members of the Subcommittee; thank you for the opportunity to come testify on this important and tragic issue.

As Representative Doggett mentioned, I have worked in the child welfare arena for more than a decade. I started out as an attorney in Los Angeles, and during my six-year tenure there representing thousands of abused and neglected children, I became interested in taking my experience and translating it into systemic improvement. I earned my Ph.D., and in 2008 I joined the Center for Public Policy Priorities in Austin, Texas.

At the Center, I conduct research, I participate in State and national coalitions, and I educate policymakers on how to improve and create better outcomes for children and families.

Let me start by saying that I absolutely agree with Representative Doggett, that even one child death from maltreatment is too many. It is the ultimate tragedy for the family and the community, and for the individuals who have to investigate it. But every single day in the United States more than four children are reported to have died from abuse and neglect. That is one death every 6 hours. And those are just the ones that we know about. As all the witnesses have testified here, the number of children dying from maltreatment is probably even higher.

As discussed in my written testimony, and as adequately and extensively documented by the witnesses here, we do need to do a better job with States getting more quality, comprehensive, and consistent data on child maltreatment deaths. But with children dying every day, we cannot wait for the data to be perfect before we act. So I am going to focus on what we do know.

We know that even taking reporting differences into account, some States have higher child maltreatment death rates than others. We also know that poverty and having a teen parent are significant risk factors for abuse and neglect, and that those risk factors are more prevalent in certain States.

So, I looked at States with high child poverty rates and high teen birth rates, which include many of the States represented on the panel today in this committee, and I looked to see if those States, on average, also had higher child maltreatment death rates. I found that States with high child poverty had a 43 percent higher death rate, on average. And I also found that States that had a high teen birth rate had a 61 percent higher death rate, on average.

As families struggle and stress levels rise, child maltreatment becomes more of a risk. And this risk is only growing. The great recession has pushed more families into poverty. As compared to 2008, the number and percentage of children living in poverty has increased nationwide in virtually every State. And although the teen birthrate has dropped nationwide, some States still struggle with the issue. In Texas, in 2008, there were 55,000 births to teenage girls.

If we want to reduce child maltreatment, now is not the time to cut support to struggling families. But as States grapple with huge budget deficits, that is exactly what is happening. The number of children receiving child abuse and neglect prevention services has declined in 17 States, many of which are represented here on the Subcommittee.

In Texas, with more than 1.6 million children living in poverty and at risk for maltreatment, there is only funding for about 6,000 to receive direct child abuse and neglect prevention services. Budgets are so tight that States are even cutting services to children who have been subjected to abuse and neglect.

In 2009, in some States, 2 of every 3 children who are child abuse and neglect victims stayed in their home and did not receive any ongoing child welfare family support services.

Early education and child care programs, which have been shown to reduce aggressive parenting behavior and maltreatment are being cut, as well. Getting children out of the home and into daycare reduces parental stress, and makes the children more visible to reporters who can identify a problem before it escalates into something serious. But in Texas's most recent budget, the legislature cut grants to support pre-kindergarten by 100 percent, and cut $.20 of every dollar that funds subsidized daycare to at-risk children. That is why Federal programs which help support struggling families, like title IV–B of the Social Security Act, the child care development block grant, and the supplemental TANF grant are so important.

Expanded health insurance options for adults under the Patient Protection and Affordable Health Care Act is important, as well. With health insurance, poor parents are struggling with substance abuse and mental health, can get access to services, and thereby reduce the risk factors for reduce and neglect, get healthy, and take care of their kids.

I know that the budget crisis that is facing States extends to the Federal Government. But to cut programs that support struggling families in tough economic times is the very definition of penny wise and pound foolish.

And if we make that choice, our children will pay for it with their lives.

[The prepared statement of Dr. Burstain follows:]

CPPP Center *for* Public Policy Priorities | **Testimony**

U.S. House Committee on Ways and Means, Subcommittee on Human Resources Hearing
Child Deaths from Maltreatment **July 12, 2011**

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
*****TUESDAY, JULY 12, 2011 AT 10:00 A.M.*****

DATA ON CHILD MALTREATMENT DEATHS

Chairman Davis, Ranking Member Doggett and members of the Subcommittee, thank you for this opportunity to testify about the important issue of child maltreatment deaths. I have worked in the child welfare arena for more than a decade. In 1998, I left my civil litigation practice and started working as an attorney for the Children's Law Center in Los Angeles (CLC-LA) representing thousands of children over my tenure there. After working at CLC-LA for almost six years, I became interested in taking my experience working with children and families and translating it into systemic improvement. I earned a PhD in policy analysis at the Pardee RAND Graduate School, writing my dissertation on improving outcomes for teenage mothers in the child welfare system. After receiving my PhD in 2008, I came to work at the Center for Public Policy Priorities, a non-profit, nonpartisan think tank based in Austin, Texas that is committed to improving public policy to better the economic and social condition of low- to moderate-income Texans. At the Center, I work on child welfare policy and budget issues. I conduct research, participate in state and national coalitions and educate policy makers on how to create better outcomes for children and families.

I think you would agree that even one child maltreatment death is too many. But in 2009,[1] every single day more than 4 children were reported to have died from abuse or neglect in the United States.[2] And since not every state reports on child maltreatment deaths and some states that do report may not be capturing all such deaths, the actual number is probably even higher. Having quality, comprehensive and consistent data from the states regarding child maltreatment deaths is an important step in understanding why such deaths are happening and what can be done to prevent them.

While improving data collection and reporting procedures is important, it can take time and resources to accomplish. But we don't have to wait for the data to be perfect before we can act. The data we have now, even though limited, shows that states with a higher rate of child maltreatment deaths also have higher rates of child poverty and teen births. As families struggle and stress levels rise, child maltreatment becomes more of a risk. If we want to address this problem, we need to invest in our families and the future of our children. To cut programs that support struggling families in tough economic times is the very definition of penny-wise and pound foolish and is a choice our children will pay for with their lives.

Some States Have Significantly Higher Reported Child Maltreatment Death Rates

There is significant variation among the states with respect reporting deaths from child maltreatment. Some states do not report at all,[3] some states report that they have no child maltreatment deaths[4] and for the other states, total numbers range from 1 up to 279.[5]

Even taking the numbers at face value, with the differences in population size among the states, a comparison based on the total number of deaths is not always useful. Texas may have more reported child maltreatment deaths than Nevada, but it also has a significantly larger child population.

To look at the number of deaths in context, a rate that takes into account differences in population size must be used. For child maltreatment deaths, the rate used is the number of deaths per 100,000 children in the population. For example, Texas reported 279 child maltreatment deaths in 2009, which translates into a rate of about 4 deaths for every 100,000 children in its population. In contrast, Nevada reported only 29 child maltreatment deaths in 2009, but with its smaller child population, it actually has a slightly higher rate than Texas of 4.26 deaths for every 100,000 children.

Even looking at reported child maltreatment death rates, however, there still is significant variation among the states. And over the years, the child maltreatment death rate ranking among the states has changed, although some states like Texas consistently have higher rates than the average.

Some States with Higher Rates Seem to Have a More Robust Data Collection and Reporting System

Although the federal government collects child maltreatment data from the states, not all states report child maltreatment fatalities.[6] And even among the states that do report, there is significant variation in how they define, investigate and report when a child's death results from maltreatment, with some systems seeming more robust than others.

Some states have a broader definition of abuse and neglect and so may be more likely to identify a child's death as resulting from maltreatment. For example, 18 states include a parent's drug use in its definition of child maltreatment,[7] while the others do not.

The procedures for investigating whether a child's death is from maltreatment vary among the states as well. Although virtually every state has some sort of process for reviewing child deaths,[8] 30 of them have local involvement in their child death review process while the process in the other states is conducted solely at the state level.[9] Input from the communities in which the deaths occur may allow those states with local involvement to better investigate and identify when a death is from abuse or neglect.

Some states also have special investigative procedures that must be followed in a child death that may increase the accuracy of a child death evaluation. For example, in Texas, all deaths of children under the age of 6 must be reported to the county medical examiner who must conduct an inquest to determine whether the death is from abuse or neglect.[10] 30 other states also have some sort of special reporting procedures for suspicious child deaths.[11]

Finally, the 39 states that have a centralized child welfare system and database may have a more comprehensive and accurate data collection and reporting system for child maltreatment deaths compared to states with a

decentralized, county-run system.[12] For example, Texas has a centralized system and reports data on child maltreatment deaths both at an individual case and an aggregate level. In contrast, California, with its decentralized, county-run system, only reports data on an aggregate level with no case-level details.

Looking at the characteristics together, only five states have all four characteristics (parental substance abuse in maltreatment definition, local involvement in death review, special investigative requirements and a state-run child welfare system): Florida, Illinois, Indiana, South Dakota, and Texas. And, collectively, these states have a higher rate of child abuse and neglect deaths as compared to other states.[13] This suggests that the higher rate of child maltreatment deaths in some states may not be because more deaths are occurring but, rather, because the state is doing a better job in investigating and reporting such deaths. In other words, it is likely that some states are underreporting and so the problem is probably even bigger than we think.

Improving the quality and consistency of available data about child maltreatment deaths, however, can be difficult. Increasing the quality of data collection and investigative procedures would require states to dedicate additional funding and resources which they simply may not have. Ensuring consistency is also problematic. Even if there were a national definition of maltreatment and some guidelines on how to classify child deaths, there may not always be consistent determinations. Determining whether maltreatment caused a child's death will always involve some level of subjective judgment and be affected by the resources dedicated to the investigation, especially when the death was accidental rather than intentional. For example, when a child dies from an accidental drowning, one state may carefully review the circumstances and conclude that the parent failed to appropriately supervise the child, classifying the death as from neglect. Another state investigating the same circumstances, however, may simply classify it as accidental and not even investigate the possibility of neglect.

States with Higher Rates of Child Maltreatment Deaths also Have Higher Rates of Risk Factors for Child Abuse and Neglect

As discussed above, a more robust data collection and reporting system may explain why some states have a higher child maltreatment death rate. But it does not fully explain the variation because even among the states with a robust system, there are differences. In 2009, Texas' child maltreatment death rate was 4.05 per 100,000 children while the average rate for the other robust system states (Florida, Illinois, Indiana and South Dakota) was statistically significantly lower at 3.1 per 100,000 children.

As discussed below, part of the differences in child maltreatment death rates appear to be related to risk factors that are more prevalent in certain states.

States with a High Child Poverty Rate Have a Higher Rate of Child Maltreatment Deaths[14]

Poverty is a consistent predictor of abuse and neglect. Children in families with an annual income of less than $15,000 are 14 times more likely to be abused and 44 times more likely to be neglected as compared to children in families with an annual income of $30,000 or more.[15] And, on average, states with high child poverty (defined as at or above 20 percent of the overall child population)[16] had a child maltreatment death rate that was 43 percent higher than states with lower child poverty.[17]

States with a High Teen Birth Rate Have a Higher Rate of Child Maltreatment Deaths[18]

Children with young mothers are at a higher risk of maltreatment.[19] And, on average, states with a high teen birth rate (defined as at or above 53 births per 1,000 teenaged females[20]) had a child maltreatment death rate that was 61 percent higher than states with a lower teen birth rate.[21]

Support for Programs that Help Alleviate Child Abuse and Neglect Risk Factors Are Needed Now, More than Ever

With the Great Recession and continued high unemployment, more families have been pushed into poverty. As compared to 2008, the number and percentage of children living in poverty increased nationally and in virtually every state in 2009, in some cases by up to 40 percent.[22]

And although the national teen birth rate has dropped in recent years, some states still struggle with the problem. In Texas, the teen birth rate has remained high for the last several years at around 63 births per 1,000 teenaged females so that in 2008, there were more than 55,000 births to girls younger than 20.[23]

In sum, the number of children at risk for child maltreatment continues to grow. To ensure that this trend does not translate into more child maltreatment deaths, Congress needs to ensure continued support and funding for programs that address risk factors.

Congress Needs to Ensure Continued Funding for Direct Child Abuse and Neglect Services

Despite an increase in the number of families at-risk for abuse and neglect, the number of children receiving prevention services has declined in 16 states.[24] As states grapple with huge revenue shortfalls, prevention programs are often the first casualties of the budget axe. In Texas, the legislature just passed a budget that cut child abuse and neglect prevention funding by 44 percent.[25] That means that in a state with more than 1.6 million children in poverty and at risk for maltreatment, only 6,000 will receive prevention services annually.[26]

Budgets are so tight that states are even cutting services to children who have been subjected to abuse and neglect. In 2008, an average of 63 percent of child maltreatment victims nationwide received services to address the family's problems. In 2009, the rate dropped to less than 60 percent and, in some states, the rate was so low that fewer than 1 in 3 child abuse and neglect victims received any such services.[27]

To avoid any further cuts, Congress must ensure that federal funding that supports child abuse and neglect services continues and is not cut. For example, funding under Title IV-B of the Social Security Act is the primary support in many states for child abuse and neglect prevention services. In 2009, Promoting Safe and Stable Families (PSSF) funding paid for more than 30 percent of prevention services nationwide and in 8 states[28], PSSF accounted for more than 50 percent of such services.[29] Funding for home visitation programs provided under the Patient Protection and Affordable Care Act is important as well. Studies have shown that such programs improve parenting and child health and safety and, in some cases, reduce maltreatment, even among the high risk population of adolescent mothers.[30]

Congress should also create a new Title IV-E waiver program so states can pilot more flexible ways to use dedicated child welfare federal funds to keep children at risk of child maltreatment safe at home instead of languishing in the more expensive and less optimal alternative of foster care. A detailed discussion of why Title IV-E waivers are necessary is contained in my recent written testimony to the U.S. Senate Committee on Finance at the hearing on Innovations in Child Welfare Waivers: Starting the Pathway to Reform.[31]

Support for Subsidized Early Education and Other Child Care for Low Income, Working Families Needs to Continue

Several studies have demonstrated that Head Start and other subsidized early education and child care programs have been successful in reducing aggressive parenting behavior that can escalate into child abuse.[32] And one study in Chicago showed that young children from disadvantaged neighborhoods who participated in a child care program had 50 percent fewer court petitions related to maltreatment compared to children in similar neighborhoods that did not have the program.[33]

Some states also use child care to keep children who have already been subjected to abuse and neglect safe in their own homes. In Texas in state fiscal 2010, the state child welfare agency used subsidized day care to keep an estimated 17,000 young child maltreatment victims safe in their own home in lieu of removal.[34] Such options are not only better for the child but cheaper for the state. In Texas, foster care costs about $1,900/month while subsidized day care is less than $600/month.

Getting children out of the home and into day care helps relieve parental stress, gives parents non-physical models for discipline and makes the children more visible to potential reporters so problems can be identified before they escalate into something serious. But like prevention programs, funding for early education and child care has fallen victim to the budget axe. In Texas' most recent budget, the Legislature cut grants to support pre-kindergarten by 100 percent, cut funding for subsidized child care for at-risk children by 18 percent[35] and cut protective day care service levels by 16 percent.[36]

The recent cuts at the state level make funding from the federal Child Care Development Block Grant more important than ever as it is often the primary funding stream for such services. In Texas in 2010, 46 percent of day care for at-risk children and 50 percent of protective day care was funded through the Child Care Development Block Grant.[37]

The Supplemental Temporary Assistance to Needy Families Grant Needs to be Reauthorized

The supplemental Temporary Assistance to Needy Families grant was created specifically to help states with high poverty rates, which are the very same states that also have high child maltreatment death rates. Given the cuts that states have already implemented, reauthorizing this funding will help ensure that these programs are better protected in the future.

Expanded Health Insurance Options for Adults Will Help Alleviate Abuse and Neglect Risk Factors by Providing Access to Mental Health and Substance Abuse Treatment

Substance abuse is a significant risk factor for child abuse and neglect. When parents abuse substances, they pay less attention to their children which may result in more accidents or a lack of necessary medical care.[38] They are more likely to use harsh parenting styles and leave their children unattended and have other problems such as domestic violence, single-parenthood and depression, all of which may increase the likelihood of maltreatment.[39] Mental illness, which often co-occurs with substance abuse, also interferes with parenting and is a risk factor for child maltreatment.[40]

But most adults living in poverty have no way of obtaining health insurance and so lack access to substance abuse and mental health treatment. In Texas alone, 5 million adults age 19 to 64 are uninsured, the majority of whom are under 400 percent of the federal poverty limit.[41] Starting in 2014, however, under the Patient Protection and Affordable Care Act, these adults will be eligible for health insurance either through Medicaid or the Health Insurance Exchange and so will be able to access services and treatment.[42]

Access to appropriate mental health treatment such as counseling is especially important as at least one study found that parents who have insight into their mental health problems had less problematic parenting behavior and a lower risk of child maltreatment.[43]

Conclusion

With the Great Recession, more families have been pushed into poverty. As families struggle and stress levels rise, more kids are at risk of child maltreatment. If we want to address this problem, we need to invest in our families and the future of our children. If we don't, our children will pay for it with their lives. To cut programs that support struggling families just when they need it the most is the very definition of penny-wise and pound foolish.

At the same time, we need to work on getting quality, comprehensive and consistent data from the states regarding child maltreatment deaths so we can better understand why such deaths are happening and what else can be done to prevent them.

Respectfully submitted,

Jane Burstain, PhD
Senior Policy Analyst
Center for Public Policy Priorities

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
*****TUESDAY, JULY 12, 2011 AT 10:00 A.M.*****

The Center for Public Policy Priorities is a nonpartisan policy institute committed to improving public policy to better the economic and social condition of low- to moderate-income Texans.
We pursue this mission to achieve our vision for a BETTER TEXAS™.

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[1] Unless otherwise noted, all years refer to the federal fiscal year.

[2] Unless otherwise noted, all data regarding child maltreatment deaths is from the *Child Maltreatment* report published annually by the U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau.

[3] In 2009, Alaska, Massachusetts, and North Carolina.

[4] For 2009, Montana and Wyoming.

[5] For 2009.

[6] For federal fiscal year 2009, Alaska, Massachusetts and North Carolina did not report child abuse and neglect fatalities to the federal government.

[7] Arkansas, Colorado, Florida, Illinois, Indiana, Minnesota, North Dakota, South Carolina, South Dakota, Virginia and the District of Columbia include pre-natal drug exposure in their definition of abuse and neglect. California, Iowa, Kentucky, Minnesota, New York, Rhode Island and Texas include a parent's drug use in the definition of abuse and neglect to the extent it impairs the ability to care for the child. *Parental Drug Use as Child Abuse.* Child Welfare Information Gateway. May 2009. Available at: http://www.childwelfare.gov/systemwide/laws_policies/statutes/drugexposed.cfm. Accessed on December 1, 2009.

[8] Idaho does not currently have a working program. National MCH Center for Child Death Review, State Spotlight-Idaho. Last updated February 2008. Available at: http://www.childdeathreview.org/spotlightID.htm. Accessed on July 8, 2011.

[9] Using state program descriptions from the National MCH Center for Child Death Review, State Spotlights (Available at: http://www.childdeathreview.org/state.htm. Accessed on November 10, 2009), local involvement is defined as reviews conducted solely at a local level, reviews conducted at both the state and local level and reviews conducted at a local level with state oversight. States with local involvement include: Alabama, Arizona, California, Colorado, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Missouri, Montana, Nevada, New Jersey, New York, Ohio, Oklahoma, Oregon, Pennsylvania, South Dakota, Texas, Vermont, Virginia, Washington, Wisconsin and Wyoming.

[10] Texas Family Code §§264.513-14.

[11] In addition to Texas, Arkansas, California, Colorado, Connecticut, Florida, Illinois, Indiana, Kansas, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Missouri, Montana, Nevada, New York, North Carolina, Ohio, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Utah, Virginia, Washington, West Virginia, Wisconsin, Wyoming and Puerto Rico all have special reporting procedures for suspicious child deaths. *Making and Screening Reports of Child Abuse and Neglect*. Child Welfare Information Gateway. Current through January 2009. Available at: http://www.childwelfare.gov/systemwide/laws_policies/statutes/repproc.pdf. Accessed on July 8, 2011.

[12] 13 states have a county-administered system: California, Colorado, Georgia, Maryland, Minnesota, Nevada, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Virginia and Wisconsin. *National Study of Child Protective Services Systems and Reform Efforts: Review of State CPS Policy.* U.S. Department of Health and Human Services Office of the Assistant Secretary for Planning and Evaluation and Administration for Children and Families Administration on Children, Youth and Families Children's Bureau. April 2003. Available at: http://aspe.hhs.gov/hsp/cps-status03/state-policy03/index.htm. (Accessed on July 8, 2011).

[13] Burstain JM. *Child Abuse and Neglect Deaths in Texas.* Center for Public Policy Priorities. December 2009.

[14] Based on an ordinary least squares regression of child poverty on the child death rate and using a p-value of .05 to determine significance. Using data from 2007, child poverty was defined as an indicator with 1 meaning that a state had a rate at or above the 75th percentile. Data on child poverty derived from the Annie E. Casey KIDS Count Data Center. Available at: http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=45 (Accessed on October 30, 2009).

[15] Sedlack AJ, Broadhurst DD. *Executive Summary of Third National Incidence Study of Child Abuse and Neglect.* Administration of Children and Families. 1996. Available at: http://www.childwelfare.gov/pubs/statsinfo/nis3.cfm#top.. (Accessed on October 30, 2009).

[16] States with child poverty rates at or above 20 percent in 2007 include: Alabama, Arizona, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Tennessee, Texas and West Virginia.

[17] Death rate was 2.51 for high poverty states versus 1.77 for other states. β =.74. The same effect was found using an indicator for states at or above the 75th percentile for: (1) children in extreme poverty (defined as an annual income of 50% or less than the federal poverty line) β =.80; and (2) children under 5 living in poverty β =.80.

***** THIS TESTIMONY IS EMBARGOED UNTIL *****
*****TUESDAY, JULY 12, 2011 AT 10:00 A.M.*****

[18] Based on an ordinary least squares regression of the teen birth rate on the child death rate and using a p-value of .05 to determine significance. Using data from 2006, teen birth rate was defined as an indicator with 1 meaning that a state had a rate at or above the 75th percentile. Data on teen birth rates derived from the Annie E. Casey KIDS Count Data Center. Available at: http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=45 (Accessed on October 30, 2009).

[19] Stiffman NM, et al. *Household Composition and Risk of Fatal Child Maltreatment.* Pediatrics 109(4):615-621. April 2002.

[20] Based on teens ages 15-19. Data derived from Annie E. Casey Kids Count Data Center. Available at: http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=2. (Accessed on October 30, 2009). States with a high teen birth rate include: Alabama, Arizona, Arkansas, Georgia, Kentucky, Louisiana, Mississippi, Nevada, New Mexico, Oklahoma, Tennessee and Texas.

[21] $\beta = .87$.

[22] Annie E. Casey KIDS Count Data Center. Available at: http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=45 (Accessed on July 5, 2011). The percentage of children living in poverty increased in Hawaii from 10 percent in 2008 to 14 percent in 2009.

[23] Teen birth data derived from Annie E. Casey Kids Count Data Center. Available at: http://datacenter.kidscount.org/data/acrossstates/Rankings.aspx?ind=2 (Accessed on July 5, 2011).

[24] Comparing 2009 to 2008. States with declines are: Alaska, Arizona, Delaware, Georgia, Idaho, Iowa, Louisiana, Minnesota, Missouri, Montana, Nebraska, New York, North Carolina, Pennsylvania, Texas and Washington. *Child Maltreatment 2008 and 2009*, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2009 and 2010.

[25] Burstain JM. *The 2012-13 Budget for Child Protective Services: The Good, the Bad and the Ugly.* Center for Public Policy Priorities. July 2011.

[26] Burstain JM. *The 2012-13 Budget for Child Protective Services: The Good, the Bad and the Ugly.* Center for Public Policy Priorities. July 2011.

[27] Alabama (18.5%), Alaska (29.2%), Colorado (26.2%), Connecticut (26.6%), Florida (22.5%), Maine (28.8%), Tennessee (29.5%) *Child Maltreatment 2009*, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2009.

[28] Alaska, California, Colorado, Iowa, Montana, Nebraska, North Carolina, and Texas

[29] *Child Maltreatment 2009*, U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2009.

[30] Howard KS, Brooks-Gunn J. *The Role of Home-Visiting Programs in Preventing Child Abuse and Neglect.* Future of Children 19(2):119-146. Fall 2009.

[31] Burstain Testimony to the U.S. Senate Committee on Finance at the hearing on Innovations in Child Welfare Waivers: Starting the Pathway to Reform, March 10, 2011, at http://cppp.org/files/4/Burstain_TitleIVWaiver_SenateFinance.pdf (accessed July 8, 2011).

[32] Waldfogel J. *Prevention and the Child Protective System.* Future of Children, 19(2):195-210. Fall 2009.

[33] Waldfogel J. *Prevention and the Child Protective System.* Future of Children, 19(2):195-210. Fall 2009.

[34] Texas Department of Family and Protective Services Legislative Appropriations Request for 2012-13.

[35] Based on what was expended for 2010 and estimated for 2011 versus what was appropriated in 2012-13.

[36] Base on the difference between what the state child welfare agency estimated it needed and what was actually funded. Burstain JM. *The 2012-13 Budget for Child Protective Services: The Good, the Bad and the Ugly.* Center for Public Policy Priorities. July 2011.

[37] Based on the Legislative Appropriations Requests of the Texas Workforce Commission and the Texas Department of Family and Protective Services.

[38] Wulczyn F. *Epidemiological Perspectives on Maltreatment Prevention.* Future of Children 19(2):39-66. Fall 2009.

[39] Wulczyn F. *Epidemiological Perspectives on Maltreatment Prevention.* Future of Children 19(2):39-66. Fall 2009.

[40] Mullick M, Miller LJ, Jacobsen T. *Insight Into Mental Illness and Child Maltreatment Risk Among Mothers with Major Psychiatric Disorder*. Psychiatric Services 52(4): 488-492. April 2001.

[41] Castro ED, Dunkelberg A, Pogue S, Mccown FS. *The Health Care Primer.* Center for Public Policy Priorities. 2011.

[42] Dunkelberg A, Pogue S. *Texas Health Reform Checklist: Key Steps to Make the Most of Reform.* Center for Public Policy Priorities. September 2010.

[43] Mullick M, Miller LJ, Jacobsen T. *Insight Into Mental Illness and Child Maltreatment Risk Among Mothers with Major Psychiatric Disorder*. Psychiatric Services 52(4): 488-492. April 2001.

Chairman DAVIS. Thank you very much. We will move to questions now.

In today's testimony we have heard a variety of numbers. I know, from my professional experience, whether it was in the military, in business, and certainly in the morass of Washington, D.C., you can't fix what you can't measure. And this is going to be one of the central questions, particularly numbers of how many children die due to maltreatment each year.

States reported over 1,700 deaths in 2009 to HHS. GAO cites this figure, and also a number from the HHS national incident study of child abuse and neglect that estimated 2,400 deaths over 2 years, from 2005 through 2006.

Ms. Tunie mentions 2,500 deaths from maltreatment per year, as does Mr. Petit. Ms. Covington speaks more generally about the undercount she witnessed in Michigan and reviewed in Nevada.

Ms. Brown, your report details a number of reasons to believe current data understates the number of children who die from maltreatment. In terms of scale, how many deaths do you believe were missing each year? Tens? Hundreds? Thousands? What is a better number if the HHS official estimate of 1,770 is an undercount?

Ms. BROWN. The challenge there is finding good research that actually measures these issues. And we did a very careful literature review of all the research that looked at the numbers of child fatalities from maltreatment, and none of them are perfect. That is the problem.

You know, the one that has the relatively high percent of child welfare undercounts covers only three States. The one that comes up with 2,400 reaches across a number of different partners, but it is such a small population that they captured, that it is hard to be really, really confident in the data.

So, we know—we have seen differences in hundreds. We have seen as much as 1,000. I would like to see a much better process for getting this information, so we can actually know.

Chairman DAVIS. What were the States that—the three States——

Ms. BROWN. In the study?

Chairman DAVIS. Yes.

Ms. BROWN. California, Michigan, and Rhode Island.

Chairman DAVIS. Okay, thank you. Would anybody else care to comment on this issue? Mr. Petit?

Mr. PETIT. Yes, I would just note that there are three peer-reviewed articles that appeared in prestigious health and scientific journals that speak to the undercount being at least 50 percent. One is the Journal of the American Medical Association, one is the Journal of Pediatrics, and one is the Journal of Public Health. Each of them have extensive documentation they put forward that say the number appears to be at least a 50 percent undercount, which is how we arrive at the 2,500 figure. But no one could defend that number as being precise, that being the whole purpose of the GAO study, is to help show just how deficient measuring is.

Chairman DAVIS. Anybody else like to share? Ms. Covington?

Ms. COVINGTON. I personally believe it is probably 100 percent undercount. I think we should double the number, when you take into account neglect deaths. Just looking at the 15 States that we

did briefly before we came here, we doubled the number of States that actually reported—you know, when you looked at that versus when was NCANDS, it was double. And I think that that is probably true across the country. So, I personally would double the number.

Chairman DAVIS. Okay, thank you. Any other——

Mr. PETIT. May I just say, as an example of what we get at—we had a case one time in which it was an open child protective case. They lived on a third or fourth floor. The mother experienced an overdose. The two-year-old child went down to the street, was run over by a car. And in most States that is listed as a pedestrian accident, not the child abuse and neglect-related death that it is.

Chairman DAVIS. So you are saying, for example, connecting the different parts of the law enforcement investigation to collate that data would be helpful?

Mr. PETIT. Let me just say that when we have done that with law enforcement, the medical community, and others—and district attorneys—it is tremendously revealing to see what actually happens, the disposition of cases.

Child welfare can say, "Here is 100 certified cases in which child sexual abuse," for example, "occurred." Police might say, "We can identify 75 cases where there was a perpetrator." There may be 25 cases that are reported to the district attorney. The district attorney may choose to prosecute 10, because they don't think the data is good enough, in terms of supporting the evidence, and you may end up 5 convictions and 2 or 3 sentences to prison—which I am not saying is the answer to this whole problem—but they are not tracking those numbers. They are keeping their information separately. And when it is blended together they can see where the structural problems are in the system.

Chairman DAVIS. Before I yield to Mr. Doggett, something I would throw open to the members of our panel, if you have suggested process improvement ideas—particularly as we can tie a cost to them, or reduce that cost burden, to get this linkage of data. We found, in many institutional settings, a great amount of success in removing error, unnecessary cost, and other problems—or quality issues, in a more generic sense—but in this case it might lead to a solution to these problems.

With that, I yield to Mr. Doggett.

Mr. DOGGETT. Thank you, Mr. Chairman. Dr. Burstain has put this in terms of one child losing a life every 6 hours. Ms. Covington, I gather what you are saying is it could be as much as one every three hours, or one every 2 hours. And that is what several of you have said with reference to the data, that those figures that are widely acknowledged are probably much greater than our understanding. Right?

And I——

Ms. COVINGTON. Yes, correct.

Mr. DOGGETT. And I gather that for everyone here, if we could do something to prevent just one of these horror stories that will take place in the next 6 hours or the next 3 hours or the next 2 hours, we would want to do that.

As policy experts looking more broadly across the country, beginning with you, Dr. Burstain, what can we do to prevent these trag-

edies? We want to have an accurate count, certainly, and I think there are measures to get a better count. But we are not counting beans here. We are counting precious children's lives. What are the things that the Congress should be doing now, beyond getting a more accurate count, to be sure that that rate doesn't go higher?

Dr. BURSTAIN. Thank you. Well, in addition to funding the programs that support struggling families, I think one of the things that could really be helpful is the title IV–E waiver program that has passed through the House.

Basically, one of the problems with the child welfare system overall is, with the funding streams, you have title IV–B, which is a block grant, and that is the money that States have flexibility to use for prevention programs, and to keep kids safe in their own home. Title IV–E basically covers foster care and adoption, so it covers the back end. And that represents a much larger part of the Federal financing on child welfare.

And so, if you had a waiver program where States could take the money that they would have spent on foster care and spend that same money up front to keep kids safe, to prevent child abuse and neglect from occurring in the first place, I think it would go a long way toward really helping these families keep their children safe.

I think funding child care is another really important issue. Child care is something that can really help—just getting the child out of the house relieves parental stress. And I think, most importantly, the parents, when their kids are in child care, know that someone is going to be looking at that child. And if there is a problem, and the child is coming with a bruise or seems to be unkempt, there is someone who can see that child every day and make a report and have the child protective services system intervene before a problem occurs.

Because one of the problems with child maltreatment deaths is a lot of those deaths happen, and the child welfare system doesn't even know about those kids. And so it is not as if the child welfare system is investigating these difficult families and not doing a good job of intervening. They don't even have an opportunity to intervene, because most of these are young kids who are not in school, and so no one sees them. And if you get child care for these struggling families, you eliminate that problem.

Mr. DOGGETT. What will be the effect on this problem of child abuse, or child deaths, if the Social Services Block Grant is eliminated, if TANF supplemental grants in States like Texas are not continued, and they are set to expire within days, and if we don't have unemployment benefits available for families?

Dr. BURSTAIN. Well, I can tell you with respect to the Social Security block grant and the TANF. Those are programs that, I know in Texas, they use to directly support child welfare services. So those are grants that are not only used to help generally families in poverty, but are specifically used to help families that are at risk of abuse and neglect, or have actually subjected their children to abuse and neglect, and they are in the system.

Mr. DOGGETT. And you are saying—just to interrupt you for a minute—that in Texas the cuts have been so severe already, even without losing these programs, that some families already identi-

fied as actually having had cases of abuse or neglect no longer get the services?

Dr. BURSTAIN. Yes. The services rate for child maltreatment victims in Texas is at about 45 percent. So about 4 of every 10 children who have been identified as abuse and neglect victims receive ongoing child welfare services. And, as I testified about earlier, in some States that rate is even lower, and you've got 7 of every 10 children staying in the home and not getting services.

Mr. DOGGETT. Ms. Tunie, you represent an impressive coalition of social workers and others. Are there recommendations that you have, with regard to what steps we can take to prevent this death rate from accelerating, from matters getting worse?

Ms. TUNIE. Yes. In agreement with Dr. Burstain, to simplify it—because I am not an expert on this issue—funding is critical, and services are critical. And the ability to collect the data accurately is critical.

Mr. DOGGETT. Thank you.

Chairman DAVIS. Thank you. The gentleman's time has expired. I would like to share with Dr. Burstain that Mr. McDermott and I introduced the child welfare waiver bill addressing this IV–E issue that passed out of the House in May. I encourage you to call your friends in the U.S. Senate, and encourage them to move faster than their glacial pace to address these things.

[Laughter.]

Chairman DAVIS. The chair now recognizes Mr. Paulsen from Minnesota.

Mr. PAULSEN. Thank you, Mr. Chairman. Ms. Brown, may I ask you a question regarding the report? The report explains the two primary sources of data that we have on child maltreatment fatalities, and the data reported to HHS and the data reported through State child death review teams. What does HHS do with the data, exactly, other than just publish summaries of the information?

Ms. BROWN. The NCANDS data that HHS collects is used for—because they oversee the State programs—it is used for things like checking to see if the States are abiding by their expectations when they do their reviews of each State program.

They also use them to—they have measures that they are expected to meet each year,for example, knowing the number of deaths from maltreatment and foster care.

But the other thing, as far as the more on-the-ground information, is that they have some technical assistance centers, and there is one that deals specifically with child protective services. And that center has done some training to try to push the information out.

Mr. PAULSEN. And then what do the States do with their child death review team data, the States, specifically?

Ms. BROWN. I am wondering if I am the right person to answer that.

Mr. PAULSEN. Ms. Covington is nodding her head. Okay, please.

Ms. COVINGTON. Forty-four States require that they use their data for a—to publish a State annual report on their deaths, which would include child abuse deaths, as well as other deaths. Most

States are really getting smart about actually creating—they—almost all the States have a State-level advisory board that reviews those findings before the report gets issued, and they make recommendations to their Governors and their State legislatures on policy and practice.

Mr. PAULSEN. Okay.

Ms. COVINGTON. And some of them have been very successful, actually, in getting those things—their recommendations implemented.

Mr. PAULSEN. Sure, Mr. Petit.

Mr. PETIT. Yes, Mr. Paulsen, if I may say, all together there is about $30 billion spent on the child welfare system, the formal child welfare system. About 55 percent of that is State and local, mostly State. About 45 percent of that is Federal.

There is a very weak Federal oversight of the child welfare system. They provide most of the money, and they actually—the Federal Government actually provides the statutory framework within which most State child welfare systems operate.

I would assert flatly that virtually every single State in the country right now is vulnerable to a successful class action litigation being brought against them, and States repeatedly lose those when, in fact, such class action litigation is brought against them.

There are very few sanctions ever imposed by the Federal Government, even when States are out of compliance for many, many years, in contradiction to what Federal standards and oversight requirements exist.

Mr. PAULSEN. And, Ms. Tunie, maybe you can just tell me. What does your National organization do with the information in general, as you collect the info and get the data?

Ms. TUNIE. Well, our mission, basically, is to raise awareness of the issue, and also to urge Congress to take action.

Mr. PAULSEN. Okay. And, by the way, thank you for helping raise awareness on this issue. And, obviously, this hearing is a part of that effort. And, I mean, what other recommendations do you have for us as individual Members in our own districts, in our own States, to also help raise awareness about this issue, other than just going through numbers and data.

Ms. TUNIE. Yes. You know, I think it is really important to put a face on it. The book that Mr. Petit put together, where you really see the faces of these children, and it really becomes a personal, as opposed to just a number or a statistic. I think that is a great way to raise awareness.

Mr. PAULSEN. Thank you, Mr. Chairman.

Ms. TUNIE. Thank you.

Mr. PAULSEN. Yield back.

Chairman DAVIS. Thank you. The chair recognizes the gentleman from Washington, Mr. McDermott.

Mr. MCDERMOTT. Thank you very much. I have watched these hearings since 1970, when I was in the State legislature. And States always lurch forward after a horrible event. It is over, and over, and over, and over again.

And, Mr. Petit, you just sort of said that there is a tremendous problem, and most States would be vulnerable. Let's go on the positive side. Tell me the States where they have the best system for

getting these cases and preventing them. Because it seems to me the problem is we are always coming in at the back end, looking at the problem, when it is already in the hands of the coroner.

And so, what I am interested in is what States have had the best system in place to predict and deal with and prevent?

Mr. PETIT. Let me—I think that is a more complicated question than I am going to spend time answering, in the sense that there are literally thousands of child protection offices across the country.

Mr. MCDERMOTT. Yes.

Mr. PETIT. Many States run it through their county system. And we have done studies looking at outcome measurements for the States, and they vary wildly, so that the differences between virtually any indicator you want to choose, removing children from their family, reports of child abuse, fatalities, foster care, et cetera, the variations between the bottom State and the top States may have multiples of five or tenfold.

But I will tell you the States that do the best overall are the ones that have smaller, whiter populations. So where—which translates into less poverty and less complicated issues around domestic violence, around imprisonment issues, around substance abuse. So all the States experience it, but some States experience much more than others.

If you take a look at the overall distribution of these issues, they are concentrated especially most severely in the States with large minority populations. And I say that, saying that that correlates, in turn, with high rates of poverty in those communities.

But if you wanted to look at a State that probably has had a significant effect in dampening down the overall amount of child abuse to begin with, which is the ultimate goal that we all have, we would say, like, Vermont, where they have comprehensive health care services, where there is home visiting for virtually all children. There is an extensive safety net that is built around welcoming a child and a family into the community, and people taking collective responsibility for overseeing what is happening with those children and families.

There are a number of other States as well, but when you get into the big States—Texas, Florida, California—it is very, very challenging to manage the huge volume of cases that are brought to their attention in the first place. Remember, that number now is about three million reports of child abuse. HHS in their national incident study says the true number is closer to probably nine million cases of child abuse and neglect each year.

Mr. MCDERMOTT. When you sit at the Federal level, when you sit at this dais, and you look out on the United States, and you try and figure out what should we do, then the question that—I mean, Dr. Jenny raises the question of more pediatric—pediatricians trained in looking at the issue. Where are the other gaps in training that we should put money or think about?

I mean we get into these stovepipe things because we try and figure out how to deal with it. But I would like to hear the other areas where you think there is a need.

Ms. COVINGTON. I think, without question, our death investigation system is—really needs assistance throughout the country. In my home State of Michigan there is a number of medical exam-

iners that tell you if you die in the first half of the year you are going to get a really good autopsy and investigation. If you die in the second half, it is going to not be so good, because they run out of money. And that is a reality.

And without really quality death investigations, we are just not getting the answers we need around these child abuse deaths. So I think training and resources for improved death investigations would be one area.

Dr. JENNY. I would like to say that the medical profession does a very bad job of recognizing abuse. I did a study and I published in Journal of American Medical Association, where we looked at 131 abusive head trauma admissions to our hospitals, serious abuse. And a third of those kids had a previous head injury from abuse, went to the doctor, and the doctor missed the diagnosis. Eight of those kids died.

And I think that there is very little education about family violence, about child abuse, in medical schools, in residencies. And I think that that is a place where we could really ramp up the prevention by early recognition.

Mr. MCDERMOTT. Is there a place for nurse practitioners in that kind of a thing?

Dr. JENNY. Absolutely. Nurse practitioners, PAs, even nurses. I did a study in Colorado where we looked at the amount of time in nursing school curriculums that was spent on family violence. It was less than 2 hours in a four-year curriculum.

So, I think that this is something that would be relatively easy to do, just by putting more emphasis on this in our professional societies and our curriculums in schools.

Chairman DAVIS. Great, thank you very much.

Mr. MCDERMOTT. Thank you.

Chairman DAVIS. The gentleman's time has expired. Mr. Reed from New York.

Mr. REED. Thank you, Mr. Chairman. Thank you to the panel. I come at this issue—when I first started my law practice we did a lot of law guardian work, and represented many abused and neglected children. And there is nothing more touching than that experience, and frustrating, and emotional, and it creates a lot of anger in me, individually, to see parents abuse their children.

So, that being said—and I get the argument from all the testimony—I was reading this last night, and I get the argument we need increased funding, we need to protect the funding. You know, the environment we live in here in Washington, D.C., so—and I don't want to spend a lot of time on that issue, just to articulate that I get it, and I understand that.

What I would be interested—what I am interested in talking about today is kind of a new way of looking at this issue. I think, from all the testimony that I have heard and I have read, each of the members of the panel here today would agree that poverty is a higher indication of child death from the parents from abuse and neglect of parents, and substance abuse—would all agree is a higher indication of death of a child.

That being said, I then—does it not beg the question, a common sense question of targeting our resources by requiring parents who are on public assistance—i.e. public assistance, the people that are

in poverty are more likely to be on public assistance—parents in that program, require them to be drug and alcohol tested?

We are talking about the death of children. And I understand there is going to be many parents that are going to be alcohol free and substance abuse free, and I get that. But if we are talking about saving the death of children, does that not trump the benefit that we could receive from identifying the higher-risk children through testing their parents for substance and alcohol abuse?

Dr. Burstain, would you have any comment on that?

Dr. BURSTAIN. Well, first, I think that I completely agree with you, that we should be looking at ways that we can prevent child abuse and neglect deaths.

I will say that drug and alcohol testing is expensive. So if you are talking about not wanting the Federal Government and not wanting the States to have to spend more money——

Mr. REED. So if we can we get the cost taken care of——

Dr. BURSTAIN. Well——

Mr. REED. I mean you are asking for money elsewhere, so if you get the money——

Dr. BURSTAIN. Yes, absolutely. And I would say that that money would be better spent, instead of drug and alcohol testing, all of the individuals who are receiving public assistance, I would say that money would be better spent actually getting drug and alcohol treatment.

Mr. REED. Well, not everyone that is on public assistance, just parents that have children in the home be tested. I am talking about a very narrow program, trying to narrow it down——

Dr. BURSTAIN. Wait——

Mr. REED. Just parents.

Dr. BURSTAIN. I——

Mr. REED. Not all those on public assistance.

Dr. BURSTAIN. I believe the majority of people who are receiving public assistance have children.

Mr. REED. Okay.

Dr. BURSTAIN. And so the majority of those people would be tested. And what I would say is that money that you would spend on testing—because what are you going to do if they turn out positive? The money would be——

Mr. REED. We would coordinate that information with CPS and with law enforcement, target those individuals, intervene, make sure that those parents are getting substance counseling, trying to lead them to a substance-free life, and that will lower the risk of death to their children, which all of you agree has created a higher risk for those children that are living in that environment.

Dr. BURSTAIN. You would be——

Mr. REED. So that would be my——

Dr. BURSTAIN. You would be absolutely right, if there was money for treatment. But there isn't money for treatment. And so, what I would say is, instead of spending your money on testing people who you have no basis to believe are actually abusing substances, I would spend the money on providing services to the people you know are abusing substances.

Mr. REED. And when they——

Dr. BURSTAIN. So once they become involved in the child welfare system, you need to get them access to substance abuse. And, more importantly, mental——

Mr. REED. So we have to wait until they abuse their children before we get—because once they abuse their children, they are in the CPS system—then we can get them the substance abuse treatment that they need?

Dr. BURSTAIN. Absolutely you do not have to wait. One of the things that I highlighted in my testimony is that, under the new Health Care Reform Act, getting people health insurance—one of the reasons people don't get treatment, and before they actually become involved in the child welfare system, is poor adults a lot of times don't have health insurance. And so the only way they can get treatment is become involved in the child welfare system, and get services through the child welfare system.

Mr. REED. Okay. I notice my time is—Mr. Petit, you are the commissioner of——

Mr. PETIT. Child welfare.

Mr. REED. Child welfare in Maine.

Mr. PETIT. I would just note that the Congress and the Senate had legislation introduced more than 10 years ago on making substance abuse treatment moneys available to State child protective agencies whenever that was identified as being an issue. And certainly there is a high relationship between the two. But the Senate Finance Committee never held a hearing on the bill. It was introduced in three consecutive legislative sessions to provide assistance in that case.

Now, that little girl that was baked to death in an oven that I mentioned, I remember the Governor saying to me, "Stop this. Take these children from these families and get—stop this issue."

I said to the Governor, "This is the first death we have had in four years. There are 12,000 children or so in our open protective custody in any given moment. And in the course of a year, 1 or 2 might die, even though this problem that you just described exists maybe in 60, 70, 80 percent of the households."

So, I think there is a way to target this much more specifically, so that you get at what you are talking about.

May I suggest—I have been doing this for 40 years. This is a panel that has been involved with this for a long time. I cannot emphasize enough the need for a national commission that brings together all of the different disciplines. We are talking about nothing less than healthy, human growth and development, which is a very complex topic, which hasn't been looked at by this congress, by any Administration in decades. The last that I know of was the Rockefeller Commission. That was almost 20 years ago. We have had no national White House conferences in this country since 1970.

This is an issue that has—receives very scant attention by the public. And it needs to be opened up. And that is why I would recommend this national commission and, at the same time, lift the confidentiality requirements.

Chairman DAVIS. I appreciate your passion, Mr. Petit. That is one of the reasons we are having this hearing today, is to move forward——

Mr. PETIT. Thank you, sir.

Chairman DAVIS [continuing]. On this. And, with that, we will recognize the gentleman from Georgia, Mr. Lewis, for 5 minutes.

Mr. LEWIS. Thank you, Mr. Chairman. Thank you, Mr. Chairman and Ranking Member Doggett, for holding this hearing.

I have been here for almost 25 years, and attended many hearings. But this has been one of the most painful. What some of you have said is almost unreal, unbelievable. But I know it is real. I know it is believable. In my own district, in my own State of Georgia, just watching the news, reading the newspaper, seem like something happened to some little child, somebody child, somebody baby, almost every other day.

And, Mr. Petit, I would really like to know from you. You mentioned race and poverty. It is not something that we should sweep under the rug or in some dark corner. We should face it, and face it head on. Could you tell me—maybe some of you have data, information on the State of Georgia—but could you tell me or speak to the whole issue of young families where there is a father, a mother, a boyfriend, a girlfriend with a child? Reading that something happened to this child. The child was beaten or left alone and died. What is happening there?

Ms. Tunie, I love what you said about putting a face on it. How do you dramatize that? How do you make it real? How do you sensitize and educate the American people that this is a major problem and we have to face it?

I think there is a great undercount, Ms. Brown. I think there is a great undercount.

Mr. PETIT. May I say very directly? The legacy of slavery endures. The behavior that we are talking about is manufactured. It is not innate to any particular culture or any DNA. And in the black community what you have is a very high out-of-wedlock birth rate. You have a very high poverty rate. You have a very high imprisonment rate of young males.

The family formation in the black community has been extremely challenged in the last few decades, and the research that does exist shows that children in a home with an unrelated male are almost 100 times more at risk of dying than when there is a biological-related father in the household.

So, I have just made some broad-sweeping statements on this. I believe it requires a much closer look. But there are realities, in the black community in particular, which shows in this report that there is a three times higher fatality rate in the black community. But it is manufactured behavior that contributes to it.

Mr. LEWIS. Could you speak about poverty? Ms. Covington, you wanted to say something?

Ms. COVINGTON. I was going to add on to that. There was a headline in the Washington Post yesterday. Keith Jackson wrote a story, and the headline was, "Would Anybody Have Cared if Caylee Anthony was of a Different Color?" And I think that is really important, because when we look at these deaths across the country, there is no question that the white, you know, middle-income kids who die at the hands of their care givers get a lot of attention. But African American kids are really over-representative in the numbers, and poverty is a huge correlation in these deaths.

In fact, in a lot of the neglect cases, that is one of the reasons they don't get counted, because, you know, people give a little room there when there is poverty issues tied in to some of the parental responsibility problems, in terms of—they are living in poor families, and so there is—that is one of the reasons they don't get counted as well.

But then it leaves us with numbers that don't make a whole lot of sense, and it doesn't give us the ability to actually be able to respond to those cases.

Mr. LEWIS. Any other member of the panel?

Mr. PETIT. On the poverty question, if I may say, in 1960 the poorest cohort were seniors, the—children were the second poorest cohort. In 2010, children are the most poor cohort and seniors are the least poor cohort. The Federal Government is spending 7 times more per senior over 65 than per child under the age of 18.

And if you look at the Federal benefits that go to seniors, they are the same from one end of the country to the next. They are the same in Maine as they are in Texas as they are in Hawaii. That is true with Medicare, that is true with Social Security.

When you look at the income security programs for children, and the health care programs for children, they are largely left up to the States to shape, which, in fact, is attributable to some of the poverty that we are talking about, is that there is wide variation among the States in dealing with this issue.

Chairman DAVIS. All right, thank you. The gentleman's time has expired. I would like all the Members to know that in the back of your packets or binders is State-specific information for your home States on this data from the Congressional Research Service.

And with that, I would like to recognize Mr. Berg from North Dakota for 5 minutes.

Mr. BERG. Thank you, Mr. Chairman. This is—you know, has to be one of the worst crimes that can be committed, a crime against a child. I—you know, these stories you talk about, putting a face on it, I mean it is just horrific.

My wife is a family practice doctor. And one of her most difficult days is when she recognizes abuse in a child. And in our State of North Dakota, the support for her has been outstanding, to get that child in a good environment, a safe as possible environment.

But, you know, in the discussion—I guess, Ms. Brown, the discussion really relates around this coordination. And I guess I am confused that, you know, almost half the States that are reporting this data are just kind of regurgitating data that you already have. And it seems to me that these States really should be accessing other information that they have in their States, whether that is a death certificate, medical examination after death, or the child death review team structure, which, to me, seems like an outstanding—somewhat volunteer, but again, you can bring some real experts into that.

So, I guess I'm just asking, how do we get more accurate information? Not necessarily recreating the wheel, but how can we get more of a response?

Ms. BROWN. Well, it seems to me that we have two places in the count where the response breaks down. And the first one is re-

lated to identifying whether a death is caused by maltreatment. And we have heard about how challenging that can be.

And then, the second one is, as you referred to, collecting the data from the community in a way that can give a more complete picture. And I agree that the child death review teams that are on the local level can be very, very useful, because that is a vehicle for bringing different organizations together.

And part of the issue there is trust, and having personal relationships. So, if you have a vehicle that regularly brings them together, that could make a difference, and it doesn't cost much.

Mr. BERG. Well, and it—again, our overall objective here is really to prevent this from happening. And, you know, we are gathering this data, and as I look at this data it is—I mean it is as accurate and current as you can get it, but we are years and years behind.

And so, again, it seems to me that what you are talking about there on the local area—and again, you have a large State, very populous, or a small State—if you could create a system where you have local experts that are getting that accurate information, but also thinking what steps can be done on the local level and on the State level to, you know, again, catch these children.

So that brings up the other question, and I just am always frustrated by the lack of communications between different agencies. And it seems to me, if you took this further in a local, you have the child death review committee and they are identifying certain trends, or certain things that really stand out—let's take drugs, for example, drug abuse. If they are saying that this is something that is a real—it is in almost every one of these cases, how can they access the other agencies within that local community that could identify and share that information, so rather than reactively waiting, become more proactive and encouraging these people to get treatment or having a higher level of watchfulness over that child? Please.

Dr. JENNY. One thing that I think is very helpful is hospital-based child protection teams. Because that is a place—in children's hospitals they have teams that meet weekly and go over every case that has been in that jurisdiction—not of deaths, but of kids that have been abused or neglected. And it is a proactive process.

And having more support in the children's hospitals for child protection teams is going to, I think, make a big difference because we all talk to each other and we do a lot of preventative work up front to avoid those deaths at the back end.

Mr. BERG. Sure.

Ms. COVINGTON. I think, too, there is a trend in States for more improved coordination of just general child protection investigations. Some States actually require it, even though they don't necessarily follow through on making sure that those investigations are done in a coordinated way.

But in places where they are done in a coordinated way, I think there is profound improvements in the way kids are identified, because you have got—you have law enforcement, the prosecutor, mental health, education, social services, they are all at the table—public health, they are all at the table, looking at this child from a more comprehensive——

Mr. BERG. It seems that those are best practices we could share with other States, if we had a little more——

Mr. PETIT. May I say that, actually, there is a lot of this going on right now through the Department of Justice? And one of our coalition members is the National Children's Alliance. And there are some 800 local jurisdictions that have district attorneys, child protection, law enforcement, medical, that come together, typically around child sexual abuse cases.

And may I just say in your own State of North Dakota, where I had the privilege of spending the better part of a year doing a project on child well-being for the North Dakota legislature, that year North Dakota ranked first or second in the national Kids Count survey. But if you had taken the 7 percent of children who are Native American and put them in a new State of East Dakota, they would have ranked 51st.

And so, the data kind of misrepresented what the overall well-being was. It took us a year to get data from the Native community. It was this question of trust. And they finally put their numbers on the table. It created a new North Dakota Commission on Indian Affairs and Child Welfare. And I have been curious—this was 15 or 20 years ago—to see what impact finally putting that data on the table had, which is what the legislature was looking for. They didn't know how to help the community——

Mr. BERG. Right.

Mr. PETIT [continuing]. Without the numbers, and they didn't want to start spending money without the numbers.

Chairman DAVIS. Thank you very much. The gentleman's time has expired. And Mr. Crowley from New York, you are recognized for 5 minutes.

Mr. CROWLEY. Thank you, Mr. Chairman. Let me sincerely thank you for holding this hearing today, and my colleague, Mr. Doggett, for bringing this issue that really, in light of the Caylee Anthony case, didn't necessarily need to be highlighted, but I think in terms of what we, as a nation, are doing to combat the abuse of children is certainly needed.

And I wonder whether or not the attention we have here today would be as strong if it were not for this particular case. I—and, Ms. Tunie, I appreciate your lending your voice and your face to this issue, and all the panelists here today. But this is a disturbing yet necessary subject matter that needs to be addressed. And I wonder, though, whether or not we would have the same attention we have today—I think you would be, and I think all of you and the panelists would be, but I am not so sure the media would be as strong as it is today.

Whether or not the death of Caylee Anthony was by means or—of—caused by accidental neglect or first degree murder, at the end of the day that young child was killed, and may very well have been preventable if signs were—and steps were taken—if signs were seen, and proper steps were taken to prevent that. And I think the death of any young child, if it can be prevented, we should be doing everything we can to do that.

I have been involved in this area for some time, going back to my days in the State legislature. I chaired a Subcommittee on child product safety. I was concerned by maybe not even accidental ne-

glect, just the aspiration of small parts in toys, and children dying from what appeared to be the cause of pneumonia, when, in fact, it was they had aspirated a small plastic piece into their lungs, and therefore, only through autopsy later on was this found, to more high-profile today of baby cribs.

I would like to ask the witnesses—you know, because I know the GAO report has been focusing on the proper gathering of statistics, and questioning whether or not we actually are getting all the reportable statistics and compiling them correctly to really get an understanding of the breadth and the extent of neglect that is taking place. But whether or not—it doesn't really address the issues of what to do once we have that information.

And I know my colleagues have asked this in some ways, but what else can we be doing to raise awareness? I know in a State like mine, in New York, we have—we have seen success in public awareness campaigns, especially as it pertains to the issue of shaken baby syndrome, as well as safe sleeping for children. What else can we be doing? What can we be doing to help parents that may not be mindfully neglectful?

If you just—they have tough lives right now. The economy being where it is, and the stress that that brings to bear on people's lives, they would never put themselves in the category of being accidentally neglectful, you know. What can we be doing to help those folks, as well?

And other care givers that just may be unaware of the dangers in everyday situations—for instance, like bath tub safety and crib safety and choking hazard safeties? What could we be doing to help those folks?

Dr. JENNY. One thing that your State has done, has been—nurse home visitation to young families, particularly at-risk young families. And they have done a randomized control trial where they have found actually that over the years it decreases welfare dependency, it increases the educational level of the child in 15, 20-year followups, and also, it decreases the abuse rate and also the illness rate.

So, David Olds model nurse home visitation would be an excellent model for prevention.

Ms. COVINGTON. And that was funded in the Health Care Reform Act, and all States are now going to start doing that. And I think that that is really, really important, that that stay there and be a large part for every State to be able to have those dollars to be able to do those family home visits, because it is one of the very few demonstrated evidence-based practices that we know could actually reduce child maltreatment.

That is part of the things I think we can do, is try to figure out what really does work, because the research is limited. Funds to figure out what really works for families is limited. So there is little research looking at evidence-based practices, but I think we need to keep doing that work. And then, when we find something that works, make sure it gets out to the general public and to communities, so they can start implementing these practices.

Chairman DAVIS. Thank you very much. The gentleman's time has expired. I would like to thank all of our witnesses for your time

and preparation, for your staffs, the investment of research, and also helping us understand this very critical issue further.

If Members have additional questions, they will submit them directly to you in writing. And what we, on the Committee, would ask is that you also send a copy of your response back to us at the Subcommittee, so that we can insert it into the record, as well.

Thank you again for highlighting this very critical subject. And, with that, the Committee stands adjourned.

[Whereupon, at 11:26 a.m., the Subcommittee was adjourned.]

[Questions for the Record follow:]

Questions for the Record
7/12 Human Resources Subcommittee Hearing on Child Deaths Due to Maltreatment

For Kay Brown:

1. On confidentiality standards, several witnesses raised this as an issue that could be addressed to improve understanding of the number of children who die from maltreatment. In general, what would be required to loosen privacy and confidentiality standards so agencies could more easily share data on maltreatment, including in cases where children have died from maltreatment and this information might prevent subsequent deaths? Does this require Federal action, such as by HHS? State action? Something else?

2. You make a number of recommendations in your report about how to improve our knowledge of the number of children who die from maltreatment, including those who were not previously involved with the child welfare system. Are there any specific changes that Congress could make to improve the quality and accuracy of data collected by HHS, by child death review teams, or others? How about other Federal actors such as HHS? If so, what changes do you believe would improve our knowledge? Would making such changes cost money or add significant complexity in terms of child welfare or other systems?

3. Do we know anything about the timing of child deaths due to maltreatment? For example, do more deaths among older children occur in summer months when school is out and children are more likely to be under a parent's supervision only? Among younger children on weekends when they may not be in day care? Around holidays when there may be more drinking or stress in the home? At the beginning of the month when government benefit checks arrive, or the end of the month when those funds may have run out?

For Tamara Tunie, Theresa Covington, Michael Petit, Carole Jenny, and Jane Bustain:

1. I noted that a number of witness recommendations at our hearing didn't involve more spending, but instead proposed better coordination or prioritization of efforts to protect children. If you could recommend up to three such policy changes that don't involve new resources but would improve understanding of child deaths from maltreatment and the ability to prevent such tragedies from occurring, what would you recommend? I encourage you to be as specific as possible. The Subcommittee is working on child welfare services reauthorization legislation now, with the hope of passing that legislation later this year. We would appreciate your help in isolating possible policy changes that might be included in that legislation that would make a positive difference for children.

GAO
Accountability * Integrity * Reliability

United States Government Accountability Office
Washington, DC 20548

August 2, 2011

The Honorable Geoff Davis
Chairman
Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

Subject: Responses to Questions for the Record -- Hearing Entitled *Child Deaths Due to Maltreatment*

Dear Mr. Chairman:

This letter responds to your July 14, 2011 request that we address questions for the record related to the Subcommittee's July 12, 2011 hearing on child deaths due to maltreatment. Our responses to the questions, which are in the enclosure, are based on our previous work and knowledge of the subjects raised by the questions, unless otherwise noted.

If you have any questions about the letter or need additional information, please contact me at (202) 512-7215 or brownke@gao.gov.

Sincerely yours,

Kay E. Brown

Kay E. Brown
Director, Education, Workforce,
and Income Security Issues

Enclosure

RESPONSE TO POST-HEARING QUESTIONS FOR THE RECORD

Child Deaths Due to Maltreatment

Subcommittee on Human Resources
Committee on Ways and Means
House of Representatives

July 12, 2011

Questions for Kay E. Brown
Director, Education, Workforce, and Income Security
U.S. Government Accountability Office

Questions for the Record Submitted by Chairman Geoff Davis

1) On confidentiality standards, several witnesses raised this as an issue that could be addressed to improve understanding of the number of children who die from maltreatment. In general, what would be required to loosen privacy and confidentiality standards so agencies could more easily share data on maltreatment, including in cases where children have died from maltreatment and this information might prevent subsequent deaths? Does this require Federal action, such as by HHS? State action? Something else?

In the GAO report that was the focus of our testimony on July 12th (GAO-11-599), we recommended that HHS help states strengthen the completeness and reliability of National Child Abuse and Neglect Data System (NCANDS) data on child fatalities from maltreatment by identifying best practices, including those that help address privacy and confidentiality concerns and foster cross-agency coordination. We believe that this recommendation, if fully implemented by HHS, would facilitate improved information sharing across state and local agencies on child fatalities from maltreatment. Specifically, ensuring that state officials involved in child protection issues are well educated about the requirements and prohibitions of applicable privacy and confidentiality laws could help state and local agencies overcome some of the barriers to information sharing. While such laws are generally intended to ensure that sensitive personal information is protected from public disclosure, these laws often permit information sharing under certain circumstances, such as for law

enforcement purposes. As a result, these laws may already permit agencies to share certain kinds of information related to child maltreatment fatalities. To facilitate this process, in implementing our recommendation, HHS could re-emphasize the importance of sharing information related to child maltreatment fatalities, help states identify the constraints and concerns about confidentiality and privacy laws, and provide guidance to facilitate information sharing among state agencies on child maltreatment fatalities. Such steps could play an important role in educating state and local officials on the front lines of child protection about the circumstances under which this information can be shared across state agencies and localities, consistent with the requirements and prohibitions of applicable laws. The Federal Interagency Work Group on Child Abuse and Neglect could also be another vehicle for clarifying requirements and exceptions to these laws so that cognizant officials can distinguish between actual and perceived legal impediments to needed information sharing.

In addition, HHS could identify successful or promising strategies that some state and local child welfare agencies have used to obtain critical data from other agencies that have enabled them to better track child maltreatment deaths and enhance the completeness of national data on these child fatalities. For example, California has a data sharing agreement between the child welfare department and the department of public health, and the state coordinates across multiple agencies to produce a more accurate estimate of child maltreatment fatalities, according to officials we interviewed. Negotiating and implementing an inter-agency MOU may help ensure that the appropriate mechanisms are in place to permit information sharing when there is a time-sensitive need to do so.

2) **You make a number of recommendations in your report about how to improve our knowledge of the number of children who die from maltreatment, including those who were not previously involved with the child welfare system. Are there any specific changes that Congress could make to improve the quality and accuracy of data collected by HHS, by child death review teams, or others? How about other Federal actors such as HHS? If so, what changes do you believe would improve our knowledge? Would making such changes cost money or add significant complexity in terms of child welfare or other systems?**

We believe our recommendations to HHS, if fully implemented, would lead to improvements in the comprehensiveness of data collected by HHS and our knowledge about the children who die from maltreatment, without requiring changes from Congress. For example, HHS' guidance for reporting NCANDS data encourages states to reach out to other state agencies; however, as noted in our report, nearly half of state agencies reported in our survey that they were not including information from other state agencies—such as Child Death Review Teams, law enforcement, and health departments—on child fatalities from maltreatment in their NCANDS data. In implementing our recommendation, HHS should therefore underscore the importance of obtaining information from other state and local agencies and entities so as to help states strengthen the completeness and reliability of data they report to NCANDs. In addition, our recommendations to expand the information HHS makes public on the circumstances of child fatalities from maltreatment and to routinely share analyses and expertise on the circumstances of child maltreatment fatalities, if fully implemented, would also improve our knowledge about these fatalities.

In our judgment, the recommendations we made in our report could be implemented without necessarily requiring significant increases in funding or additional complexity. For example, identifying best practices for strengthening collaboration among state or community partners on child maltreatment fatalities could entail discussions with state officials at annual NCANDS meetings or use of the Web-based portal for NCANDS state officials. Routinely sharing information on the circumstances of child maltreatment fatalities could be achieved by making greater use of existing interagency work groups and other mechanisms. To improve our knowledge of these issues, HHS could also, for example, analyze NCANDS and other data more thoroughly on the circumstances surrounding the deaths of children who were disproportionately fatally maltreated, such as children under 4 years of age. These and other such efforts may not require significant expenditures or add complexity to current programs.

3) Do we know anything about the timing of child deaths due to maltreatment? For example, do more deaths among older children occur in summer months when school is out and children are more likely to be under a parent's

supervision only? Among younger children on weekends when they may not be in day care? Around holidays when there may be more drinking or stress in the home? At the beginning of the month when government benefit checks arrive, or the end of the month when those funds may have run out?

To respond to your question on whether timing is a factor related to child deaths from maltreatment,[1] we identified three studies. Collectively, the studies provide conflicting information regarding this issue. A study published in 2002—covering the years 1976 to 1998—found that child homicide risk increased for infants, toddlers, and preschoolers during the winter and increased for primary and middle school children during the summer. However, a 2010 study of death certificate data for children younger than age 5 found that child homicides occurred uniformly throughout the year. Also, a 2006 study of data from the Center for Disease Control and Prevention's National Violent Death Reporting System for children ages 0 to 4 found no evidence of a pattern between child homicide and certain days of the week.[2] We note, however, that we did not fully assess the methodological soundness of these studies, nor was our search comprehensive. Other research may be found with additional search efforts.

For understanding the circumstances under which child fatalities from maltreatment occur, a key issue is whether children are in a setting where they are visible to professionals—such as day care providers, police officers, doctors, teachers, and other professionals—who are generally mandated to report suspected child abuse and were responsible for nearly 60 percent of all reports of suspected maltreatment to child protective services in fiscal year 2009. According to NCANDS data, the youngest children–under age 4—are at the highest risk of fatal maltreatment: Such children may spend much of their time at home with a parent and may not be in day care or another setting where they can be seen by a mandatory reporter.

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[1] In our July report, we noted that the NCANDS data system does not ask states to identify the date of a child's death and that establishing maltreatment as the cause of death can take many months, particularly when a criminal proceeding is involved.

[2]Richard McCleary and Kenneth S.Y. Chew, "Winter Is the Infanticide Season: Seasonal Risk for Child Homicide," *Homicide Studies* (Aug. 2002); Antoinette L. Laskey, et al, "Seasonality of Child Homicide." *The Journal of Pediatrics*, Volume 157, Issue 1, July 2010, M. D. Bennett, Jr. et al, "Homicide of children aged 0–4 years, 2003–04: results from the National Violent Death Reporting System," *Injury Prevention*, 2006;12.

The National Coalition to End
Child Abuse Deaths

The Honorable Geoff Davis
Chairman
House Ways and Means Subcommittee on Human Resources
1119 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Davis:

Thank you for holding a hearing on child deaths due to maltreatment and the opportunity to testify on this tragic issue.

Thank you also for this additional opportunity to share the recommendations of the organization for which I am the celebrity spokesperson; the National Coalition to End Child Abuse Deaths. The Coalition is made up of five national organizations (see above) that came together over a collective concern for the growing number of child abuse deaths in the United States.

The Coalition developed a list of recommendations at the Summit to End Child Abuse and Neglect Deaths in America in 2009. They are based on research and collaboration with 150 national experts in child welfare. While some of the recommendations would require additional funds spent on child protection and prevention, many no-cost items could reduce deaths and improve how states respond the these deaths.

No-Cost Recommendations:

1. *Amend current federal and state confidentiality laws:* Originally intended to protect living child victims from publicity, confidentiality laws have become a hindrance to a better public understanding of child abuse and neglect fatalities. The withholding of such information, especially between jurisdictions and between agencies, can be detrimental and cost children their lives. Congress should consider modifications to confidentiality laws to allow policy makers, the press, and the public to understand better what protection policies and practices need to be improved in the aftermath of a child's death, while still protecting the rights of children and families.
2. *Child welfare financing reform* is crucial to make child protective services an entitlement for eligible children, creating a system in which families are able to get the supports and services they need to prevent maltreatment from occurring.
3. *Standardize data collection about maltreatment deaths to lead to quality national statistics that will inform effective prevention strategies,* and require states to provide such data to the

Department of Health and Human Services and within and across systems in order to receive federal funds.

4. *The creation of a federal child death review law.* Even though child death review is the most effective way to identify and count child abuse and neglect deaths, not all states review every death from external causes.
5. *Health and Human Services in conjunction with the Department of Justice should develop a model protocol to ensure that civil and criminal legal proceedings related to child abuse and neglect are closely coordinated with relevant agencies.* Included in this multidisciplinary approach should be law enforcement, prosecutors, child welfare workers and also medical professionals, who may be the first to come into contact with an abused child.

Low-Cost Recommendations:

6. *Develop a public education campaign to encourage public reporting of child abuse and neglect and to enlist communities in the protection of children.* Many maltreatment deaths arise from neglect; thus the issue of child neglect should receive equal focus in a public education campaign and by child protection professionals.
7. *Develop a national, multi-agency strategy for stopping maltreatment deaths*. NCECAD is calling for a **National Commission on Child Abuse and Neglect Deaths** to study and evaluate federal, state, and local public and private child welfare systems. Currently, child welfare systems operate independently from state to state, and even county to county. Variations in policy and competency among states can make the difference between whether children live or die. A low-cost commission on this complex policy issue would provide an opportunity for in depth examination and reduce the risk of implementing policy changes that may lead to unintended consequences.

Cost Recommendations:

8. *Increase current federal spending on child protection by three to five billion dollars.* Current levels of federal spending are far below the level needed to protect all children at imminent risk. Increased funds would allow child protective workers and other frontline personnel to have smaller caseloads and better training to be better prepared for immediately protecting children, With smaller worker caseloads, the children would be better protected, and the workers would consider lifelong careers in child protection, thus bringing needed maturity and experience to the system. Continuing education and training across disciplines should be mandated, focusing especially on licensure, accreditation, and support for sub-specialties. Funds are also needed to provide a wide array of public health and social services to help at-risk kids, including comprehensive in-home services for all children already in the system.

Again, thank you for this opportunity. If there is anything else I can do to help raise awareness of this issue, please let me know. If you have further questions about the above recommendations, our Coordinator, Kimberly Day, will be happy to assist you. She can be reached at 202-223-8864.

Sincerely.

Tamara Tunie

The National Center for the
REVIEW & PREVENTION
OF CHILD DEATHS

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July 27, 2011

The Honorable Geoff Davis
Chairman
House Ways and Means Subcommittee on Human Resources
1119 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Davis:

Thank you very much for holding a hearing and inviting me to speak on July 12th on Fatal Child Maltreatment to coincide with the release of the GAO Report on *Strengthening National Data on Child Fatalities*. I very much appreciated the opportunity to bring national attention to the 2,500 children and more who die from child abuse every year in the U.S.

It was obvious at the hearing that you care very much about child maltreatment deaths and are looking for solutions. You asked me for specific suggestions on no-cost solutions. While I truly believe real solutions will come with additional funds spent on child protection and prevention, I also believe that the development and implementation of national requirements for coordinated investigation, reporting and child death review will improve how states respond to these tragedies. Specifically I would suggest the following:

1. The Child Death Review Process has been shown to be the most effective approach to identifying and counting child maltreatment deaths.[1] There is currently no federal law addressing child death review. All states but Idaho have teams, and most have state legislation mandating or enabling reviews. Yet many states face insurmountable challenges in conducting quality case reviews because agencies will not provide them with case records on the child and family, or because agencies at the table do not feel they have adequate protections related to the sharing of information. I would ask that you consider writing a *national child death review law* that: requires case reviews of all child deaths due to external causes; supports the establishment of teams, provides access to and sharing of case information from all available agency sources, preempting other federal confidentiality laws; protects team members from tort damages for participating on reviews, etc. I would be happy to provide you with more information on what we believe is needed to ensure quality case reviews across America. None of this would cost a penny-states are already using federal and state funds for the process.

[1] Schnitzer PG, Covington TM, Wirtz SJ, et al: Public health surveillance of fatal child maltreatment: Analysis of 3 state programs. Am J Public Health 2008;98:296-303.

2. CAPTA law (Title 42, chapter 67, Subchapter I, § 5106a) currently requires that states receiving CAPTA funding establish citizens review panels, and to include the reviews of child fatalities or near fatalities within the scope of their work. Currently only 14 states coordinate their Child Death Review Program with their CAPTA CRP. You could require this coordination among the two processes.
3. Require that states using federal dollars for child protection investigations demonstrate that they conduct investigations in a coordinated way using established protocols, and at a minimum coordinate with child protection services, law enforcement, prosecutors and health care professionals. A number of states have excellent protocols but few require that they be implemented. Again, this would not cost anything.
4. Create a mechanism to require that training be provided to mandatory child maltreatment reporters such as medical professionals and teachers.
5. Require that every state report its number of child maltreatment fatalities to NCANDS or another source only after a multi-disciplinary review of records from databases from multiple sources, including, at a minimum, child welfare, law enforcement, medical examiners/coroners, child death review and vital records. A number of states, such as Michigan, do this every year to obtain a more accurate count of deaths.
6. Create requirements to encourage the timely linking of state birth records with records of parents from child protective services that have had rights terminated or killed a child; and then require investigation when there is a match. Michigan has implemented this program, called Birth Match, and every year identifies several hundred infants at risk who would otherwise have gone undetected. These new infants are evaluated, provided services and oftentimes removed from the parent's care if their life is deemed to be at risk.
7. I also believe a national commission would go far towards identifying and clarifying many of these requirements and the best way to implement them across states. This would cost a small amount of funds to manage (approximately $500,000).

I am happy to provide you with more information. I can always be reached via e-mail at tcovingt@mphi.org or via cell at 517-927-1527. And again, thank you very much for the hearing and for caring.

Sincerely,

Theresa M. Covington, MPH
Director

August 5, 2011

The Honorable Geoff Davis
Chairman
House Ways and Means Subcommittee on Human Resources
1119 Longworth House Office Building
United States House of Representatives
Washington, DC 20515

Dear Chairman Davis:

Thank you for the opportunity to testify on July 12th at the hearing on Child Deaths Due to Maltreatment and for this opportunity provide further clarification on one of the recommendations made at the hearing.

To better protect children at imminent risk of severe harm, the federal government, led by the Departments of Justice and Health and Human Services, and in cooperation with states, should adopt a model protocol for assuring that civil and criminal legal proceedings are closely coordinated between child protection and law enforcement agencies. The current lack of coordinated intervention for children at risk of fatal child maltreatment is a key flaw in the current response system. Differing protocols for identification of, and response to, those children who are most at risk have contributed to the disparate risk of death for maltreated children by state and locality. Enhancing coordination between law enforcement, child protection, prosecution, medical providers, victim advocates, and mental health professionals, would empower local communities to effectively intervene in high risk physical abuse and neglect cases and prevent child abuse fatalities. There is substantial evidence that Children's Advocacy Centers have been an efficient and effective mechanism in child sexual abuse cases to coordinate a multidisciplinary response and assure better outcomes for sexually abused children. Indeed, Children's Advocacy Centers, have been long-recognized as a Model Program by the US Department of Justice, and funded by the Office of Juvenile Justice and Delinquency Prevention for just this purpose. I propose expanding this model to cases of severe physical abuse and high-risk neglect cases as a strategy for preventing child abuse fatalities.

There are now over 700 Children's Advocacy Centers in the US. These centers served more than 259,000 sexually abused children in 2009. Some of these centers already serve children who have been severely physically abused and/or neglected. The goal of the proposed Project for Children's Advocacy Center and Multidisciplinary Team Intervention would be to apply the multidisciplinary team approach to child abuse investigations, prosecution, and treatment for those children most at risk of fatal child maltreatment.

This could be accomplished by:

- Identifying existing model protocols for response to children most at risk of fatal child abuse and neglect.
- Partnering between the existing Child Death Review Team and the Children's Advocacy Centers to ensure that cross-communication is timely and information-sharing complete.

An important factor in identifying which cases would participate in the CAC's pilot project is the identification of cases using commonly understood definitions of child maltreatment. Therefore, another recommendation would be that Congress address the differences in state definitions and interpretations of maltreatment.

If you have questions about the above recommendations, please do not hesitate to contact me at 202-223-8177.

Sincerely,

Michael Petit, President
Every Child Matters Education Fund

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July 14, 2011

The Honorable Geoff Davis, Chairman
House Ways and Means Committee Subcommittee on Human Resources
US House of Representatives
Washington, DC

Dear Chairman Davis,

Thank you for opportunity to testify before your Subcommittee yesterday. The questions asked were profound and thoughtful.

As to suggestions for 'budget neutral' policies that could help alleviate the problem of child maltreatment deaths, I would ask you to consider the following. The Federal government funds many fellowship training programs in pediatrics through various agencies including NIH and MCHB. Perhaps money to train the critically needed experts in Child Abuse Pediatrics fellowships could be obtained by trimming other fellowship programs to a slight degree and pooling that money to fund fellowships in this field. Unlike some other fields, the candidates for Child Abuse Pediatrics fellowship training come from very prestigious institutions and are highly qualified. There are pediatricians anxiously waiting for these training slots, which are few.

My own fellowship training program is funded on a "hand to mouth" basis. We have no faculty support for fellowship training. Our faculty trains fellows in addition to the other work we do—patient care, research, and community outreach (such as participation in child death review in our state, which is also an unpaid activity). We raise some money from donations from charitable organizations (recently we received gifts from the Blackstone Valley Harley Owners Group and the Rhode Island Bartenders Association), but money from these sources is sporadic. Our hospital provides some funds, but as all hospital, it is coming under more and more financial pressure and also a dwindling source of support.

I am attaching a description of our Fellowship Training Program in Child Abuse Pediatrics here at Brown Medical School. It gives an outline of what fellowship training programs in this field cover.

Again, thank you for caring about the difficult problem of child abuse and neglect deaths.

Sincerely,

Carole Jenny, MD, MBA, FAAP
Professor of Pediatrics
Warren Alpert Medical School of Brown University
Director, Child Protection Program
Hasbro Children's Hospital
Providence, RI

CPPP Center *for* Public Policy Priorities | **Testimony**

U.S. House Committee on Ways and Means, Subcommittee on Human Resources Hearing
Child Deaths from Maltreatment **July 29, 2011**

DATA ON CHILD MALTREATMENT DEATHS

Chairman Davis, thank you for the opportunity to provide additional information to the Subcommittee regarding child maltreatment deaths. You have asked me to recommend up to three policy changes that would improve understanding of child deaths from maltreatment and the ability to prevent such tragedies from occurring without requiring additional funding. As set forth in my original written and oral testimony before the Subcommittee, the only way to substantively fix the problem of child maltreatment is to invest in and support struggling families. But until that happens, there are ways to make improvement within existing resources. My recommendations are as follows:

1. Amend Federal Child Welfare Law to Identify the Key Data Elements States Should Be Reporting about Child Maltreatment Deaths

As every witness testified at the hearing on child maltreatment deaths, the number of child maltreatment deaths is underreported. Part of the problem is that some states do not report any data on child maltreatment deaths.

The Child Abuse Prevention and Treatment Act (CAPTA) requires states to work with the Department of Health and Human Services (HHS) on reporting certain data on child maltreatment, including the number of child maltreatment deaths. But states are only required to report the data "to the maximum extent practicable."[1] As a result, if a state finds it is not practicable to report on a particular element, presumably they are not required to do so. In 2009, there were only 2 states (Missouri and New Hampshire) that reported on all the data elements identified in CAPTA.[2] Only 19 states[3] reported on all the data elements relating directly to child maltreatment deaths and 3 states (Alaska, Massachusetts and North Carolina) did not report on child maltreatment deaths at all.

Collecting, analyzing and reporting data is expensive and, given the current economic environment, it is unrealistic to expect that every state has the resources needed to start reporting on all of the data elements outlined in CAPTA. But it does seem reasonable to expect that every state child welfare system should be able to report some data on the number of child maltreatment deaths in the state, even if it is not a perfect measure.

If we want an accurate count of how many child maltreatment deaths there are, the first step is to get some level of data from every state.

In addition to getting a more accurate count of the number of child maltreatment deaths, there also needs to be a focus on finding out what factors or characteristics are related to such deaths so efforts to prevent them can be better targeted. This requires data regarding the details surrounding child maltreatment deaths such as characteristics of the child and perpetrator, family circumstances and dynamics and type of maltreatment. With this type of data, the children most at risk can be identified and appropriate preventative services can be targeted to their families.

Under CAPTA, however, states are only required to work on reporting the number child maltreatment deaths, how many were in foster care and how many received family preservation or reunification services in the last 5 years. There is no

requirement that states report other details about the child and family, although some states voluntarily provide this information on some of their child maltreatment deaths to HHS through the National Child Abuse and Neglect Data System (NCANDS).[4]

If we want particular information about child maltreatment deaths, it should be clearly defined in federal child welfare law so states know what data they should be collecting and reporting.

In determining what additional data to require, it is important to balance the need for additional data against the consistency and cost of obtaining the data. Some data such as a child's age is an objective measure and fairly easy to obtain from a review of available documents such as the child's birth and death certificates. Other data, such as the family's financial situation or the existence of substance abuse or domestic violence issues, involve a level of subjective judgment and may require substantial investigative resources to obtain.

Balancing the interests of cost versus the need for accurate and comprehensive data on child maltreatment deaths, I recommend the following:

- Legislation mandating that all states report to HHS the number of known deaths from child maltreatment
- Legislation to require that states work on providing additional data elements on child maltreatment deaths as outlined below. But to avoid imposing an unfunded mandate on states in difficult economic times, I also recommend that states only be required to report the data to the maximum extent practicable:
    - Year in which the death occurred to the extent it is different from the year in which the death was reported as resulting from maltreatment
    - Age, race and sex of the child
    - Perpetrator's relationship with the child
    - Location where maltreatment occurred (home, other residence, etc.)
    - Type of maltreatment – sexual abuse, physical abuse, neglect, psychological maltreatment and medical neglect
        - For physical abuse, whether a weapon such as a firearm was used
        - For neglect, the manner of death (drowning, asphyxia, motor vehicle, etc.)

One option is to amend the data provision in CAPTA to include the foregoing recommendations. Another option is to amend section 432(a)(8)(B) of Promoting Safe and Stable Families under Title IV-B of the Social Security Act which currently requires states to annually provide certain information to HHS.

2. Amend Title IV-B of the Social Security Act to Require States to Submit a Data Improvement Plan

As every witness testified at the recent hearing, even among those states that do report on child maltreatment deaths, what is reported is often incomplete because of limitations in a state's data collection and reporting system.

One option to address this problem is to require every state to submit to HHS a data improvement plan that evaluates and addresses any deficiencies in its child welfare data collection and reporting system. The data improvement plan should include the following: (1) an evaluation of any barriers or limitations to accurate and comprehensive data collection and

reporting on child maltreatment, including the data elements identified in CAPTA and any other data elements identified in other child welfare laws; (2) a plan to address and eliminate each barrier and limitation; and (3) identification of any changes to state or federal law that would enable better data collection and reporting. The data improvement plan should also identify whether the state's data on child maltreatment deaths includes information from any of the following sources: (1) the child welfare system; (2) the vital statistics department; (3) the prosecutor/attorney general's office; (3) state and/or local child death review team; (4) state and/or local health departments; (5) law enforcement; (6) medical examiners and/or coroner's office; and (7) any other source. To the extent a state does not obtain or include information from one of the sources identified in (1) to (6), the state should describe why such information is not included and its plan for obtaining information from such sources in the future. After submitting an initial data improvement plan, any subsequent plan should address progress made in addressing previously identified barriers and limitations. My recommendation is that states be required to submit a data improvement plan biennially.

Currently, Promoting Safe and Stable Families, section 432(a)(8)(B), requires states to submit certain documents to HHS. This provision could be amended to also require states to submit a data improvement plan as outlined above. Additionally, section 432(c), which requires HHS to compile the reports required under section 432(a)(8)(B) and submit them to the House Ways and Means Committee and the Senate Finance Committee, could be amended to also require that HHS prepare a report based on the states' data improvement plans.

Another option is to include the data improvement plan requirement as part of the state plan provisions under section 422(b) of the Stephanie Tubbs Jones Child Welfare Program.

3. Amend Title IV-B of the Social Security Act to Require that a State Identify and Target Priority Populations for Child Maltreatment Prevention Services

Until there is sufficient funding to provide child maltreatment prevention services to all at-risk families states, states should be allocating their limited prevention resources to the families with the highest need.

States should be required to identify priority populations within those children and families generally at-risk of abuse and neglect. For example, poverty is one of the most consistent predictors of abuse and neglect.[5] But there is not enough funding to provide prevention services to all children living in poverty. In 2009, there were more than 12 million children living in poverty nationwide, but states had a capacity to provide child abuse and neglect prevention services to only about 3 million children.[6] As a result, to most effectively utilize the limited prevention resources it has, a state should go beyond providing services to families in poverty and, instead, target those who are poor *and* who have other risk factors as well such as young children[7] or teenage mothers.[8]

Or a state can target certain geographic areas or communities that have multiple risk factors for abuse and neglect such as those with high rates of poverty, teen parents, community violence and unemployment and a lack of access to social services and community resources.[9] The state can calculate the rates on these various measures (e.g., the child poverty rate and the unemployment rate) and create a vulnerability score for each county. It can then use these scores to prioritize among the different communities and geographic areas around the state.

But a state should not target its resources based on communities with higher rates of *reported* maltreatment as the reported victimization rate is not an accurate measure of how many children are actually abused or neglected in any given community. Studies have shown only a minority of children who are abused and neglected are actually reported to and

investigated by a state child welfare agency.[10] And the magnitude of underreporting may vary significantly among different communities.

For example, children in communities that lack access to medical care have a higher risk of abuse and neglect.[11] But without adequate medical care, children are less likely to see the doctor and so the abuse and neglect may go unnoticed. Ironically, this means that more children in counties with little or no medical coverage may be abused or neglected, but the reported victimization rate may actually be lower. Conversely, children in communities with a strong support system for families may have a higher reported victimization rate. This may not be because there is more abuse and neglect actually occurring. Instead, as more families access services (e.g., go to the doctor, attend parenting classes), there is simply more opportunity for the abuse or neglect to be identified.

Section 432(a) of Promoting Safe and Stable Families already requires states to develop a state plan. This section could be amended to include a provision that requires states to identify and prioritize populations at-risk for abuse and neglect and to target its prevention services to those at the highest risk of maltreatment.

Respectfully submitted,

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Center for Public Policy Priorities

The Center for Public Policy Priorities is a nonpartisan policy institute committed to improving public policy to better the economic and social condition of low- to moderate-income Texans.
We pursue this mission to achieve our vision for a BETTER TEXAS™.

· 42 U.S.C. §5106a(d).

· *Child Maltreatment 2009*, U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2010.

· Arkansas, D.C., Florida, Idaho, Kansas, Kentucky, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, Oklahoma, Oregon, Puerto Rico, Tennessee, Texas, Utah, Vermont, Washington

· *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention*. Government Accounting Office. GAP-11-599. July 2011.

· Sedlack AJ, Broadhurst DD. *Executive Summary of Third National Incidence Study of Child Abuse and Neglect*. Administration of Children and Families. 1996. Available at: http://www.childwelfare.gov/pubs/statsinfo/nis3.cfm#top.. (Accessed on October 30, 2009).

· Based on the 44 states that reported number of children receiving prevention services data. *Child Maltreatment 2009*, U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2010. Data on children in poverty is from the Annie E. Casey Foundation KIDS Count database.

· *Child Maltreatment 2009*, U.S. Department of Health & Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. 2010.

· Stiffman NM, et al. *Household Composition and Risk of Fatal Child Maltreatment*. Pediatrics 109(4):615-21. April 2002.

DFPS Strategic Plan for Child Abuse and Neglect Prevention Services, December 2008. Available at: www.dfps.state.tx.us/documents/Prevention.../2008-12-01_ICC-SP.pdf (Accessed on July 21, 2010). Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

· Sedlak, A.J., Mettenburg, J., Basena, M., Petta, I., McPherson, K., Greene, A., and Li, S. (2010). *Fourth National Incidence Study of Child Abuse and Neglect (NIS–4): Report to Congress*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families.

DFPS Strategic Plan for Child Abuse and Neglect Prevention Services, December 2008. Available at: www.dfps.state.tx.us/documents/Prevention.../2008-12-01_ICC-SP.pdf (Accessed on July 21, 2010).

[Submissions for the Record follow:]

WRITTEN TESTIMONY

of the

AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION

and its affiliate the

NATIONAL ASSOCIATION OF PUBLIC CHILD WELFARE ADMINISTRATORS

Submitted to the

HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HUMAN RESOURCES

HEARING ON

CHILD DEATHS DUE TO MALTREATMENT

July 26, 2011

INTRODUCTION

The American Public Human Services Association (APHSA) and its affiliate, the National Association of Public Child Welfare Administrators (NAPCWA), respectfully submit this statement for the record regarding the hearing July 12, 2011 on "Child Deaths Due to Maltreatment."

APHSA is a nonprofit, bipartisan membership organization that was established in 1930 and represents state, territorial and local health and human service agency commissioners and their key program administrators. APHSA houses nine affiliate organizations, whose members represent health and human service programs serving low-income children and families, which include child welfare, the Supplemental Nutrition Assistance Program (SNAP), child care, and Temporary Assistance for Needy Families (TANF). APHSA is well-positioned to speak about the impact of federal public policies, legislation and regulations on the delivery of health and human services from an integrated perspective.

NAPCWA is committed to supporting and enhancing the public child welfare system's ability to successfully implement effective programs, practices and policies. NAPCWA is recognized as a national leader in promoting sound public policy, modeling programs and practices and developing critical capacity building resources needed to achieve positive outcomes for children and families. NAPCWA brings an informed view of the problems that today's families are facing to the forefront of child welfare policy and its members work tirelessly to ensure they meet the needs for the safety and well-being of children.

The U.S. General Accountability Office (GAO), in conjunction with the hearing, released a report, *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention* (hereafter *July 2011 GAO Child Maltreatment Report*), that explores the issue of child deaths due to maltreatment, states' challenges in reporting information about these deaths, and the extent to which the U.S. Department of Health and Human Services (HHS) collects and reports this information.[1] The report also includes recommendations for the HHS Secretary that provide a meaningful opportunity for states and the federal government to work together to improve and strengthen the quality and accuracy of information on child deaths due to maltreatment. APHSA supports the recommendations outlined in the *July 2011 GAO Child Maltreatment*

[1] *Child Maltreatment: Strengthening National Data on Child Fatalities Could Aid in Prevention* .GAO-11-599 July 7, 2011. Retrieved July 12, 2011 from *http://www.gao.gov/new.items/d11599.pdf/*

Report so long as states are engaged in the planning process and no current funding is required to be diverted from service delivery to administrative activities.

Our comments focus on: (1) what the national database system tells us and how state's use collected information to inform practice; (2) the need to engaged states in implementation of the GAO recommendations; and (3) what Congress can do to support states and the federal government as they focus on reducing child fatalities due to maltreatment and foster strategies that focus on early intervention and prevention. We also share state practices in reviewing child fatality cases.

WHAT THE NCANDS TELL US AND HOW STATES USE THE INFORMATION THEY HAVE

The National Child Abuse and Neglect Data System (NCANDS) is a voluntary national data collection and analysis system that was created directly in response to a set of mandates from the Child Abuse Prevention and Treatment Act (Public Law 93-247) as amended. This national data system is comprised of two key components where states can contribute data on child abuse and neglect: (1) the Summary Data Component (SDC) and (2) the Detailed Case Data Component (DCDC). Through SDC, states submit a compilation of aggregate data on child abuse and neglect reports, investigations, victims and perpetrators. DCDC houses case-level information submitted by child protection agencies from their automated systems and electronic records.

The NCANDS collects key information but the data does not reflect state variations in defining and collecting information on child death due to maltreatment. This makes this information misleading for accurate national analysis. In addition, there are measures of performance that do not lend themselves to data collection in automated systems such as the quality and relevance of services provided on a prior report of maltreatment. Both quantitative and qualitative data must be available and balanced for comprehensive analysis of the factors that lead to the death of a child. It is a function of the qualitative data to help detect underlying factors. Qualitative data also allows policymakers, states and other stakeholders to validate quantitative data, establish any trends and determine special circumstances that may affect the trajectory of reported data. In a recent study, *Counting is Not Enough,* the Annie E. Casey Foundation and the Center for the Study of Social Policy noted the importance of qualitative data in looking "more deeply at the forces that shape and could improve protection."[2]

[2] Annie E. Casey Foundation. (July 2010). *Counting is Not Enough.* Available from *http://www.aecf.org/*

States use collected data from the NCANDS and from other sources to drive effective decision-making, target resources for program development, and inform legislative bodies. For example, in **Missouri** State Technical Assistance Teams collect information from local fatality review panels and provide annual reports and routinely collaborate with community partners for awareness and training related to that data. Combining both data sets—NCANDS and local fatality panel information—allows Missouri to comprehensively use the information for preventive efforts. Similarly, **Indiana** has laws, protocols and cooperative agreements that enable the protective service agency to collect information about child maltreatment fatalities from multiple sources. This information includes, but is not limited to, medical histories, coroner reports, death certifications, emergency medical services/paramedic reports, fire department reports and autopsies. The State Fatality Committee relies upon the records of the Department of Children's Services (DCS) for most of its information. The state legislature used the information provided by the State Fatality Committee using DCS data to pass a "ladder law" regarding home pool safety.

THE NEED FOR STATE ENGAGEMENT IN IMPLEMENTATION OF GAO RECOMMENDATIONS

As more fully set out below, APHSA supports the recommendations outlined in the *July 2011 GAO Child Maltreatment Report*. Our members encourage Congress and HHS/ACF to actively engage public and private stakeholders, including all state public child welfare agencies, in discussions that may lead to changes in law, regulation or policies. Moreover, to the extent additional data collection is needed, current funds should NOT be diverted from service delivery to meet new administrative or technological requirements. We provide the following specific comments on GAO's recommendations.

Improve the Completeness and Reliability of State-Reported Data

States support the need to further assess the adequacy of available data, including the consistency with which the federal data is gathered and analyzed. The child welfare system functions as part of a larger system of care network. When a child fatality occurs, information must be pulled from that larger system to fully and accurately capture child deaths due to maltreatment. When examining ways to improve the completeness and reliability of national data and how to use that information to inform practice and prevent further death, we must look beyond information collected by child welfare agencies.

An effective approach for doing so is the use of multidisciplinary child review teams. [3] At the local and state level, multidisciplinary death review teams use data gathered from multiple resources to comprehensively analyze the cause of child death and to reliably determine whether it was due to maltreatment. These boards are helpful in determining whether a child death is the result of maltreatment. However, the type of cases the teams review varies from state to state. Some state teams review any suspicious child death while other teams review only the death of a child under the care and supervision of the child protective service agency. If the results of these child fatality review teams is to be used at a national level to determine the extent of child deaths due to maltreatment and the contributing factors, federal guidelines are needed to standardize data collection on the deaths that each state investigates. State examples of possible guidelines for reviewing cases include: (1) any death of a child under the age of one that is sudden, unexplained or unexpected or (2) all deaths with a suspicion of abuse or neglect, not just the deaths of children that are "known" to public agency protective services.

If child fatality review boards were to be established nationwide, it is essential the burden of collecting information and reviewing all suspicious child death's not become the sole responsibility of the child welfare system and that adequate funding follow any mandates.

The Web-based Reporting System data collection of the National Center for Child Death Review (NCCDR) was discussed at the hearing on "Child Deaths Due to Maltreatment" as a potential mechanism to inform national dialogue. At this time some participating states report that the NCCDR tool leaves room for interpretation on many questions; thus, we caution against its use without further examination and discussion with the states.

Expand Available Information on Child Fatalities

We recognize the importance of greater access to case information when a child has died from maltreatment, particularly when the child was known to the child welfare system. Legislatures, the media, stakeholders and, most importantly, consumers of services deserve to have a clear picture of the circumstances associated with a child fatality and the interventions that were used (if any) in addressing the presenting abuse and neglect needs.[4] However, significant

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[3] P.G. Schnitzer et al., "Public Health Surveillance of Fatal Child maltreatment: Analysis of 3 State Programs", *American Journal of Public Health*, February 2009, Vol. 98, No. 2

[4] APHSA/NAPCWA. (May 2011). *States' Child and Family Services Review (CFSR) and Program Improvement Plan (PIP) Recommendations.* Available from *http://www.napcwa.org/Home/docs/States-CFSR-PIP-Recommendations.pdf/*

consideration needs to be given to protecting the privacy of surviving siblings and family members who may be caring for them.

Improve Information Sharing

We support recommendations to strengthen collaboration among federal, state and local agencies. The high correlation of child maltreatment-related fatalities with poverty, teen pregnancy, substance abuse, mental health challenges and domestic violence, supports the need for increased resources and information sharing. The complexities in many of these cases require a multi-system approach (and not solely child welfare interventions). They also require political will, resources and community partnerships. A review of current confidentiality laws and regulations would facilitate cross-agency/cross-program dialogue.

Estimate the Cost and Benefits of Collecting National Data on Near Fatalities

APHSA supports the GAO recommendation to conduct a cost-benefit analysis for a national data collection activity on near fatalities and examine the analysis and results of the data to inform follow-up activities. The GAO report states that simply adding another data field to NCANDS would be difficult to operationalize, and would highlight state variation in defining and collecting information on near fatalities. Our members note this as a major concern and impediment to using the current data collected for national dialogue. Significant consideration should be given to the state variation on the definition of near fatalities and the definition for maltreatment, safety and risks.

WHAT CONGRESS CAN DO TO REDUCE CHILD FATALITIES DUE TO MALTREATMENT

Preserve funding levels and align funding with program needs

Federal funding streams are fragmented and tethered to an array of laws. Given the current economic stress that states are experiencing, it is critical that each law affecting child maltreatment and fatalities that comes up for reauthorization should, at a minimum, sustain current federal funding levels.

Experts agree that better outcomes for children are achieved by engaging families in the safety assessment process and having families as partners determine interventions. Most child welfare funds, however, are not available to support safety and prevention practice but are concentrated on support of out-of-home placements. While states struggle to keep families

intact by providing supportive services on the front end, and to keep children safe in their own homes, they need flexibility to use federal funds based on the unique needs and demographics of their respective jurisdictions. With a few modifications indicated in a May 25, 2011 letter[5] APHSA supports passage of H.R. 1194 that renews the authority of the HHS secretary to approve new demonstration projects to test innovative strategies at the state level. Notwithstanding the need for this extension of authority, waivers are a stop-gap measure that highlight the need for comprehensive child welfare finance reform. Federal funding should be aligned in a way that promotes services to children and families in their own homes. Proven effective prevention and diversion pilot programs should be expanded to full-scale initiatives.

No Unfunded Mandates

States must be able to implement any changes for data gathering without diverting resources from direct services. Past experience suggests that automated data system enhancements are expensive and time consuming. Federal funds must be allocated to implement any changes to address the need for better data collection. States also need flexibility in developing internal systems that complement what is currently in place. States also need the ability to develop systems that complement what is currently in place, such as building information systems that allow for the upload and download of information from multiple sites or agencies into a central system or ancillary systems – noting that these different systems will generate information that can be analyzed nationally through federal guidelines that clarify what information should be included in each data field.[6]

Additionally, HHS should be granted the authority to allow statewide automated child welfare information systems (SACWIS) funds to be used to build data systems that are flexible, dynamic and nimble enough to gather data from the other systems (e.g., medical, mental health, educational). In addition, HHS should facilitate cross-program/cross-agency initiatives to gather and gain access to information that promotes service collaboration beyond the child welfare system. To the extent requirements are established, states must be given adequate time to implement them, particularly because changes may be needed at multiple governance levels prior to implementation at the front-line practice level.

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[5] APHSA. (May 25, 2011). *Support Letter HR1194.* Available from http://www.napcwa.org/Home/docs/HR-1194-Support-Letter-Combined-Proposal05-26-11.pdf

[6] APHSA/NAPCWA. (October 2010). AFCARS Letter in response to *Request for Public Comment and Consultation Meetings on AFCARS*, published in the *Federal Register*, July 23, 2010 (Volume 75, Number 141). Available from *http://www.aphsa.org/Home/Doc/APHSA_ON_AFCARS_FederalRegisterNotice.pdf/*

Rebalance Systems to Allow Funding to Follow the Family

Child welfare is concerned about sustaining other programs that support the safety of children. Research and data indicate that investments in front-end prevention services for children at risk and families in crisis yields more benefit and is a better allocation of federal funds. This approach leads to a family's self-sufficiency and the safety of all its members. Children and families at risk face an array of challenges, including poverty, substandard housing, substance abuse, domestic violence and mental health issues. In addition to giving child welfare agencies flexibility in directing funds to front-end prevention services, other federally funded programs are essential to supporting families to enable them to adequately care for their children, such as affordable, quality child care that allows a parent to work and food supports such as SNAP and WIC.

Funding for Training

Information sharing goes beyond breaking down the barriers of agency confidentiality and turf. Many child deaths due to maltreatment are not known to the protective service system and therefore there was never an opportunity to intervene. Professionals who come in contact with children must have the skills to identify risk and act to ensure safety. There should be specialized training in professional schools for social workers, day care providers, educators and medical providers, particularly for pediatricians, emergency room personnel and nurses. The federal government should provide funding for this training.

Meaningful Accountability

Gathering quality data can support effective child welfare decision-making and ultimately reduce child maltreatment. We recognize that every child death is a tragedy. Child welfare administrators and front-line workers firmly understand this notion and work diligently to prevent and/or reduce instances of child abuse and neglect. We would be remiss if we did not point out that thousands of children benefit each day from interventions from the public child protection system.

When a state's performance falls short on preventing child abuse and neglect in the federal view, withholding funds usually makes the situation worse as the lost funds are necessary for correcting deficiencies. The current penalty structure outlined in the Child and Family Services Review forces states into a defensive posture and encourages allocating resources to avoid the loss of funds rather than finding innovative solutions. Every dollar taken away is a dollar that is

no longer available to protect children at risk of abuse or neglect. A meaningful accountability process should fuel momentum for continuous improvement and allow for the changing needs, circumstances and demographics at the state level.

Charge HHS to align rule making and ensure collaboration among its agencies

Any new regulations for child welfare must align with rule-making across units and departments to avoid conflicts and to set priorities for implementation. To effectively identify contributing factors and ultimately determine whether child death is due to maltreatment, information is required from many other systems, such as education, health and criminal justice. More important, the open exchange of information and collaboration of agencies is needed to maximize the cost-effective use of resources to prevent maltreatment and provide services that will restore children, youth and families.

CONCLUSION

Again, thank you for the opportunity to submit these comments. Building from GAO's recommendations, we urge Congress to consider the following:

- **Seek states' input on reform efforts to improve the quality and comprehensiveness of national data on child fatalities.** States need to be a part of the national discussion and fully engaged in this process. Public child welfare administrators are well positioned to offer solutions on the topic. National forums and roundtable discussions sponsored by HHS could help guide this work. As a result, we hope to see a better federal and state partnership focused on preventing deaths due to child maltreatment.

- **Do not include unfunded mandates on states.** States should not have to divert funds from direct services that protect children and support families to gather national data on child fatalities. States have internal data sources that are used in combination with the national data to make data-driven decisions about programs. Currently, the process for national data collection and reporting has become administratively burdensome and costly for states. Posing unfunded mandates on states regarding data collection and reporting requirements would exacerbate, rather than improve, the issue. States agree that there needs to be more comprehensive and accurate data that paints a true picture of what is currently happening to at-risk children and families. Therefore, there needs to be a requirement for HHS to provide better assistance for states to establish a

consistent collection of valid and credible data targeted to improve practice at state and county levels and that guide research.

- **Require HHS to create better guidelines to improve NCANDS data collection on child fatalities.** In addition to the technical assistance that HHS currently offers, training and technical assistance should focus on state-identified needs, targeted areas of improvement, and include a variety of methods such as peer-to-peer training, mentoring and site-visit observation of successful programs to replicate best practices.

- **Provide federal funding to support specialized training in professional schools** for social workers, day care providers, educators and medical providers, particularly for pediatricians, emergency room personnel and nurses. These professionals are mandated child protection reports. Therefore, a uniform approach for training professionals on child maltreatment is critical. Professionals need to be better educated on child abuse and neglect and know when and how to report it. This could contribute to reduced instances of child abuse and neglect and improve the way professionals properly address child maltreatment.

We appreciate your concern and interest in the issue of child fatalities as a result of abuse and neglect. We look forward to working with you to make the necessary improvements to child protection systems and data collection. APHSA and NAPCWA urge you also to consider enhancing prevention services and supports to address the needs of this vulnerable population.

If you or your staffs have any questions about this statement, please contact Ron Smith at (202) 682-0100 x 299 or *rsmith@aphsa.org*.

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Title of Hearing: July 12, 2011 House Ways and Means Subcommittee on Human Resources hearing on *Child Deaths Due to Maltreatment.*

The Ways & Means Committee Hearing on Child Deaths Due to Maltreatment

July 26, 2011

Dear Chairman Davis and Committee Members:

We are writing on behalf of our children and the many lives we have witnessed that have been harmed by this significant health, economic and societal problem. Our intention is to encourage this committee to focus on prevention. Our children deserve to feel safe especially in their homes, at school and in their communities.

Children dying and being abused at the hands of the adults who care for them is the most heinous of actions. Domestic abuse and violence has repercussions that impact health care, education, and our financial institutions for generations.

We have outlined 6 areas which we feel call for immediate attention and are places our current judicial systems allow children to fall through the cracks of bureaucracy and neglect.

1. Children need a national unified bill of rights.
2. Modification of the current legal bias, which views children as property of the father, needs national clarification. These biases put significantly more focus on the parent's rights over the child's right to be safe in their home.
3. Uniform and broad legal definitions of child maltreatment need to become a national standard.
4. Courts in all States must be accountable to following current judicial guidelines put forth by the directors of the National Council of Juvenile and Family Court Judges. These guidelines are very clearly defined in the book that has been adopted as the position of the Council: A Judicial Guide to Child Safety in Custody Cases By Dr. Margaret Drews. (2008)
5. Create Standards and benchmarks, which unify measure that ensure accurate fact finding, data intake, record keeping & record sharing between agencies nationwide.
6. Institute preventive measures including educational standards for all court professionals involved in child abuse cases. Education for parents who are trying to protect their children. Include best practices from research that shows effective strategies to stop the cycle of power, control, and violence towards are country's most vulnerable citizens.

Background

Based on Center for disease development fact sheets, http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf , What we do know is that:

• 1,740 children died in the United States in 2008 from abuse and neglect.

• 772,000 children were found to be victims of maltreatment by child protective services in 2008.
There are many not even in the records or discarded. Children are taken across State lines when actions are reported and the fear of retaliation by the abuser limits parents and lawyers in acting. Clear intent is difficult to establish an abuser will lie and deny the act. The patterns not individual actions are the correct way to come up with safe plans for the child. There are numerous cases that child care workers teachers therapists and concerned citizens report which go undocumented by systems that are underfunded, undereducated and misguided in their focus.

Definitions

Child maltreatment includes all types of abuse and neglect of a child under the age of 18 by a parent, caregiver, or another person in a custodial role.

There are four common types of abuse.

• Physical abuse is the use of physcial force, such as hitting, kicking, shaking, burning or other show of force against a child.
• Sexual abuse involves engaging a child in sexual acts. It includes fondling, rape, and exposing a child to other sexual activities.
• Emotional abuse refers to behaviors that harm a child's self-worth or emotional well-being. Examples include name calling, shaming, rejection, withholding love, and threatening.
• Neglect is the failure to meet a child's basic needs. These needs include housing, food, clothing, education, and access to medical care.

Unfortunately current laws used in courts vary from State to State and many do not recognize abuse at all in their laws. This lack of uniformity compromises the safety and rights of a child as well as limits the protective parent or agent to get enforceable orders to intervene. There are cases when protective parent insists on protection , and courts rule against the protective parent to alter custody and expose the child to ultimate danger and their own devices.

Co-Morbidities

While Child maltreatment and intimate partner violence can be separate issues and should be handled separately in some cases, some cases are strongly linked. Edleson, J.(1997, April). The overlap between Child Maltreatment and Women Abuse , the article can be found at http://www.vawnet.org . Thus, intimate partner violence (IPV) is another serious problem in the United States and there is a growing body of credible research that significantly links domestic violence to high risk of future child maltreatment years after a couple has separated. Especially since it is common in such cases when the underlying maltreatment is minimized, ignored and undetected.

Based on Center for disease development fact sheets, http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf , What we do know is that:

- Each year, women experience about 4.8 million intimate partner related physical assaults and rapes. Men are the victims of about 2.9 million intimate partner related physical assaults.
- IPV resulted in 2,340 deaths in 2007. Of these deaths, 70% were females and 30% were males.2
- The medical care, mental health services, and lost productivity (e.g., time away from work) cost of IPV was an estimated $5.8 billion in 1995. Updated to 2003 dollars, that's more than $8.3 billion.

IPV can affect health in many ways. The longer the violence goes on, the more serious the effects.

Many victims suffer physical injuries. Some are minor like cuts, scratches, bruises, and welts. Others are more serious and can cause death or disabilities. These include broken bones, internal bleeding, and head trauma. Not all injuries are physical. IPV can also cause emotional harm. Victims may have trauma symptoms including flashbacks, panic attacks, anxiety, PTSD and serious depressive disorders. Victims develop low self-esteem have a hard time with trust and relationships. Work and productivity are at risk.

Costs

"Dollars and Lives: The Economics of Healthy Children, by - Dr. Phaedra S. Corso indicates that: "Healthy children lead to healthy adults. And healthy adults are more productive and drive a healthy economy. Because the nation cannot sustain its productivity potential if it has a large number of unhealthy adults, ensuring the physical and emotional well-being of our children through the prevention of child abuse and neglect must be one of this country's top priorities. The immediate, short-term economic impacts of child maltreatment are clear. They include the cost of healthcare services for acute injuries, the utilization of social and protective services to investigate and treat abused children, and the money spent on the legal and criminal justice systems involved. Perhaps the greatest economic impact of child maltreatment on society, however, is the unhealthy adults that are produced as a consequence

The Cost to Society of Adults who were Childhood Victims of Abuse and Neglect

Research has revealed the impact on society of unhealthy adults who were exposed to childhood abuse. First, adult survivors of child maltreatment are more likely to have decreased health-related quality of life(1) as shown by considerable evidence of higher levels of chronic and mental health diseases relative to non-abused adults(2). There is evidence of a strong correlation between childhood exposure to abuse and adult obesity, cardiovascular disease, and adverse lifestyle behaviors such as alcohol and tobacco use. The economic implications of these and other adult chronic and mental health conditions being associated with abuse are very serious, resulting in excess utilization of our healthcare system. Research done by(3) Dr. Amy Bonomi at Ohio State University

reveals that the annual healthcare costs for adult women reporting physical abuse during childhood were 22% higher than costs for women reporting no abuse during childhood. If one considers this excess cost, which is about $500, and multiplies it times the number of adult women in the US (about 110 million) and the prevalence of self-reported physical abuse from this study and others, ranging from 19 to 34 percent, then the excess healthcare costs associated with childhood physical abuse for women in the US is between $10.4 and $18.7 billion per year. Add to this the excess medical expenditures for men, which could be higher because their prevalence of self reported physical abuse is higher(4) and the excess medical expenditures for other types of abuse (sexual, emotional), and the economic impact on our healthcare system is even greater. When adult survivors have access to employer based health insurance, these excess expenditures are borne by the employer and the survivor in terms of out-of pocket expenditures and health insurance premiums. In cases where adult survivors do not have access to private health insurance, these excess expenditures are paid by society through tax dollars that support publicly-funded health insurance, primarily Medicaid and Medicare, or by cost shifting that results from uncompensated care delivered in hospital settings. In addition, there is a Impact on the Labor Force: Higher levels of chronic and mental health conditions among adults who were victims of childhood abuse and neglect may also affect the labor supply through lower productivity. Good health, while vital for individual wellbeing, also plays a large role in employee productivity. When adult survivors of child abuse and neglect suffer from long-term effects of chronic and mental health conditions, the results are increased number of sick days and increased number of days at work marked by low productivity. Some studies have noted that productivity losses for chronic diseases can be up to 4 times higher than the costs of the associated medical expenditures(5). This means that in addition to the direct medical expenditures estimated above, female survivors of childhood physical abuse cost the economy an additional $40 to $75 billion in lost productivity each year. Finally, childhood exposure to abuse and neglect has been linked, both anecdotally and scientifically, to a lifetime trajectory of violence perpetration and victimization,(6) non-violent criminal activity(7), and increased utilization of social and welfare services. This means there is less money available for the criminal and legal justice systems, including police, prosecution, courts, probation, prison, and legal aid; and social welfare services, such as social security disability benefits. Beyond the economic impact associated with the actual survivor, it is also important to consider the influence on society and the family. For example, if child maltreatment has long-term impacts on the adult survivor's social functioning, coping skills, and relationship potentials, then one should also assume that there are negative spillover effects on the quality of life, physical and emotional well-being, and productivity potential for those in the survivor's sphere of influence. While not easy to quantify, these spillover economic impacts of child abuse and neglect may be no less important than those specific to the individual victim. The costs to individuals and to society of childhood abuse and neglect are enormous. The savings through prevention in lives and dollars should be an important public policy objective.

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(Corso p 1. aper; Edwards paper),

2. (Felitti, and other papers),
3. Bonomi et al. found that,
4. (Briere and Elliott, 2003),
5. (Loeppke et al., 2007).
6. (Fang papers),
7. (Widom, NIJ cites),
8. R Loeppke et al., "Health and Productivity as a Business Strategy," Journal of Occupational and Environmental

The Adverse Childhood Experiences (ACE) Study findings suggest that adverse childhood experiences are major risk factors for the leading causes of illness, disability and death as well as poor quality of life in the United States. Progress in preventing and recovering from the nation's worst health and social problems will benefit from the understanding that many of these problems arise as a consequence of adverse childhood experiences. There are more than 50 peer-reviewed publications from the ACE Study. A complete listing of the findings is
available by subject at: www.cdc.gov/NCCDPHP/ACE.
A video discussion of the ACE Study is available at:
http://www.cavalcadeproductions.com/ace-study.html
About the Author Dr. Robert Anda is a Senior Researcher in Preventive Medicine and Epidemiology and a consultant to the Centers for Disease Control and Prevention. He is the Principal Investigator with the Adverse Childhood Experience (ACE) Study which is the largest-scale study ever done of the health and social effects of adverse childhood experiences over the lifespan.
The Adverse Childhood Experiences Study: Child Abuse and Public Health,
http://www.preventchildabuse.org/publications/cap/documents/AndaWHTPPR.pdf

Some of the Other resources on financial impact:
"Dollars and Lives: The Economics of Healthy Children" by- Dr. Phaedra Corso, Head of the Department of Health Policy and Management at the University of Georgia's College of Public Health.
"Prevention Programs and Strategies: State Legislative Experiences"by -Kelly Crane, policy specialist for the National Conference of State Legislatures, in their Children and Families Program.
"A Better Future for America. A Better Future for America's Children: Strengthening our Capacity to Prevent Child Abuse and Neglect", Lisbeth B. Schorr , a Senior Fellow at the Center for the Study of Social Policy, and Lecturer in Social Medicine at Harvard University.
"Prevention Creates the Future by Transforming Culture" by - Dr. Jeff Linkenbach, the Director of the Center for Health and Safety Culture a Montana State Uninversity.
"The Adverse Childhood Experiences Study: Child Abuse and Public Health", by - Dr. Robert Anda, a Senior Researcher in Preventive Medicine and Epidemiology and a consultant to the Centers for Disease Control and Prevention.
"Better Lives for Children Lead to a Better Climate for Business", -Michael E. Axelrod, is the Managing Member of Trinova Partners LLC, a business consulting firm in Atlanta,

Additional Resources
Greenbook Initiative

Professor Drew has published several articles, including "Recognizing Financial Control as Abuse" (86 Women Law. J. 9 2000-2001) and Lawyer Malpractice: Are We Re-PVictimizing Our Domestic Violence Clients? in the 2005 spring volume of The Family Law Quarterly. In the 2006 winter volume of the University of Cincinnati Law Review, Professor Drew and her co-author, Sarah Buel, published "Do Ask and Do Tell: Rethinking the Lawyer's Duty to Warn in Domestic Violence Cases." The article was part of a symposium held on the 30th anniversary of the Tarasoff case. Her projects include a domestic violence discovery handbook.

Professor Drew was an editor and contributing author of the ABA 2005 publication, The Impact of Domestic Violence on Your Legal Practice, 1st and 2d ed. In 2007, she served on a steering committee and edited the ABA's Standards of Practice for Lawyers Representing Victims of Domestic Violence, Sexual Assault and Stalking in Civil Protection Order Cases. She also assisted the National Consumer Law Center in editing its publication: Massachusetts Guide On Consumer Credit for Victims of Domestic. November 2010,As Director of the Domestic Violence and Civil Protection Order Clinic, Margaret signed on to testimony submitted to Congress urging the passage of The Convention for the Elimination of all forms of Discrimination Against Women ("CEDAW"). testimony was organized by the Leadership Conference of Civil and Human Rights, a coalition of over one hundred and sixty organizations. Margaret drafted a portion of a briefing paper to be submitted to the United Nation's Special Rapporteur on Violence Against Women in conjunction with the Special Rapporteur's visit to the United States in 2011. Margaret's section of the paper addressed the financial difficulties abused women face when they engage the legal system for assistance in achieving safety for themselves and their children.
National Council of Juvenile and Family Court Judges, University of Nevada, " Executive Summary of Effective Intervention in Domestic Violence and Child Maltreatment Caes: Guideline for policy and Practice, June 1999.

Legal Disparities

Sample of different state laws on definition of child abuse and some times does not even have it. ALABAMA: STATUTE defines child abuse as harm or threatened harm of physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury against a child under the age of 18. Statute contains an exemption for religious reasons for a parent's failure to obtain medical help for the child.
ALASKA: Statute defines child abuse as harm or threatened harm of physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury of a child under the age of 18. Statute contains an exemption for religious reasons for a parent's failure to obtain medical help for the child.
ARIZONA: Statute defines child abuse as inflicting or allowing physical abuse, neglect, sexual abuse, sexual exploitation, emotional/mental injury, or ABANDONMENT of a child under the age of 18. Statute contains an exemption for Christian Scientists or unavailability of reasonable resources for a parent's failure to obtain medical help for the child.
ARKANSAS: Statute defines child abuse as intentionally, knowingly, or negligently without cause inflicting physical abuse, neglect, sexual abuse, sexual exploitation,

abandonment or emotional/mental injury of a child under the age of 18. Statute contains exemptions for poverty or corporal punishment.
CALIFORNIA: Statute defines child abuse as inflicting by non-accidental means physical abuse, neglect, sexual abuse, or sexual exploitation of a child under the age of 18. Statute contains exemptions for religion, reasonable force, and informed medical decision.
COLORADO: Statute prohibits threats to a child's health and welfare due to physical abuse, neglect, sexual abuse, sexual exploitation, emotional/mental injury, or abandonment. Statute contains exemptions for corporal punishment, reasonable force, religious practices, and cultural practices.
CONNECTICUT: Statute prohibits injuries inflicted by non-accidental means involving physical abuse, neglect, sexual abuse, sexual exploitation, emotional/mental injury, or abandonment. Statute contains exemption for Christian Scientists.
DELAWARE: Statute prohibits injuries inflicted by non-accidental means involving physical abuse, neglect, sexual abuse, sexual exploitation, emotional/mental injury, or abandonment. Statute contains exemption for religion.
DISTRICT OF COLUMBIA: Statute prohibits persons from inflicting and requires people to take reasonable care not to inflict injuries involving physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains exemption for poverty and religion.
FLORIDA: Statute prohibits willful or threatened act that harms or is likely to cause harm of physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains exemptions for religion, poverty, or corporal punishment.
GEORGIA: Statute prohibits injuries inflicted by non-accidental means involving physical abuse, neglect, sexual abuse, or sexual exploitation. Statute contains exemption for religion and corporal punishment.
HAWAII: Statute prohibits acts or omissions resulting in the child being harmed or subject to any reasonably foreseeable, substantial risk of being harmed with physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains no exemptions.
IDAHO: Statute prohibits conduct or omission resulting in physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains exemption for religion.
ILLINOIS: Statute prohibits persons from inflicting, causing to be inflicted, or allowing to be inflicted, or creating a substantial risk, or committing or allowing to be committed, physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains exemptions for religion, school attendance, and plan of care.
INDIANA: Statute prohibits act or omission resulting in physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains exemptions for religion, prescription drugs, or corporal punishment.
KENTUCKY: Statute prohibits harm or threat of harm, or infliction or allowance of infliction of physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains exemptions for religion.
MARYLAND: Statute prohibits harm or substantial risk of harm resulting in physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains no exemptions.

MICHIGAN: Statute prohibits harm or threatened harm of physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains exemptions for religion.
MISSISSIPPI: Statute prohibits persons from causing or allowing to be caused physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains exemption for religion and corporal punishment.
NEBRASKA: Statute prohibits knowingly, intentionally, or negligently causing or permitting physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains no exemptions.
NEW MEXICO: Statute prohibits knowingly, intentionally, or negligently causing or permitting physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains exemption for religion.
NORTH DAKOTA: Statute prohibits serious harm caused by non-accidental means resulting in physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains no exemptions.
OKLAHOMA: Statute prohibits harm or threat of harm resulting in physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains exemptions for religion or corporal punishment.
PENNSYLVANIA: Statute prohibits recent act or failure to act resulting in physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains exemptions for religion or poverty.
SOUTH DAKOTA: Statute prohibits threat with substantial harm resulting in physical abuse, neglect, sexual abuse, sexual exploitation, abandonment, or emotional/mental injury. Statute contains no exemptions.
TENNESSEE: Statute prohibits persons from committing or allowing to be committed physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains no exemptions.
UTAH: Statute prohibits harm or threat of harm resulting in physical abuse, neglect, sexual abuse, sexual exploitation, or emotional/mental injury. Statute contains no exemptions.
WASHINGTON: Statute prohibits harm of health, welfare, or safety resulting from physical abuse, neglect, sexual abuse, or sexual exploitation. Statute contains exemptions for Christian Scientists, corporal punishment, or physical DISABILITY.

We appreciate your committee's hearing our concerns. We hope that with continued education and enforcement this will improve.

Respectfully Submitted,

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Hearing on Child Deaths due to Maltreatment

I am one of 180 board-certified child abuse pediatricians in the United States. I have been part of the Child Protection Team at Children's Hospital of Pittsburgh of UPMC for more than 10 years and have evaluated well over a thousand children with suspected child abuse and neglect. I have been part of my state's Child Abuse and Neglect Work Group for more than seven years and have spent considerable time involved in public policy issues related to detection, evaluation and assessment of child abuse. This past month, I wrote an opinion piece in the Pittsburgh Post-Gazette, which focused on the importance of proper ascertainment of child abuse cases (available at: http://www.post-gazette.com/pg/11163/1152807-109-0.stm). I am also one of only a handful of child abuse physicians whose career has focused on child abuse-related clinical research. I spoke with the GAO during the preparation of their report related to child deaths due to maltreatment.

As our medical system does a better and better job of developing new vaccines, finding cures for childhood cancer and caring for children with chronic diseases, the leading cause of death and disability in children has shifted from disease to injury. Child abuse and neglect account for a significant proportion of injuries in childhood. Correct ascertainment of the number of cases of fatal child abuse is critically important for numerous reasons, which have been explained by other witnesses. It is also important to recognize that due to advances in medicine, cases of child abuse, which may have been fatal five years ago, are now survivable, but often result in significant morbidity. Being able to correctly ascertain the number of deaths from child maltreatment is only a first step. To understand the true burden of child abuse on our society, we need to count all cases, not just the fatal ones.

There are several barriers to proper ascertainment of the number of fatal (and non-fatal) cases of abuse. The most important barrier, I believe, is that the official child abuse data in this country are based on the results of child protective services (CPS) investigation. The ability of CPS to indicate (e.g. count) a case of maltreatment, fatal or not, is dependent on state law. We can never overestimate the importance of this. As you know, every state has its own definition of child maltreatment; what counts as child abuse in one state may not count in another. For example, in the state of Pennsylvania, the law requires the perpetrator of abuse to be known before a case can be counted as abuse. As a result, a child can die from unequivocal child abuse, but if it cannot be determined who injured the child, the case is not indicated and would not appear in the national statistics. However, if that same child lived in neighboring Ohio, the case would be counted. Why? Ohio does not require a perpetrator to be identified. The tremendous state-to-state variability in assessment of neglect is even more problematic; again, state definitions are critically important. In Pennsylvania, most forms of neglect are not included in the state definition of abuse. As a result, in a state with 4 million children, there were just nine deaths due to neglect in 2010.

To properly count the number of cases of fatal (and non-fatal) child abuse, I believe we need to recognize there are data sources other than CPS data. For example, medical data from publically available datasets can be used to identify cases of medically diagnosed physical abuse. It's important to note that the medical diagnosis of abuse is independent of state definition. Multiple published studies have used these datasets to study the epidemiology of different types of child abuse. Not surprisingly, data from several of these studies seem to contradict data from official CPS data sources.

To overcome the marked differences in state laws, I believe we need to adopt federal standards by which we, as a society, define child abuse and neglect. Cases of abuse and neglect that meet these standards would be counted as abuse on a federal level. Even if we can only agree on the most egregious cases - the fatal ones - this at least will allow us to begin the process of counting deaths from child maltreatment.

A second, but still important barrier to proper ascertainment of the number of cases of fatal abuse relates to the assumption that all cases are 'unequivocally abuse' or 'not abuse.' There needs to be a way in which our system can recognize that while death is certain, the cause of death is not always so clear. While some deaths are unequivocally due to abuse, there are some which are not - either because the proper investigation was not carried out (an unfortunate, but far too common situation) or because there is legitimate debate about the level of certainty with which experts can state that the death was due to abuse. The level of certainty, which is necessary for CPS to indicate a case as abuse or neglect, for example, is often different from the level of certainty required in a criminal court. An ideal system of ascertainment would allow for classification of fatalities as 'unequivocal' or 'probable' child maltreatment. Since all unexpected childhood deaths should undergo evaluation as part of county-specific death review teams, it would not be difficult to classify the likelihood of abuse in each case.

A related, but important, barrier to identifying child maltreatment deaths is the lack of adequate investigation and/or consideration of abuse. If we do not look for maltreatment, we will not find maltreatment and if we do not consider neglect, we will not identify neglect. There needs to be a standard evaluation performed on all infants and young children who die unexpectedly. Without a complete scene investigation and proper medical evaluation (e.g. a post-mortem skeletal survey, a complete autopsy), cases of child abuse and neglect will certainly be missed.

A final, but important barrier is our own discomfort, as a society, with the concept of child maltreatment. It's not easy to accept that thousands of children in this country die each year due to the actions, or inactions, of their caregivers. By not 'counting' certain deaths as maltreatment because of technicalities in the law; by not evaluating maltreatment when we assess injuries and or deaths; and/or by calling what should be labeled neglect as 'terrible accidents,' we are able, as a society, to believe that deaths due to abuse and neglect are rare. I believe this committee has the ability to start addressing this barrier simply by acknowledging the problem and searching for a solution.

Nelson Mandela said, "There can be no keener revelation of a society's soul than the way in which it treats its children." Whenever a child dies of child maltreatment, we have failed as a society to protect that child. It is therefore incumbent upon us to try to make something positive come from that child's death. Ensuring that that child's death is counted is the first and perhaps most critical step in doing this.

PREVENTING CHILD DEATHS DUE TO MALTREATMENT

Written testimony submitted by

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to

Subcommittee on Human Resources
Committee on Ways and Means

July 12, 2011

Hearing on "Child Deaths Due to Maltreatment"

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On behalf of the 145,000 members of the National Association of Social Workers (NASW), the world's largest professional association of social workers, I am pleased to submit written testimony for the hearing on "Child Deaths Due to Maltreatment" that was held by the Subcommittee on Human Resources of the House Ways and Means Committee on July 12, 2011. NASW advocates for sound social policies that support children, families and communities.

Social Work and the Protection of Children

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

High Rates of Child Abuse Fatalities

While many valuable programs focus on child abuse prevention and intervention, our societal response is insufficient to prevent the estimated 2500 children's deaths due to abuse and neglect that occur each year (Every Child Matters Education Fund [ECM], 2010). Although federal reports indicate that overall child abuse and neglect rates are decreasing, child abuse deaths are on the increase (U.S. HHS, 2009). The Government Accountability Office (GAO, 2011) found that the current data and tracking we have on deaths from child abuse and neglect is woefully inadequate and concurs with the National Coalition to End Child Abuse Deaths (NCECAD) that the number of deaths from child abuse and neglect are undercounted. The GAO recommends that there be greater federal investments in strengthening the quality of data as well as the information available on child abuse fatalities so that this increased knowledge can help prevent future deaths.

Identifying and Reporting Child Abuse and Neglect

Many of the deaths due to child abuse and neglect that were profiled in *We Can Do Better* (ECM, 2010), a report about deaths from child abuse and neglect across the United States, prepared by the Every Child Matters Education Fund, were children who were not previously known to the child protective system. These deaths signal that as a society we need to do more to nurture and support both children and their caregivers and ensure that children are safe. Doctors, teachers, nurses, social workers, clergy, family members and neighbors all are stakeholders in protecting children. Slightly more than one half of child abuse and neglect reports are from professionals who come in contact with children suspected of being abused and neglected. The remaining reports are from friends, caregivers, coaches, neighbors and relatives (Children's Bureau, 2009). We do know, also, that many children at risk are never reported to the child protection system (Sedlak, et al., 2010).

Professionals who are legally mandated to report children who are suspected of being maltreated should have confidence that the child protection agency has the necessary resources to make an

adequate and appropriate response, and that such reports will be assessed and heeded in a timely fashion. However, high workloads, inadequate staffing and lack of resources and training often result in systems that do not respond adequately to maltreatment reports.

Addressing Child Neglect

It is important to note that child neglect is the most prevalent type of maltreatment (75% of maltreatment victims and 35 % of child fatalities [Child Welfare Information Gateway, 2011]), yet we continue to have inadequate responses to what is frequently a chronic problem. The services offered to those who are maltreated and their families are usually episodic and crisis-oriented rather than focused on long term concerns (Blome & Steib, 2009). To appropriately address chronic neglect there is a need for targeted on-going services and supports as well as early intervention services for new parents. The provision for the early childhood evidence-based home visiting program included in the Patient Protection and Affordable Care Act is one attempt to address this need for parents most at risk.

The Need for Skilled Social Workers in Child Protection Work

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

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

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

Addressing Racial and Ethnic Disparities in Child Abuse and Neglect

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

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

Recommendations

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

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

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

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

   NASW recommends that federal funding be enhanced to support the education and training of professional social workers to work in public and private child welfare agencies, including support for the education and training of supervisors. In addition, child protection agencies should increase their staffing standards, by requiring a minimum of a bachelor's degree in social work (BSW) for front-line workers and a master's degree in social work (MSW) and experience for supervisors in

child protection programs. Resources should also be available to ensure that other professionals, including physicians, lawyers, and nurses, have the necessary training to recognize and assess child abuse and neglect and to ensure that there are high quality multi-disciplinary services available. In addition, all health and behavioral health, legal, and social service professional should have training related to child abuse and neglect assessment and prevention.

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

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

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

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

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

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

If you have questions or would like additional information, please contact Joan Levy Zlotnik, PhD, ACSW, Director, Social Work Policy Institute, NASW Foundation at 202 336 8393 or jzlotnik@naswdc.org.

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NATIONAL COALITION FOR CHILD PROTECTION REFORM

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EVERY FACT MATTERS:

Evidence-based solutions, not hype and hysteria, will save children's lives

Submission for the record of Richard Wexler, Executive Director, National Coalition for Child Protection Reform for the Hearing of the Subcommittee on Human Resources of the Committee on Ways and Means, U.S. House of Representatives, July 12, 2011.

Reducing the time child protective services workers spend on false allegations, trivial cases, and needless removal of children is the best way to help overloaded child welfare agencies find and protect children in real danger.

The worst thing Congress could do would be to take $3 billion to $5 billion in scarce funds and redirect that money toward hiring more child abuse investigators to intrude on more families and take away more children needlessly. Inevitably, that money will reduce the amount available for safe, proven programs to keep families together. It also will further overload child protective services agencies, making it even harder for them to find children in real danger.

Yet that is the proposal from the group calling itself Every Child Matters (ECM) and its allies. Michael Petit and his colleagues at ECM mean well; they really want to protect vulnerable children. But those good intentions appear to have bred an ends-justify-the-means mentality. **In the name of advancing a noble goal that we all share, ending child abuse deaths, the group has exploited tragedy and misused data.** When real horror stories aren't enough, Petit offers up a hypothetical horror story in his written testimony on page 5 which also serves to discredit efforts to keep families together. The token rhetoric about prevention thinly disguises a take-the-child-and-run agenda that will only make all children less safe.

Though ECM offers up some token rhetoric about the need for "prevention," they favor only primary prevention that expands the net of intervention into families, and "soft" services like "counseling" and "parent education" that often do more for the "helpers" than the families. They are silent about *family preservation* which provides real services, often concrete help to ameliorate the worst effects of poverty, to families on the verge of losing their children to foster care.

And even primary prevention is not where ECM is talking about pouring more money. According to ECM's website, the group wants to spend $3 billion to $5 billion not on prevention of any kind but on child protective services investigations - more investigators and more removal of children. (Petit's written testimony rewrites this recommendation a bit to imply that they might favor using the money for other services as well, but the version on the

ECM website indicates that the money is meant for hiring more investigators, training them, and paying them more – not for concrete help to impoverished families.)

Even without the money, the scare rhetoric, hype and hysteria fueled by ECM leaves the false impression that every parent reported to child welfare agencies is a brute and a sadist about to beat, maim or kill their children. Nothing could be further from the truth.

Who could walk out of the June 12th hearing, after listening to two hours about the worst (and least representative) cases, without wanting to demand that workers rush to tear apart families at the slightest suspicion that anything is wrong. Nothing could be more harmful to children.

This kind of rhetoric ratchets up the pressure on frontline workers to tear apart families needlessly, rather than be scapegoated for leaving a child at home and having something go wrong. Such "foster care panics" have wrought havoc all across the country – and led to increases in child abuse deaths. (For details see our Issue Paper on foster-care panic, available here: http://bit.ly/afoIfN).

Even one child abuse death is one too many. The only acceptable goal for such deaths, and for all child abuse, is zero. But even if one took the official estimate of child abuse deaths and tripled it, that still would mean that in any given year, 99.99 percent of American children do not die of child abuse at the hands of a parent - or anyone else. Every such case is a needle in a haystack. And there is no hope of finding the needles by trying to vacuum up the haystack, which is what ECM proposes to do.

In contrast, the overwhelming majority of cases alleging child maltreatment allege neglect. Sometimes such allegations can involve very serious, malicious behavior. But more often it means only that a family is poor.

A TRULY TYPICAL CASE

To see a truly typical case, just consider the case of the Leonard family in Houston Texas, a married couple raising six happy, healthy children. Unable to find a good paying job, the only safe housing Mr. Leonard has been able to afford is a storage shed. He built shelves and a loft area, and even heating, electricity and air conditioning.

No one has ever alleged that any of Mr. Leonard's children has been beaten, tortured, or starved. On the contrary, everyone who knows the family says the children are happy and healthy – or at least they were until someone did exactly what ECM encourages everyone to do – phone in their slightest suspicion of maltreatment to child protective services.

Instead of helping the family find housing, or simply moving them all to a motel, CPS took away the children on the spot. Though grandparents took them in, being uprooted from their parents by force of law still is a trauma severe enough to risk leaving lifelong scars, especially for a young child. To do this to children when it is not absolutely essential for their safety is, in itself, an act of emotional abuse. (For details on this case, and links to news coverage, see this post to the NCCPR Child Welfare Blog at http://bit.ly/oAKBEo).

Unlike fatalities, cases like this are *not* extreme aberrations. Three major studies have found that 30 percent of America's foster children could be home right now if their parents simply had decent housing.

It's easy for this to happen since typical state neglect statutes commonly define neglect as lack of adequate food, clothing, shelter and supervision – a perfect definition of poverty. That made it all the more alarming to hear one of the witnesses at today's hearing suggest that poor people get too much "leeway" and the harm to their children actually should be labeled neglect even more often.

But it's not only these children who suffer. Think of all the time, money and effort that Texas CPS has wasted investigating, traumatizing and tearing apart this family. All of that time money and effort could have been used to find those needles in a haystack – children in real danger who really should be taken from their homes. Now multiply this case by the hundreds of thousands of other false allegations, trivial cases and cases of poverty-confused-with-neglect. Think of how many more children in real danger we could find if CPS agencies stopped harassing families like these.

Yet ECM has not uttered a word about this recent case in Texas, or the hundreds of thousands of others in which family poverty is confused with neglect. These are the children who don't matter to "Every Child Matters." But they should matter to the rest of us.

Jane Burstain offered far wiser solutions in her prepared testimony and at the hearing. Particularly encouraging was her support for restoring the authority of the Department of Health and Human Services to issue waivers allowing states to use federal funds now limited to foster care for better alternatives as well. The House of Representatives passed such legislation in May and Chairman Davis was right when he urged the Senate to act quickly to do the same. (There is more about waivers in this post to our Blog: http://bit.ly/qdHp3G)

In contrast, we are not aware of Every Child Matters taking a position on waivers, and in past years, the group has opposed similar approaches to flexible funding.

THE BETTER SYSTEMS EMPHASIZE FAMILY PRESERVATION

Perhaps it is precisely because real solutions differ so starkly from the phony solutions proposed by ECM that Petit ducked a question at the hearing. He was asked which states had relatively successful child welfare systems. He avoided a direct answer.

In fact, no state is good enough. But a few states are notably better than most of the rest, and NCCPR would be pleased to discuss these success stories with the committee in detail and provide contacts in these states. These states have one thing in common: They did more to keep families together and reduced the misuse and overuse of foster care.

Illinois and Alabama, for example, transformed their systems as a result of class-action lawsuit settlements. But unlike most such settlements, the settlements in these states emphasized rebuilding the systems to do more to keep families together. Today, these states tear apart families at rates well below the national average – and independent court appointed

monitors say child safety has improved. *The New York Times* examined Alabama's reforms in a front-page story available here: http://bit.ly/5ydDoW

Michael Petit's own state of Maine is now a national model – something it could not claim while its child welfare system was run by Michael Petit. On the contrary, by 2001, Petit and his successors left Maine with a system that held proportionately more children in foster care than almost any other. Only after a little girl named Logan Marr was taken from her mother because of the mother's poverty and placed in the foster home a former child welfare caseworker who killed her, did Maine face up to the fact that the heart of the problem was taking away too many children.

A new governor brought in new leadership that cut the rate of removal, significantly increased the use of kinship care, and sharply reduced the use of the worst form of placement, institutionalization. There was no compromise of safety, so it's no wonder Harvard's Kennedy School of Government made the transformation of child welfare in Maine a finalist for its innovations in American Government awards.

One final, sad irony: Remember the publication Michael Petit held up at the hearing? The one from ECM featuring pictures of dead children. One of those pictures is of Logan Marr. It profanes the memory of Logan Marr to have her picture used in a publication designed to stampede the American public into supporting the very take-the-child-and-run approach to child welfare that contributed to her death.

Still another state that has made enormous progress is Florida. Not long ago the state was *the* national example of child welfare failure. Today it's a national leader. Gov. Jeb Bush made Florida the only state in the nation to accept a waiver like the ones I described above, before HHS' authority to issue those waivers expired. Then Gov. Charlie Crist brought in reform-minded leaders who knew how to make the best use of the funds – rebuilding the system to emphasize safe, proven programs to keep families together. The result: significant reductions in entries into foster care and improvements in child safety – according to the independent monitors evaluating the waiver, as required by federal law. Once again, *The New York Times* was sufficiently impressed to do a story on the turnaround. That story is available online here: http://nyti.ms/f3L9Mh

But ECM's behavior has been particularly shameful when it comes to Florida. During a telephone news conference last year, Michael Petit and his allies spent much of the time trashing the Florida system – because it appeared that Florida had a high child abuse death rate, based on the phony scorecard ECM issued that year. In fact, this was due to the fact that Florida dramatically expanded the definition of child maltreatment deaths – exactly the kind of change ECM claims to favor. Further details are available on our website here: http://bit.ly/fgrbeI

For two years in a row, ECM has issued these grisly scorecards, even as the organization admits the comparisons are invalid because, in the absence of national standards, it is impossible to compare rates of child abuse deaths. The result: **Any state that does what ECM claims to want and investigates child abuse deaths thoroughly and comprehensively is penalized by false claims that they rank high in such deaths. States that do a sloppy job of investigating benefit by appearing to rank low.**

ECM simply cannot be relied upon for information that is accurate and in context. In 2009, the group had to retract an entire section of its report on child abuse fatalities after NCCPR pointed out that the data on child welfare spending were incomplete and out of date.

I am a tax-and-spend liberal and proud of it. There is nothing at which I'd rather "throw money" than keeping vulnerable children safe. But it is a crime against children to take scarce funds and waste them on approaches which only make things worse. Texas actually tried a massive caseworker hiring binge in 2005 – the result was exactly as we predicted in a report we issued at the time (available on our website here (http://bit.ly/aViRUZ): the same lousy system only bigger – and cases like the case of the Leonard family in Houston.

But, of course, Every Child Matters makes no mention of such cases. On the contrary, in his written testimony Petit implies that all parents caught up in the system are "abusive parents [who] are much more likely to learn how to care for their children safely" if ECM's recommendations are followed. The Leonards already know how to care for their children safely – and they were doing just that until Texas child protective services tore the family apart.

INFERENCE PEDDLING

Petit further stacks the deck by claiming that a caseworker's choice boils down to "leave a child in harm's way … or exercise powerful state authority that can result in termination of parental rights."

He wants readers to infer that any move to leave a child in her or his own home puts the child at risk, while if a child is removed only the parents rights are at stake. That kind of "inference peddling" distorts the child welfare debate.

In the overwhelming majority of cases, leaving the child in her or his home is the safer alternative – it is foster care that gambles with children's futures.

• When a child is needlessly thrown into foster care, he loses not only mom and dad but often brothers, sisters, aunts, uncles, grandparents, teachers, friends and classmates. For a young enough child it can be an experience akin to a kidnapping. Other children feel they must have done something terribly wrong and now they are being punished. A major study of foster care "alumni" found they had twice the rate of post-traumatic stress disorder of Gulf War veterans and only 20 percent could be said to be "doing well."[1]

• Two more studies, of 15,000 typical cases, are even more devastating. Those studies found that in these typical cases even maltreated children left in their own homes with little or no help fared better, on average, than *comparably-maltreated* children placed in foster care.[2]

• All that harm can occur even when the foster home is a good one. The majority are. But the rate of abuse in foster care is far higher than generally realized, far higher than in the general population, and vastly higher than the official figures, which involve agencies investigating themselves. For example, that same alumni study found that one-third of foster children said they'd been abused by a foster parent or another adult in a foster home. (The

study didn't even ask about one of the most common forms of abuse in foster care, foster children abusing each other). Switching to orphanages won't help -- the record of institutions is even worse.

Furthermore, the more a foster care system is overwhelmed with children who don't need to be there, the less safe it becomes, as agencies are tempted to overcrowd foster homes and lower standards for foster parents. And that is exactly what happens when the public confuses the horror stories peddled by groups like Every Child Matters with the norm.

• But even that isn't the worst of it. The more that workers are overwhelmed with children who don't need to be in foster care, the less time they have to find children in real danger. So they make even more mistakes in both directions. That is almost always the real explanation for the horror-story cases that make headlines.

None of this means no child ever should be taken from her or his parents. Rather, it means that foster care is an extremely toxic intervention that must be used sparingly and in small doses. But for decades, America's child welfare systems have prescribed mega-doses of foster care. ECM's scare tactics threaten to up the dose still further.

So if by some chance Congress has an extra $3 billion to $5 billion lying around, spend it on rent subsidies for poor families like the Leonards, spend it on low income child care, so single parents don't have to choose between getting fired or leaving their children home alone and having them taken away. But don't spend it on repeating the same mistakes the child welfare system has made ever since 19th century "child savers" used horror stories to gain unprecedented power over impoverished families.

The definition of insanity, it is said, is doing the same thing over and over and expecting a different result. By that standard, at a minimum, the proposals from Every Child Matters could use a "psychiatric evaluation."

Below, we present a more detailed examination of the misleading statements, misuse of data and factual errors by Every Child Matters concerning these issues. Unfortunately, many of these same errors are included in Michael Petit's prepared testimony for today's hearing.

EVERY FACT MATTERS:
How children are harmed by ECM's Reign of Error

An analysis from the National Coalition for Child Protection Reform

In the 19th Century, Societies for the Prevention of Cruelty to Children would raise funds by taking the very few extreme cases of maltreatment they encountered and exploiting them, sometimes complete with "before" and "after" pictures. Those rare cases hid an agenda that consisted largely of confiscating the children of the immigrant poor, an agenda fueled by racial, religious and class prejudice. Proudly calling themselves "child savers," their theory was that it was permissible to distort facts in order to build support for the noble goal of "saving" children.

In some quarters, things have not changed all that much. Though the group means well and is pursuing a goal that all of us share, ending child abuse deaths, the group calling itself Every Child Matters (ECM) repeatedly has misused data and sometimes gotten facts flat wrong. Just as the ends-justify-the-means mentality of 19th Century child savers did enormous harm to children then, that same mentality on the part of the latter-day child savers at ECM does enormous harm to children now.

ECM gets the facts wrong about fatalities

In 2009 and 2010 ECM published reports containing what amount to scorecards, purporting to compare child abuse fatality rates among the states.[3] Then the group set up the states it claimed were worst for what amounted to rhetorical public floggings at news conferences and in press releases. So in 2010, an ECM press release declared that: "The child abuse/child neglect crisis is one of national concern, but it also is of particular significance in the top 12 states that are above the national average for child abuse/neglect deaths."[4]

In fact, there is no way to know which state is worst, or best, because there is no valid way to compare. There is no valid "national average." And ECM actually admits this when pressed. On December 14, 2010, ECM held a telephone news conference during which its director, Michael Petit, and others spent 45 minutes blasting the states that supposedly rank high. Only at the end, when pressed by NCCPR, did Petit admit the very comparison they'd been making is impossible:

"We emphasize all over the place that it is impossible to compare states because of the different definitions, and we've been encouraging Congress and HHS to establish measurable and comparable standards between the states."

In fact, ECM doesn't emphasize this at all; at best they bury it in the fine print. ECM knows full well that reporters love scorecards, and any state they label as worst or among the worst will be tarred by that false claim in story after story. ECM also knows that local "child savers" opposed to reform plans that involve safe, proven alternatives to foster care will use the phony rankings in an effort to undermine those reforms.

It also undermines one of ECM's own stated goals: rigorous investigation of child deaths. Any state that makes its reporting more rigorous risks being attacked by ECM for supposedly having an above-average rate of child abuse deaths, while states that are sloppy about reporting such deaths are rewarded by being portrayed as safer for children.

ECM gets the facts wrong on child welfare spending

In 2009, ECM's report also purported to compare the amount states spend on child welfare. ECM criticized states that supposedly spent less. But the data were two years older than the most recent available. Worse, the data for several states were incomplete. This was clearly stated in the source material used by ECM (a report from the Urban Institute), but ECM ignored it – as well as overlooking the more recent data, prepared by some of the same researchers, though these data were readily available online.

Under pressure from NCCPR, which pointed out these facts on our Child Welfare Blog in these posts: http://bit.ly/liSq8y, ECM retracted the section of its report purporting to compare spending – but not before it did real damage.

The *Kennebec Journal* in Augusta Maine was badly burned when the newspaper ran a huge story based on ECM's inaccurate numbers – requiring them to run another huge story setting the record straight after ECM's error became apparent.[5]

ECM gets the facts wrong on false allegations of maltreatment.

Every year, Child Protective Services agencies investigate allegations of child maltreatment involving about 3.6 million children.[6] About 77 percent of those allegations, involving 2.77 million children, turn out to be false allegations.[7] Not only does this do enormous harm to the children traumatized by needless investigation, it also means that **CPS workers spent more than three-quarters of their time spinning their wheels – no wonder they don't have time to find all of the children in real danger.**

ECM uses a series of evasions to try to get around these 2.77 million inconvenient facts. In its 2009 report, ECM claimed that "many" reports initially labeled false will turn out to be true when the same family is reported again. But "many" can mean anything – or nothing. And ECM offers no support for that claim – an endnote leads only to a government statistics home page, with no indication of how ECM came up with this claim, or even where to look. Furthermore, when multiple reports do lead to substantiation, that may be only because there were multiple reports - so CPS workers may assume they must be true.

In contrast, the one serious study we know of to examine this issue found that caseworkers are two to six times more likely to wrongly substantiate a case than to wrongly declare one to be unfounded. So if anything, the official number of false reports understates the problem.[8]

ECM's statistics abuse doesn't stop there.

●Their 2009 report claimed that 30 percent of allegations of child maltreatment were substantiated in 2007. In fact it was 23 percent that year, just as it was in 2009, the most recent year for which data are available.

● In addition to overstating the percentage of cases that workers substantiate, ECM calls these cases "confirmed." That is not true. No judge or jury reviews such decisions; it's just a caseworker checking a box on a form. So it is no wonder we are aware of no state that actually uses the term. In many states the worker is supposed to "substantiate" the case even when there is more evidence of innocence.

● But ECM's mastery of evasion is most apparent when the group says, in that same 2009 report, that "there is no evidence which suggests that intentionally false reports alleging maltreatment are a serious issue." The weasel word is "intentionally." Whether a child is subjected to a traumatic investigation, a stripsearch and separation from everyone she knows and loves because of a malicious report or because of a well-meaning error by someone who

listened to one of those endless exhortations to report anything and everything isn't likely to matter much to that child.

Bottom line: No matter how much ECM tries to obscure the issue, the fact remains that, malicious or not, at least 77 percent of reports are false.

Furthermore, of the "substantiated" reports, the overwhelming majority are neglect – which often means poverty, since typical state laws define neglect as lack of adequate food, clothing shelter and supervision – a perfect definition of poverty. (For details and full citations, see NCCPR Issue Papers 5, 6 and 7 at www.nccpr.org.)

Indeed, out of every 100 children investigated as possible victims of abuse, at least 79 simply weren't - the report was false. Fourteen were "substantiated" victims of neglect, and 7 were victims of either sexual abuse or any form of physical abuse, from the most minor to the most severe. (Three of those eight may have been victims of both and/or other forms of maltreatment as well.) One was a victim of psychological maltreatment. One more falls into a category listed as "other."[9]

ECM's "Bait and switch"

Here are some facts you won't find in any of ECM's material:

● ECM says the "real" number of child abuse deaths may be 50 percent higher than the official figure. That may be true, though a recent series of reports by NPR, ProPublica and the PBS series *Frontline* also provide ample evidence that the official figure may be overstated. In fact, there likely are serious errors in both directions.

But even if you go much further and triple the official estimate, in any given year, 99.99 percent of American children will not die of child abuse.[10]

● In any given year, 98.9 percent of American children will not be abused or neglected in any way – and that's true even when one counts all those cases in which what child protective services agencies call "neglect" really is poverty.[11]

The reason you almost never see those numbers is because groups like ECM have successfully intimidated critics away from mentioning them, using a kind of "bait and switch" technique. The bait: First they use inflated, phony numbers to lure us into their tent to sell us snake oil solutions. Then, if anyone tries to put the numbers into context, comes the switch: They say, in effect, "How dare you quibble about numbers when children are dying? If even one child dies of abuse it's one too many."

In one sense they are right, in another, tragically wrong. They are right in the sense that the problem of child abuse is not minor. The United States is a very big place, even a small percentage is a big number. And yes, even one child's life lost to the sadism or brutality of a parent is one too many – so is one child whose life is ruined by needless placement in the chaos of foster care.

But it is wrong to dismiss the importance of getting the numbers right. The numbers are significant not for what they say about the importance of the problem, but for what they say about how to solve it. The problem of child abuse is serious and real. It's ECM's solutions that are phony. Using bad numbers to promote phony solutions only makes it more likely that the real numbers, whatever they are, will get worse.

The fact that the percentage of children who face child maltreatment is, in fact, quite low, and the horror story cases that make headlines – or are ripped from the headlines for *Law & Order* scripts - is tinier still, has profound implications for how we try to reduce the number still further.

The horror story cases are needles in a haystack. Real solutions require finding more precise ways to detect the needless. Instead, we keep trying to vacuum up the entire haystack. The net of coercive intervention is made ever wider, with resources diverted into hiring more caseworkers to investigate more families, new categories of mandated reporters, broader definitions of maltreatment and constant exhortations to turn in our neighbors at the slightest suspicion of maltreatment.

All of that only compounds the real problems in American child welfare – and makes all children less safe.

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[1] Peter Pecora, et al., *Improving Family Foster Care: Findings from the Northwest Foster Care Alumni Study,* (Seattle: Casey Family Programs, 2005).
[2] Joseph J. Doyle, Jr., "Child Protection and Child Outcomes: Measuring the Effects of Foster Care," *American Economic Review*. 97(5), December 2007: 1583-1610; Joseph J. Doyle, Jr., "Child Protection And Adult Crime: Using Investigator Assignment To Estimate Causal Effects Of Foster Care," *Journal of Political Economy* 116(4), August 2008: 746-770.
[3] *We Can Do Better: Child Abuse and Neglect Deaths in America* (Washington DC: Every Child Matters Education Fund). First Edition, October, 2009, Second Edition, September 2010. All references to ECM's "2009 report" are to this document.
[4] News Advisory: "Child abuse deaths: The most ignored major social problem in America?" Dec. 14, 2010.
[5] Scott Monroe, "Official criticizes Child poverty study," *Kennebec Journal,* October 24, 2009.
[6] U.S. Department of Health and Human Services, Child Maltreatment, 2009, p.ix, available online at http://www.acf.hhs.gov/programs/cb/pubs/cm09/cm09.pdf
[7] Ibid., p.viii, reporting that only 23 percent of allegations are either "substantiated" or "indicated."
[8] Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988 (Washington: U.S. Dept. of Health and Human Services, National Center on Child Abuse and Neglect, 1988), Chapter 6, Page 5.) Although this is an old study, nothing has changed in the way CPS workers investigate cases to suggest that the findings would be any different today.
[9] The figure is based on the breakdown of types of reports and the rate of substantiation in the federal government's annual *Child Maltreatment* reports. For full details on how this figure was estimated, see NCCPR's Issue Paper, *Understanding Child Abuse Numbers* available online at http://www.nccpr.org/reports/OTHER2.pdf
[10] This figure is calculated by taking ECM's figure for child abuse fatalities in 2007, tripling it, and then dividing it by a Census Bureau estimate of the total population of Americans under age 18.
[11] This figure is calculated by taking the total estimated number of children for whom allegations of maltreatment were "substantiated" and dividing that figure by the total population of Americans under age 18.

Testimony of George Lithco
Advocacy Coordinator, SKIPPER Initiative
submitted to
the Subcommittee on Human Resources of the
House Ways and Means Committee
United States House of Representatives
Hearing on Child Deaths Due to Maltreatment
July 12, 2011

July 26, 2011

My name is George Lithco.

I am an attorney in private practice, and my wife Peggy is a elementary school arts teacher. We reside at 1011 Dutchess Turnpike, Poughkeepsie, New York.

I offer this written testimony for the record of the Subcommittee's hearing on Child Deaths from Maltreatment.

I have had opportunity to read the GAO Report on Child Maltreatment, review the testimony of the witnesses before the Committee, and view the video record of the hearing.

While the charge of the GAO report is limited, it is apparent from the record of the hearing that the members of the Subcommittee and the witnesses who testified share a deep and abiding concern about preventing child fatalities, not merely compiling an accurate record of those deaths.

We commend Chairman Davis, Ranking Member Doggett and the members of the Subcommittee for their interest knowing what can be done to prevent deaths from child maltreatment.

While I and the other members of the SKIPPER Initiative have no formal training in child welfare or child protection, we have learned much about prevention.

Dr. Jenny noted at the beginning of her testimony that she was probably the only person in the room who had watched a child die.

I share that experience. Only once, but it was a very personal experience.

It was watching our son die.

Our education began on November 30, 2000, when our eleven month old son, "Skipper," was shaken by an "informal" child care provider. She did not fit the "high risk" abuse: she was a 51 year old grandmother with four children of her own.

That day, she was also caring for her grandson and one other toddler: both, it turned out, were coming down with a cold and were cranky. Skipper was teething. When he spit up on her during an afternoon feeding, she confessed that she lost control and shook him.

Skipper died three days later. Our tragedy, but only one of many that became the child death statistic for 2000.

Shortly after our son died, we began working with family, friends and concerned parents as The SKIPPER (*Shaking Kills: Instead Parents Please Educate and Remember*) Initiative.

The SKIPPER Initiative works with parenting educators, hospitals, child care programs and local, state and federal agencies to increase awareness of the vulnerability of young children - children as old as 5 years of age - to inflicted head injuries, to educate everyone who cares for young children about the danger of shaking children.

Most of all, we educate parents and caregivers about what they can do to help protect children and keep them safe from injury, starting with talking to all of a child's caregivers about the need to be prepared for the inevitable frustrations that are part of caring for children.

Shortly after our son was shaken, we learned about a prevention program that was started by Dr. Mark Dias at Children's Hospital of Buffalo in 1998. He is a pediatric neurosurgeon treats children with inflicted head injuries. Dr. Dias speaks frankly about the event that inspired him to develop a simple education program for new parents: one night, he was up late with his infant son, became frustrated with his son's crying, and suddenly realized why parents shaken their child.

The program has been remarkably successful: since it began, the cases of inflicted head injury in the Buffalo area dropped by 50%. It has sustained that reduction for 13 years.

Now, hospitals in New York and many other states offer new parents the opportunity to learn what they can do to help keep their child safe. Child care providers are required to be trained about shaken baby syndrome and abusive head injury. In our county, foster care parents and high schools students have that opportunity.

We have advocated for prevention legislation in other states: as an example, I submit our testimony to the State Legislature in Hawaii for the committee's files. I also offer a summary of state legislation related to shaken baby syndrome/abusive head trauma.

As a result of our experience and education, I offer the following comments on the issue before the Subcommittee - Child Deaths from Maltreatment:

1. Even though the deaths of children under age 5 represent the most substantial proportion of child deaths, they are significantly underreported for a variety of reasons.

The community of parents and advocates know that children are remarkably resilient, and even when their brains are devastated by inflicted trauma, they can survive for years. Deaths from maltreatment can occur years later, and while the official cause of death may be the immediate one, the unrecognized cause is the consequence of maltreatment.

2. While I do not believe it discussed in the report or witness testimony, I have been told on more than one occasion that a decision not to classify injuries to a child as abuse were deliberate decisions motivated by the desire of an individual to avoid the criminal justice system.

In one instance, a doctor bluntly explained to a parent that since the evidence in her child's death was equivocal, and he had been a prosecution witness in a similar case that had, in his view, not only wasted a great deal of time, but subjected him to cross-examination that he found

humiliating, he would not draw any conclusion about whether injuries were inflicted. There is other anecdotal evidence which suggests that happens in an undetermined number of cases.

3. While children can be isolated at any time, vulnerable children and vulnerable parents are especially isolated between birth and school enrollment. The literature shows a significant correlation between parents with psychological dysfunction and child abuse deaths during this time. When depression, mental illness or other factors are present that result in homelessness or isolation, the death of a child can easily go unnoticed and unreported.

Caylee Anthony is merely one example.

While we acutely understand the significance of a child's death, I respectfully submit that there are two even larger issues that should be before the Subcommittee.

1. The national significance of surviving an act of maltreatment with inflicted injuries.

We have learned that the risk of inflicted injury is substantial: nationwide, the best estimate - from a study reported in the Journal of the American Medical Association - is that one child is shaken for every 2400 children born. Perhaps 300 children die from those inflicted injuries, and twice as many survive with one or more significant neurological injuries.

There is great personal cost to the families of many survivors, as they direct their energies to the care and well being of their child.

The available national data suggests that 80,000 children annually suffer physical abuse. In view of the consequences of surviving inflicted injuries, and particularly the consequences for the most vulnerable children, those children should be counted, and counted accurately.

2. The cost of surviving maltreatment.

The burden of inflicted injury lies directly on federal, state and local taxpayers.

As the Subcommittee is undoubtedly aware, Medicaid pays for approximately 41% of US births; and in all likelihood, pays for a comparable share of medical and rehabilitation care for surviving children

Yesterday, I learned a child shaken in Ohio has now survived one year. The cost of his medical care for that year is nearly $1,000,000. In the words of his grandmother "thank God Medicare is paying his bills."

Gabbi Poole from Florida has survived 16 years with two-thirds of her brain damaged by inflicted injuries. The injuries were inflicted by her father: she was adopted by her grandmother. So far, the cost of her medical care and rehabilitation care is more than $7,000,000.

Other costs follow when there is death or injury to a child.

Some are obvious: in addition to medical costs and rehabilitation, the costs of investigation, prosecution and incarceration of a perpetrator - in New York, a full trial may cost $250,000 and a year in jail costs the state $44,000.

Some are not so obvious: the loss of income taxes when a parent foregoes work to remain at home with a child, the learning disabilities inflicted up the child that require school districts to fund special education and reasonable accommodations, long term SSI benefits, long term health consequences for parent and child that are associated with adverse events and the stress of long term care. In many cases, all of the surviving children may be placed in foster care.

Yet, compelling evidence suggests those costs may only be the tip of the iceberg.

As we are learning with veterans who survive IED blasts, the greatest toll of maltreatment may be the unknown number of maltreated children who suffer subtle but long-term neurological trauma from inflicted head injuries.

The literature suggests that two to five percent of children under 2 years of age may suffer from physical abuse, and that a significant proportion of those children will suffer "mild" brain trauma. A 2009 report by the another House subcommittee found that 53% of abused children suffer from learning disabilities. In contrast, only 16% of children who aren't abused have disabilities. The consequence of such trauma is similar to those experienced by veterans..

In essence, one largely unrecognized cost of inflicted head injury is inflicted learning disabilities and other cognitive disabilities. Through our school districts, we pay the cost of those injuries for twelve years.

A reasonable estimate of the overall toll of inflicted head injuries in the United States: $2.5 billion a year.

At a time when all levels of government are under stress, the Subcommittee, and indeed the Ways and Means Committee as a whole, should understand the fiscal consequences of maltreatment, both the loss of revenue and the burden of the unavoidable expenses that result so that federal policy is informed and that opportunities to reduce that cost are identified.

For example, I note that the federal budget provides approximately $5 billion dollars for foster care programs in the states, yet only $297 million for "prevention", including the construction of child abuse prevention centers.

I believe the cost and benefit of educating parents and caregivers, versus treating the consequences of maltreatment, is clear and compelling.

The evaluation literature clearly exists to show that prevention programs do more than prevent death and injury: they don't just pay for themselves, but provide a sound return on the public investment that makes them possible.

We need a strategy that does more than just spend money on consequences. We need sustainable programs that can survive times of recession, when the need is greatest. We need program that readily translate to new communities and different cultures.

In a time when one-third of parents in the United States say they don't have sufficient knowledge about raising children, when 10 million children under the age of 5 are in some form of child care for part of a week, we need education that enlists the natural desire of parents and caregivers to protect children.

The GAO Report on improving data on deaths from child maltreatment is a necessary first step, but not sufficient by itself to understand the true scope, consequences and costs of maltreatment, or to direct national policy.

I believe that the Subcommittee - and, indeed, the Congress as a whole - would benefit if the GAO is directed to do two things:

1. assemble the evidence with respect to the toll on children who survive maltreatment, their families and their communities, the number of such survivors, and the cost of those injuries, informed by reasonable estimates of prevalence; and

2. identify existing best practices, the cost of implementing those practices, and the benefit of those practices if efficiently and effectively adopted, and provide a cost benefit analysis to the Congress, and to the states, that will serve to direct federal and state investment in an effective, efficient and profitable manner.

I appreciate the opportunity to provide our testimony on the subject of this hearing.

I would be pleased to provide additional information to the Subcommittee staff, amplifying our comments above and providing source materials.

Respectfully submitted,

George Lithco

Statement of Submission

Testimony of George Lithco is submitted on behalf of the SKIPPER Initiative and "Skipper" Lithco.

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State Legislation

State	Adopted	Location	Status	Organizations	Statutory Reference
Washington	1993	Hospital(B)	Active	WPCCAN	Rev. Code Wash. (ARCW) § 43.121.140
California	1994	Hospital(B)	Regional	PCA California	Cal Health & Saf Code § 24520
		Childcare			
Tennessee	1996	Hospital(B)			Tenn. Code Ann. § 68-143-103
		Childcare			
		Awareness Campaign			Tenn. Code Ann. § 68-143-102
Indiana	1999	Hospital(B)			Burns Ind. Code Ann. § 16-41-40-5
		Childcare			
Florida	2002	Hospital(B)	Regional		Fla. Stat. § 411.233
	2004	Childcare			Fla. Stat. § 402.305
Pennsylvania	2002	Hospital	Active		11 PS 2123 et seq.
Missouri	2004	Hospital(V)	Active	Missouri CTF	§ 191.748 R.S.Mo
New York	2001	Hospital			
	2003	Childcare	Active	NYS OCFS	
	2004	Hospital(V)	Regional		NY CLS Pub Health § 2803-j
	2006	School			NY CLS Educ § 804-b
	2006	Awareness Campaign			NY CLS Pub Health § 2745
Minnesota	2005	Hospital(V)	Active		Minn. Stat. § 144.574
		Childcare			Minn. Stat. § 245A.1445
Illinois	1991	Hospital(B)			(Ch. 127 p 55.62) 20 ILCS 2310/2310-305
	2005	Hospitals(V)			20 ILCS 2310/2310-305
		Childcare			
Texas	1999	Childcare		PCA Tx – SBA	Tex. Hum. Res. Code § 42.0421
	2005	Hospital			Tex. Health & Safety Code § 161.501
Virginia	2005	Hospital(B)			Va. Code Ann. § 32.1-134.01
Wisconsin	2006	Hospital(V)	Active		Wis. Stat. § 253.15
		Childcare			Wis. Stat. § 253.15
		School			Wis. Stat. § 121.02
Nebraska	2006	Hospital(V)			R.R.S. Neb. § 71-2103
		Childcare			R.R.S. Neb. § 43-2606
		Awareness Campaign			R.R.S. Neb. § 71-2104
Rhode Island	2006	Hospital			R.I. Gen. Laws § 40-11-17
Massachusetts	2006	Hospital			

Pending Legislation

Hawaii	2007	Hospital/child care(B)	To Governor [enacted]
South Carolina	2007	Hospital/child care(V)	To Governor [enacted]
Iowa	2007	Hospital/child care(V)	Senate Committee review
Alabama	2007	Hospital(B)	Senate Committee suspend
Oregon	2007	Hospital/campaign	Passed Assembly
Ohio	2007	Hospital/campaign	Passed Senate [Enacted]
California	2007	Demonstration project	Senate/House Committees review

Voluntary Regional Hospital-Based Education Programs

State	Start	Brochure Video	Status	Sponsor Organization	Contact
Arizona	2004	Hospital(V)	Active	PCA Az	
Oregon	2006	Hospital(V)	Active	Legacy	
Massachusetts	2004	Hospital(V)	Active	Central Mass - MCC	
Ohio	2003	Hospital(V)		PCA Ohio	
Maine	2002	Hospital	Active	Don't Shake Jake	
Minnesota		Hospital		Twin Cities Metro	
Connecticut	2005	Hospital		CT CTF	
Iowa		Hospital		Univ of Iowa	
New Jersey	2004	Hospital		Steve Kairys	
New York	1998	Hospital(V)	Active	Upstate NY SBS	
New York	2004	Hospital(V)	Active	HV SBS Prev	
Utah		Hospital(V)	Active		
California	2005	Hospital		(Sacramento)	
	2005	Hospital		(Linda Loma)	
Ontario CA	2006	Hospital(V)	Active	Richard Volpe	
Quebec CA	2004	Hospital	Active	St. Justine	

Voluntary Individual Hospital-Based Education Programs

State	Start	Brochure Video	Status	Sponsor Organization	Contact
Iowa, Council Bluffs				Jenny Edmundson Hospital	

Voluntary Regional Awareness Programs

Alberta CA	2005	Active	
Colorado	2006	Active	Kempe Children's

Testimony submitted to
the Legislature of Hawaii
in support ofSenate Bill 1750

February 18, 2007

My name is George Lithco. I am an attorney in private practice, and my wife Peggy is a elementary school arts teacher. We reside at 1011 Dutchess Turnpike, Poughkeepsie, New York.

On November 30, 2000, our eleven month old son, "Skipper," was shaken by an "informal" child care provider. She was a 51 year old grandmother with four children of her own, who was also caring for her grandson and one other toddler that day. Skipper died three days later.

We offer this written testimony in support of Senate Bill 1750, introduced by Senator Hanabusa. It will help parents and caregivers protect the children of Hawaii from death or serious injury as the result of being shaken.

That risk is substantial: nationwide, the best estimate is that one child is shaken for every 2400 children born. The good news is that the risk can be cut in half by a simple program that educates parents before they leave the hospital.

We applaud Senator Hanabusa for his initiative in sponsoring this bill. The number of states that have adopted legislation to ensure that all new parents have the opportunity to learn how to protect their child from shaking injuries is still relatively few: Pennsylvania, New York, Missouri, Illinois, Nebraska, Wisconsin, Rhode Island and Massachusetts - although South Carolina, Iowa and New Jersey are also considering legislation this year.

Our support for this bill comes from our personal tragedy, but our tragedy is not unique. We live in Dutchess County, New York, a quiet, relatively affluent suburban county of 225,000 people. It is home to Vassar College, Marist College, the Culinary Institute of America, Franklin D. Roosevelt's home and three large IBM manufacturing facilities.

Even so, there were 7 shaking cases here between June of 2000 and March of 2003. Three of those children died and two suffer significant brain injuries.

Research reported in the Journal of the American Medical Association in August, 2004 estimates that there are 1400 to 1600 cases each year where a caregiver inflicts head injuries on a child so severe that medical attention is required. Like Skipper, one-quarter of those children die. Half of the surviving children suffer serious disabilities.

Since our son died, we have been working with family, friends and concerned parents as The SKIPPER (*Shaking Kills: Instead Parents Please Educate and Remember*) Initiative to educate everyone who cares for young children about the danger of shaking children as old as 5 years of age, and the need for caregivers to be prepared for the inevitable frustrations that are part of caring for children.

Educating new parents about the danger of shaking, the need to cope with the inevitable moments of frustration, and ways that they can help protect their child from injury is the single most important way to protect babies - and children as old as 5 years of age - from shaking injuries.

We have learned that it is not sufficient just to give parents written information. They have to hear it and realize it will help them protect their children. And they have to learn how to talk to every caregiver who takes care of their child and make a commitment to do that.

It is not easy. If you have a young child yourself, or if you are a grandparent or know a relative, friend or employee who has a child under age 5, have you talked about the danger of shaking, or even the SIDS "Back to Sleep" campaign, with other caregivers of that child? The babysitter? The child care provider? By the time they are three, 77% of children have at least one other caregiver besides their parents.

We have learned that nearly all parents and caregivers have "heard" of Shaken Baby Syndrome, yet many do not realize how dangerous shaking can be to babies. Many more do not realize that shaking can inflict injury on infants and toddlers. The American Academy of Pediatrics warns of the danger to children as old as five years of age. And most parents do not realize that in most states, even licensed child care providers are not trained about the danger of shaking young children.

Parents assume that day care professionals, foster parents, grand-parents, siblings, babysitters and other trusted caregivers know about the danger of shaking. But some recent surveys indicate that 25-50% of the general public are not aware of the danger of shaking young children.

That was born out by our experience when we began offering child care organizations training about Shaken Baby Syndrome. Nearly 50% of the licensed day care provider we surveyed in our training classes tell us that they didn't know that children up to age 5 are vulnerable to shaking injuries.

In New York, the Legislature has required that training about SBS be included as part of the licensing procedure for new providers. We had the opportunity to work with New York's Office of Children and Family Services on a statewide teleconference dealing with Shaken Baby Syndrome in child care settings. That program, called "Skipper's Story", was seen by more than 6,000 licensed providers and is now part of the licensing curriculum for new child care providers.

But we still tell parents that they cannot assume that any caregiver knows about that danger. We know the danger of assumptions.

Moments of frustration and anger are an inevitable part of raising children. New parents increasingly confront increased economic pressures and have unrealistic parenting expectations, at the same time as they are losing the support of extended families and other social support networks. As the need for two incomes increases, more parents are forced to rely on some form of child care.

There are no good long term statistics on the incidence of shaking injuries. However, from the surveys that have been done and anecdotal evidence, it seems clear that the increased pressures on inexperienced caregivers are causing more shaking incidents and inflicted injuries.

The toll on our children is enormous. Not just for those who die - according to a study published in the Journal of the American Medical Association, about 300 a year - but for those children who live with serious brain injuries and those who suffer learning disabilities.

For every fatality, two children live with permanent disabilities.

The good news is that education of new parents makes a dramatic difference in the incidence of Shaken Baby Syndrome. In 1998, with the support of the Hoyt Children and Families Trust Fund, Dr. Mark Dias developed a simple program at Children's Hospital of Buffalo to educate new parents.

It uses a short video called "Portrait of Promise", which tells the story of three children and their families who have been affected by Shaken Baby Syndrome, seven minutes of a nurse's time, and a "commitment statement" signed by the parents after watching the video, to educate new parents and ask them to make a commitment to never shake their child.

The April, 2005 edition of *Pediatrics*, the journal of the American Academy of Pediatrics, reported on the extraordinary success of this program. Since it was introduced in the Buffalo area, the rate of shaking incidents decreased by nearly 50%, and few of the cases that have occurred since the program began involved parents who had seen the video and signed the commitment statement.

Under the auspices of the Upstate New York SBS Prevention Project, the Dias program has been expanded to serve nearly 40 hospitals in western and upstate New York that have approximately 39,000 births a year. A second regional program was set up in the Hudson Valley of New York that supports 21 hospitals that have approximately 26,000 births a year. The regional trauma center that used to get one shaken baby case every quarter has only received two in 20 months.

We also know of regional or statewide programs based on the Dias model in Pennsylvania, Massachusetts, Michigan, Utah, Arizona, Oregon and Ohio. In 2004, New York and Missouri adopted legislation that requires hospitals not just to offer new parents information on the causes and consequences of Shaken Baby Syndrome, but the opportunity to watch this video.

We hope we can use this opportunity to share some lessons we have learned from helping to implement that program at Vassar Brothers Medical Center in Dutchess County, New York.

Shortly after Skipper died, we found out about the Dias program. With the support of Vassar Brothers Medical Center and the Junior League of Poughkeepsie, the program started at Vassar in August of 2001. Over the next year, it was extended to the five other hospitals that serve Dutchess County.

Vassar serves the City of Poughkeepsie and surrounding areas of Dutchess County. It has 28 birthing suites, and averages about 2,500 births a year. In August of 2001, it became the first hospital in New York south of Albany to offer Shaken Baby prevention education to new parents.

The issue of SBS was added to the discharge protocol. A nurse discusses SBS awareness, advised new parents that three awareness brochures were included in their maternity information handbook, and invited them to watch the Portrait of Promise video. After the video, they sign a short evaluation form that asks if they have learned about the danger of shaking young children.

The nurse's message is simple: "as you probably realize, there have been several cases of shaken baby syndrome in Dutchess County. We know you're concerned about it, and want to help you learn how to protect your baby by watching this short video."

To date, the parents of nearly 11,000 babies have chosen to participate in the Shaken Baby prevention program. With the assistance of the Junior League of Poughkeepsie, we conducted a follow up survey of a representative sample of those parents.

The results are compelling:

1. **Parents remember the information**. 100% of the parents surveyed say that they remembered the SBS video; 93% said it was the most memorable part of the SBS education program;

2. **Parents recommended the video.** 100% of the parents recommend that all new parents watch the video;

3. **Parents use the information.** 86% of the parents report that they are talking with other caregivers about the danger of shaking injuries. This is especially important because the *Zero to Three Foundation* reports that **48%** of babies between birth and 6 months of age are regularly cared for by someone other than their parents;

4. **Most parents only get information in the hospital.** Even though there were seven (7) shaking incidents in Dutchess County since 2000, only 21% of parents reported that they received any information about SBS from their pediatrician or other community sources after discharge;

5. **Brochures are not sufficient.** Although Vassar gives all new parents three (3) different SBS awareness brochures in their instruction book for new parents, 10% of the parents we surveyed say they don't remember getting a brochure (those members of the Legislature who have raised children will understand).

We are using these lessons and our experience working with Dr. Dias, the Hoyt Trust Fund for Children and Families, the New York State Office of Children and Family Services and the New York State Department of Health to promote the extension of the program here in New York.

There is a compelling need for education. The best information available, which includes baseline data developed by Dr. Dias, indicates approximately 1 child in 2400, on average, will be shaken seriously enough to require medical attention.

According to the National Center for Health Statistics, Hawaii had 18,114 births in 2003: that means approximately eight children will be shaken, on average, every year seriously enough to require medical care. And that doesn't include those who will suffer "mild" brain traumas that are not detected.

If that number is reduced by half, four children would not be shaken. One would not die and two would not suffer permanent disabilities. It is not uncommon for the medical and rehabilitation costs of one surviving child to exceed $100,000 a year. Add those costs every year, and the costs of the "tail" of SBS become a significant burden on the state.

In Hawaii, Medicaid pays for 33% of the births, and therefore is likely to pay for one-third of the medical costs. When all of the costs incurred by health insurors and the unreimbursed costs for hospital treatment to the other costs of SBS - investigation, prosecution and incarceration of the perpetrators; shattered families; lost earnings; special education and SSI payments to survivors - the benefit of effective prevention is obvious.

That is why we believe SB 1750 should be amended to include an opportunity for parents to watch an educational video. The hospital education program is a vitally important element in preventing shaking injuries to children for a number of reasons.

1. It is an effective and efficient opportunity to educate nearly all new parents. Prenatal and postnatal education misses a substantial number of families. Even when families do enroll, it is not less common for the father to attend classes, yet fathers and boyfriends are responsible for the majority of shaking injuries.

2. The video is ***significantly*** more memorable than brochures or other traditional means of "pushing" information to parents. Not only does it contain a constant message, but it features parents of shaken children talking to new parents about how they can prevent their child from being inured.

As our survey shows, when the message is delivered by video it is much less abstract and much more compelling. It is not a happy video to watch, but parents commonly tell us they appreciate the knowledge and they think it is important that all new parents see it.

Although SBS information has been available in New York for nearly 10 years, few parents just ask for it or recognize how important awareness is to their child's safety. Relying on parents and caregivers to "pull" brochures or other available information has been, and will be, ineffective to protect babies and infants from the risk of shaking injuries.

3. We believe the message is more effective when delivered by a health professional or hospital volunteer in the hospital setting. We have found that even pediatricians and other health professionals find it difficult to initiate a discussion about the danger of shaking because it typically has had a connotation of "child abuse."

In Dutchess County, where there have been six SBS cases in the last three years, fewer than one-quarter of the parents (21%) who we surveyed said their pediatric office had provided information about the causes or consequences of shaking a young child.

Moreover, relying on an expectant mother or a new mother to deliver this important message to the spouse and other caregivers in many cases is not only unrealistic, but unfair to the mother and to the other caregiver. Most importantly, it is unfair to the child.

Both parents should get this education for a neutral third-party who has been trained to present the information in a positive, non-accusatory manner that emphasizes helping the parents prevent injury to their child.

4. The hospital is also the point when new parents are most receptive to information about prevention. Birth makes the experience real and immediate, yet the parents are not yet exhausted and isolated by caring for a new born child.

Once they have heard their baby cry, new parents can truly understand why they will need to develop coping techniques to deal with the frustration and anger that comes when a baby cries inconsolably. Only through experience do they come to learn that frustration and anger is a normal part of caring for infants.

5. Crying is far more common that parents anticipate. A recent research study reported in the *Archives of Pediatrics and Adolescent Medicine* indicates that nearly 20% of all babies will cry inconsolably during the first four months of birth. Dr. Ronald Barr, a researcher at McGill University, reports that crying precipitates 95% of shaking injuries to babies.

Inconsolable crying is frequently cited as the cause of shaking. A 2004 study in *Lancet* reported that 5.6% of new Dutch mothers admitted they had smothered, slapped or shaken their child by six months of age. A 2005 study published in *Pediatrics* reported that 2.6% of mothers in North Carolina admitted they or someone in their household has shaken a child under 2 years of age.

When we talk with parents, new and old, about how crying is frequently cited as the precipitating factor in shaking an infant, stories of their own frustration and uncertainty about dealing with crying area nearly universal. Many new parents have told us that their strong feelings of frustration led to feelings of inadequacy and failure as a parent that they were ashamed to discuss even with their spouse.

Mark Dias is a pediatric neurosurgeon. He tells the story of the moment he was inspired to start the program: he was up early in the morning caring for his infant son and realized that the only difference between his reaction and that of someone who shakes a child is that he knew the consequences.

Our second son was born on March 20, 2002. I have similar memories. Every new parent does. In that moment, they need to know and remember how dangerous shaking can be.

6. The hospital education covers a topic that has not been comfortable for parents or professionals to talk about. One issue that we discovered early on is that many parents are upset or offended by the message that "*you* should never, ever shake *your* baby."

Instead, we tell parents that this is information that "you need in order to protect your baby by educating others who care for your child." Nurses and other educators tell us that this makes the education experience much more positive.

The Vassar program is successful because it teaches parents two things: the danger of shaking infants and that they can help protect their child from that danger by educating - in a positive, non-accusatory manner - every caregiver who looks after their child so that they are prepared to cope with frustration.

Educating parents in the hospital to advocate for the safety of their children is the most efficient way we have available, in the short term, to get this important message to those who care for infants.

7. Developing a means to evaluate the effectiveness of individual hospital programs is also critical for two reasons. First, it allows the educators to ensure that they continue to effectively communicate with parents and that parents have been able to use that information to talk to other caregivers. Second, parents will tell you the true value of the program, which is wonderful motivation for the educators and those administering the program.

Other Forums

Initiating a hospital education program offers the opportunity to bring SBS prevention education into two other critical venues: day care settings and school parenting programs.

Once parents become aware of the danger, they recognize the importance of educating all of the caregivers who look after their children. Hospital programs show the community that awareness is important.

The SKIPPER Initiative has made presentations to day care providers, high school students, foster parents and social services about preventing Shaken Baby Syndrome. It is more and more common for us to find that someone has already heard about Shaken Baby Syndrome because of the education program at Vassar. We also hear that message from pediatricians.

That message needs to be available and reinforced in school and child care settings. In that regard, the Shaken/Impacted Baby Syndrome Action would require training for child care providers and education in schools, including an opportunity for students to watch an effective SBS prevention video.

Not only is it important to educate future parents - in local high schools, over 50% of students are babysitting now for siblings, relatives and for hire. They need this education, and the children in their care need for them to have it.

Consider that the *Wall Street Journal* reported last year that nearly 6 million children under the age of 5 are in day care for all or part of a day.

Unfortunately, I have read a number of news reports in the past year about children who have shaken infants in their care: the youngest is a 9 year old boy in Cleveland who allegedly shook one of two 21 month old twins he was watching.

Again, there is good new. We have presented prevention information to students and teachers in nearly 25 middle school and high school classes, and worked with educators who teach parenting at other schools: students are receptive, and they appreciate the opportunity for this education.

We have also worked with our local day care councils to offer education about the causes and consequences of Shaken Baby Syndrome. Providers appreciate the education, but still find it difficult to talk with parents about this issue.

In response to requests by nearly every provider for posters that can serve as "icebreakers", we have prepared a series of awareness posters for day care centers. I have forwarded a few examples. We are working with the child care licensing agency to make them available statewide to schools and hospitals, as well as child care providers, in order to create a continuum of awareness.

Costs

Dr. Dias estimated that an expansion of the Upstate New York SBS Prevention Project statewide would cost $10 per birth (which would include five nurse coordinators for program support, and an extension of his associated data collection and research on the effectiveness of the program).

Our experience is simpler. The initial costs of implementing the program at a local hospital would be $750 for videos, dedicated TV/DVD players and written materials.

We were aware that some hospital administrators express concern about the burden on overworked nursing staffs. The nursing staff at Vassar and the other local hospitals has been remarkably supportive of the program. Nearly 75 % of the parents at Vassar watch the video before they leave.

It may take seven minutes of a nurse's time to introduce the video, answer questions and have the parents complete an evaluation form/commitment statement. Vassar and other hospitals have incorporated that procedure into their discharge routine and the hospital administrator has told us it not a significant burden.

We know that nurses and other healthcare professionals want to help parents learn how to keep their children safe. If you ask the nurses at maternity hospitals in Hawaii to help prevent shaken babies they will do this.

This program not only prevents injury to children, but makes economic sense.

There are models for sharing the cost savings of prevention. In Utah, Dr. David Corwin convinced private insurors and the State Medicaid program to share the cost of educating parents by making a payment for SBS education for each birth, using the analogy that education essentially is a "vaccination" against shaking injuries that saves the Medicaid program money that will otherwise be spent on treating shaking injuries.

For instance, the Utah Medicaid program pays $6 per birth. In Hawaii, the American Academy of Pediatrics reported that Medicaid covered about 33% of births in 2000, or about 5,997 children. Using the 1 shaking case per 2,400 births incidence rate, it would be reasonable to anticipate that 2 or 3 children a year would require medical treatment.

Spending $6 to educate the parents of every baby that Medicaid pays for would cost about $36,000 a year. But if only one of those shaking cases were prevented, the Medicaid program would not have to spend an average of $75,000 in medical and other costs each year. The benefit is obvious.

Of course, the State has should also have to add into that equation the costs of rehabilitation for survivors, special education for children who develop learning disabilities, and the costs of investigating, prosecuting and incarcerating the perpetrators. These are all costs that the taxpayers are paying today.

Absent education, significant liabilities can result. Merced County in California was recently held liable for $8.3 million for negligently placing a child with a foster parent who shook her so hard she went blind. And the Cochran Law Firm filed suit against New York City seeking $500 million in damages for a child who was allegedly shaken in foster care.

Shaken baby prevention not only saves the lives of young children, and prevents tragedies that affects the lives of their families, but it is cost effective.

Conclusion

We support SB 1750, but urge you to add a requirement that hospitals offer parents an effective opportunity to learn how to protect their children by offering a video education program based on the Dias model.

If the members of the Legislature have any doubt about the need for education in hospitals, schools and child care centers, I urge them to ask family, friends and acquaintances with young children whether they have experienced moments of frustration and anger when caring for their child.

Then ask them whether they know about the danger of shaking injuries.

New parents are bound up in a world of unexpected complexity. It will be difficult for them, but it is the single point when they can best inform you about the reality of becoming a parent, about the need for parenting education and how they feel about learning how to protect their child from shaking injuries.

Take testimony from those high school and middle school students who babysit. Or those who have children of their own. As them if they know that danger of shaking infants and young children.

Listen to those voices. They will tell you that this is a necessary thing.

And also listen to the voices you will not hear.

In New York, the silent voices of children include our son, Dale Anderson, Jr., Brittney Sheets, and Cynthia Gibbs. They died between November 2000 and June 2001. They were all shaken by a child care provider. Listen to the ventilator that breathes for the foster care child who was shaken in Wappinger Falls in 2003 and now lives in a nursing home on Staten Island.

If we all had learned about the danger of shaking young children and how to protect them by talking to all caregivers about the danger, those voices might not be still today. If you visited President Roosevelt's home at Hyde Park this summer or brought your child to Vassar College this fall, you might hear their laughter as they ran and played in the fields.

And the State of New York would not be paying to incarcerate the four women who shook them.

We can't change the past. But you and the other members of the Legislature have the opportunity to change the future for some of the children who will otherwise be shaken this year.

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Testimony for the Record

July 12, 2011

Hearing on Child Deaths Due to Maltreatment

Subcommittee on Human Resources
Committee on Ways and Means
U.S. House of Representatives

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Chairman Davis, Ranking Member Doggett and Members of the Subcommittee, thank you for the opportunity to provide testimony in response to your hearing on child deaths due to child maltreatment. CLASP is a non-profit organization that develops and advocates for policies at the federal, state, and local levels to improve the lives of low-income people. We focus on policies that strengthen families and create pathways to education and work. Part of this work focuses on the prevention and treatment of child maltreatment.

The death of even one child is an incredible tragedy. When that death is the result of maltreatment that could have been prevented, it is unacceptable and represents a failure on the part of the community, state and our country as a whole. Knowing more about a problem, accurately quantifying it and learning about how to best identify it can help inform and enhance the best solutions. But we know enough about preventing and treating child maltreatment to act now while simultaneously working to continually improve data and information.

We know that, in addition to fatal maltreatment, non-fatal and near-fatal maltreatment also have significant and lasting negative impacts. Beyond the immediate physical and psychological trauma of maltreatment, children suffer a host of problems long into adulthood. They are at greater risk of alcohol and drug abuse, depression, suicide attempts, unintended pregnancy, intimate partner violence, sexually transmitted diseases, fetal deaths, smoking, ischemic heart disease, liver disease and chronic obstructive pulmonary disease.[1] Children who have been in foster care, including those who "age out" of foster care upon turning 18, typically attain fewer years of education and have less steady employment. Not surprisingly then, they are more likely to experience homelessness and poverty and to be involved with the criminal justice system. [2]

We know that, in spite of what is commonly portrayed in the media, the vast majority of child maltreatment is neglect. Over three-quarters (78.3 percent) of all child maltreatment is neglect. Similarly, two-thirds of all child maltreatment *fatalities* involve neglect. Neglect alone is responsible for more (35.8 percent) maltreatment deaths than is physical abuse (23.2 percent) though the majority (36.7 percent) of child maltreatment fatalities child are due to multiple maltreatment types.[3]

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[1] Centers for Disease Control and Prevention, *Adverse Childhood Experiences, Major Findings*, available at: http://www.cdc.gov/nccdphp/ace/findings.htm

[2] P. Pecora, R. Kessler, J. Williams, K. O'Brien, A. Downs, et al. *Improving Family Foster Care, Findings from the Northwest Foster Care Alumni Study*, (Casey Family Programs, 2005) http://www.casey.org/NR/rdonlyres/4E1E7C77-7624-4260-A253-892C5A6CB9E1/923/CaseyAlumniStudyupdated082006.pdf; M. Courtney, et al. *Midwest Evaluation of the Adult Functioning of Former Foster Youth: Outcomes at Age 21,* (Chapin Hall Center for Children at the University of Chicago: 2007) http://www.chapinhall.org/article_abstract.aspx?ar=1355&L2=61&L3=130; English, D., Widom, C. & Brandford, C. *Childhood Victimization and Delinquency, Adult Criminality, and Violent Criminal Behavior: A Replication and Extension, Final Report Submitted to NIJ.* (2002)*;* and, U.S Department of Health and Human Services, *Coming of Age: Employment Outcomes for Youth Who Age Out of Foster Care Through Their Middle Twenties*. (Washington, DC: 2008) http://www.urban.org/UploadedPDF/1001174_employment_outcomes.pdf.

[3] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. *Child Maltreatment 2009.* (Washington, DC: 2010).

Though neglect can have just as, if not more, dire of consequences for children than does physical abuse, the appropriate response to neglect, particularly that which may be a symptom of poverty, is likely a much different one than that needed for sadistic physical or sexual abuse.

We know that poverty is the single best predictor of child abuse and neglect. This is not to say that most poor parents abuse or neglect their children—indeed the vast majority does not. In 2009, there were over 14 million poor children[4] and about three quarters of a million children were found to be abused or neglected after an investigation by authorities.[5] The true incidence of maltreatment may be as high as three million children annually[6]—but even that number shows that most poor parents are not abusing or neglecting their children. Nonetheless, poverty and socioeconomic status are consistently the best predictors of child abuse and neglect.[7] In addition, those who experience abuse and neglect as children are much more likely to experience a host of lifelong challenges, including poverty, in their adulthoods.

Undoubtedly, poverty contributes to maltreatment and maltreatment to poverty in a myriad of complex ways. But it is useful to think of three basic pathways:

1) For some, poverty and the lack of resources associated with it prevent parents from adequately caring for their children. Think of the single mother who can find work only during the night shift but cannot afford child care during that time. She must decide whether to leave her children alone so she can work to put clothes on their backs, a roof overhead, and food on the table. She may tuck the children in bed, kiss them goodnight, hope that they do not awaken, and pray that nothing happens before she returns.

2) For others, the stress of poverty may serve as the straw that breaks the camel's back. Think of the father who has recently lost his job who is feeling inadequate because he can't provide for his family and is unable to find a new job. Feeling powerless and facing immense stress, he no longer has the patience to cope with a crying newborn or a defiant toddler, and lashes out by shaking the child for the few seconds it takes to cause permanent brain damage or death.

3) For others, underlying conditions – substance abuse, domestic violence, or mental health issues – may interfere with a parent's ability both to hold down a job and to care for her children—thus leading to poverty and maltreatment. This is especially true when treatment is unaffordable or unavailable. Think of the mother who was abused as a child and is now in a relationship fraught with domestic violence. She is struggling with depression and using alcohol or drugs in an attempt to cope. All of these factors prevent her from reliably attending work, and therefore she cannot keep a job. She also neglects her children and sometimes lashes out at them emotionally and physically.

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[4] CLASP calculations of American Community Survey data, Table C17024, http://www.census.gov/acs/.
[5] *Child Maltreatment 2009*
[6] U.S. Department of Health and Human Services, *The Fourth National Incidence Study of Child Abuse and Neglect*, (Washington, DC: 2010).
[7] NIS-4 and personal communication with Andrea Sedlak, December 9, 2010

We highlight the connection between poverty and maltreatment not in an effort to excuse the maltreatment but rather to make clear that the causes of maltreatment are varying and sometimes complex and point to the need for a comprehensive range of responses.

Perhaps most importantly, **we know a great deal about how to prevent and treat child maltreatment.** Research provides guidance about what works to prevent child abuse and neglect, to stabilize families in crisis and keep children safely in their homes so they are not torn from everyone and everything that they know. There are a number of programs and initiatives at the state and local level to be built upon. Congress has already taken important strides in this direction by investing in voluntary, evidence-based, early-childhood home visitation in the Maternal, Infant and Early Childhood Home Visiting program created last year[8] and in Promise Neighborhoods initiative. Similarly, when Promoting Safe and Stable Families was reauthorized in 2006, Congress created a competitive grant program in Title IV-B of the Social Security Act for regional partnerships to provide comprehensive family-based substance abuse treatment.[9] Home visiting programs connect families to the supports and services they need to care for their children. They improve the health of children and their parents, as well as prepare children for school. These programs break down isolation and engage families in community life – enriching the community as it strengthens families and improves outcomes for children.[10] Promise Neighborhoods are modeled after the Harlem Children's Zone which provides comprehensive services in a community struggling with concentrated poverty and violence and offers much promise as a model for reaching families in an entire neighborhood.[11] Comprehensive, family-based residential treatment services have been found to very effective, particularly for mothers with children who are involved in or at risk of involvement with the child welfare system.[12]

These are exciting steps forward but represent fairly modest investments and none of these approaches offers a "silver bullet". In addition to continued support for home visiting, Promise Neighborhoods and family-based substance abuse treatment, there are other interventions that are effective at preventing and treating child maltreatment. For example, differential or alternative response[13] and "family teaming" approaches like Family Group Decision Making[14] hold great promise. Unfortunately, current federal child welfare financing fails to adequately support these

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[8] For more information on the program see: http://www.clasp.org/admin/site/publications/files/home-visiting-detailed-summary.pdf

[9] For additional information on the program, see: http://www.clasp.org/admin/site/publications/files/0337.pdf and http://www.clasp.org/resources_and_publications/publication?id=0346&list=publications.

[10] See, for example, http://homvee.acf.hhs.gov/.

[11] For more information on the Harlem Children's Zone see: http://www.hcz.org/. El Paso County, Colorado and Allegheny County Pennsylvania offer examples of other communities where collaboration has led to the provision of comprehensive services – in these cases led by the county human services agency. For more information see http://www.clasp.org/publications/El_Paso_report.pdf.1 and http://www.alleghenycounty.us/DHSAboutDHS.aspx?id=11630&LinkIdentifier=id

[12] For an overview of the type of programs that work and a review of the evidence see The Rebecca Project on Human Rights' overview at: http://www.rebeccaproject.org/index.php?option=com_content&task=view&id=71&Itemid=151

[13] See, for example, U.S. Department of Health and Human Services, *Differential Response to Reports of Child Abuse and Neglect*, 2008, http://www.childwelfare.gov/pubs/issue_briefs/differential_response/.

[14] See, for example the review of the research by the American Humane Association available at:, http://www.americanhumane.org/children/programs/family-group-decision-making/bibliographies/research-and-evaluation/

kinds of interventions. Instead, Title IV-E dollars, which constitute about half (49.11 percent in FFY 2006) of all federal spending on child welfare, are largely limited to providing room and board, and related casework services, for children who have already been removed from their homes. In comparison, Title IV-B which provides funding to a range of preventive and treatment services and supports accounts for just 5 percent of federal child welfare funding.[15] Federal child welfare financing does not support the goal we all share – preventing child maltreatment.

We know that the child welfare system lacks adequate resources. The capacity to serve even those whose maltreatment is detected is sorely lacking. Of those children who are reported and substantiated, nearly 40 percent get no services at all – not foster care, not counseling, not family supports.[16] The other 60 percent who get some service may not get the right services. Research indicates that half of children involved with the child welfare system have clinically significant behavioral or emotional problems, but only about a quarter are getting mental health services.[17] Similarly, research indicates that while roughly three-quarters of parents of children in foster care need substance abuse treatment less than a third gets it.[18] In addition to an inadequate service capacity, the workforce that provides those services is under-resourced. Currently, the typical child welfare worker – a person often making life and death decisions – has less than two years experience and often carries twice the recommended number of families on his or her caseload.[19]

Comprehensive child welfare financing reform is essential to preventing child maltreatment, including fatalities. At the hearing, there was a great deal of discussion about the need to collect better information about the true incidence of child fatalities. CLASP is not opposed to enhancing our knowledge about child fatalities. However, that alone should not be seen as a solution. If we want to reduce child fatalities and all child maltreatment, we need to work steadily towards comprehensive finance reform that can address the range of challenges children and their families face. From CLASP's perspective, comprehensive financing reform includes three components: (1) expanding Title IV-E to support the full continuum of services needed by children who have experienced or are at risk of experiencing child abuse and neglect, as well as their families; (2) increasing support to enhance the child welfare workforce which provides the critical link that ensures that children and families actually receive the right services and supports once a robust continuum of services is developed; and (3) increasing accountability – both fiscal accountability and accountability for the outcomes children and families experience – to ensure the new investments and flexibility provided by comprehensive financing reform are well used. We would be happy to work with you to provide more detail on each of these components and hope that you will take up the challenge of moving towards comprehensive

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[15] CLASP & the Children's Defense Fund, *Child Welfare in the United States*, 2010, http://www.clasp.org/admin/site/publications/files/child-welfare-financing-united-states-2010.pdf.

[16] *Child Maltreatment 2009*

[17] Barbara Blum, Susan Phillips et al. "Mental Health Needs of and Access to Mental Health Service Use among Children Open to Child Welfare," Journal of the American Academy of Child and Adolescent Psychiatry, Vol. 43, No. 8 (August 2004).

[18] U.S. Department of Health and Human Services, *National Survey of Child and Adolescent Well-Being: One Year in Foster Care Report*, (Washington DC: November 2003) available at: http://www.acf.hhs.gov/programs/opre/abuse_neglect/nscaw/reports/exesum_nscaw/exsum_nscaw.html

[19] U.S. General Accountability Office, *Child Welfare: HHS Could Play a Greater Role in Helping Child Welfare Agencies Recruit and Retain Staff, GAO-03-357* (Washington, D.C.: March 31, 2003).

child welfare financing reform to effectively promote child well-being and prevent child maltreatment, including fatalities. Thank you for your commitment to improving the lives of children and families.

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