COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES
SALT LAKE CITY, UTAH PUBLIC MEETING TRANSCRIPT
May 19-20, 2015

DAY ONE—MAY 19, 2015

Presenters:

- Brent Platt, Director, Utah Division of Child and Family Services (DCFS)
- Lana Stohl, Deputy Director, Utah Department of Human Services (DHS)
- Cheryl Dalley, Fatality Review Coordinator, Office of Services Review, DHS
- Kristine A. Campbell, M.D., M.Sc., Associate Professor, Department of Pediatrics, University of Utah
- Sean Reyes, Utah's 21st Attorney General
- LaRene Adams, R.N., B.S.N., Program Manager, Fostering Healthy Children Program, Utah Department of Health
- Chief Greg Butler, Woods Cross Police Department
- Robert Parrish, J.D., Deputy District Attorney, Special Victim Team, Salt Lake County
- Vicky Roper, M.S.Ed., Prevent Child Abuse Kansas Director at Kansas Children's Service League
- Vera Bothner, Managing Partner, Bothner and Bradley, Wichita, Kansas

CHAIRMAN SANDERS: Good morning.

COMMISSIONER DREYFUS: Good morning.

CHAIRMAN SANDERS: It's exciting to be here in Salt Lake City for the Commission to Eliminate Child Abuse and Neglect Fatalities, and we will commence our meeting. We have a full day.

We're here in large part because Utah has one of the lowest fatality rates in the country, and we are here to learn what is happening here that has resulted in that kind of environment for children.

Much of our morning today will be spent hearing about work in Utah and how the system responds to children who've been abused or neglected and are at risk for a later fatality. We also will have the opportunity to hear about Wichita, Kansas, which Commissioner Dreyfus actually first identified as a community that has done a remarkable job in addressing child abuse and neglect fatalities.

And then this afternoon we have the opportunity to deliberate as a commission. We'll have additional recommendations from the public policy sub -- the public health subcommittee as

well as update and recommendations from the research roundtable. And then tomorrow we'll spend the full day -- full half day of meeting in deliberations.

Before we get started with our first panel, I'm going to ask the commissioners to introduce themselves.

Commissioner Covington.

COMMISSIONER COVINGTON: Good morning. My name's Teri Covington. I'm the Director of the National Center for the Review and Prevention of Child Deaths. Thank you for having us here in Utah.

COMMISSIONER MARTIN: Good morning, ladies and gentlemen. My name is Patricia Martin, and I'm the Presiding Judge of the Child Protection Division in Cook County, Illinois. Thank you for being here.

COMMISSIONER STATUTO BEVAN: Hi, I'm Cassie Statuto Bevan. I -- oh.

CHAIRMAN SANDERS: The mic.

COMMISSIONER STATUTO BEVAN: Never mind. Clearly not the brightest bulb on the commission. Cassie Statuto Bevan, I -- I'm retired from everything so I meddle into everything, and this is one of the things I meddle in and I care a lot about.

COMMISSIONER PETIT: I'm Michael Petit - - I'm Michael Petit, the founder of the Every Child Matters Education Fund which is a national child advocacy group.

COMMISSIONER RODRIGUEZ: I'm Jennifer Rodriguez. I'm the Executive Director of the Youth Law Center. We're a national public interest organization working on behalf of children in the child welfare and juvenile justice system.

COMMISSIONER DREYFUS: Mine doesn't work. I'll use yours. What? It doesn't work.

Hi, I'm Susan Dreyfus. I'm the President and CEO of the Alliance for Strong Families and Communities and previously the secretary of the Washington State Department of Social and Health Services.

CHAIRMAN SANDERS: And we have three commissioners who are not going to be here. At least one will join us on the phone for much of the meeting, and Commissioner Ayoub, who is here, is not in here yet.

So our first panel includes a -- some of the leadership in child welfare in Utah: Brent Platt, Lana Stohl, and Cheryl Dalley, and I'm going to have them go ahead and come up to the podium for their presentation. And while they're coming up, just to remind everybody that this is an opportunity for the commission to learn. We will not have an opportunity for audience questions or interaction. If you have questions or have feedback for the commission, please send them to our website. And for the panelist we are -- we have a very tight agenda as you can see, and so we will be asking you to adhere closely to the timelines, and we'll make sure that there's plenty of time for questions from the commission.

So we'll start with Mr. Platt.

BRENT PLATT: Actually if it's okay we would like to start with Lana Stohl, the deputy director of the department.

CHAIRMAN SANDERS: Go ahead.

BRENT PLATT: Okay.

LANA STOHL: Good morning. Welcome. On behalf of the Utah Department of Human Services, we are really pleased to welcome the commission to Eliminated Child Abuse and Neglect Fatalities to our state. Ann Silverberg Williamson, our department's executive director, sends her regrets. She is out of state this week and was unable to attend.

As a department we are very proud of the progress that our child welfare system has made over the last several years. Currently, as Chairman Sanders indicated, we are among the lowest states in the country in terms of both child fatalities and also in terms of the number of children coming into custody.

In order to understand the significance of our child welfare numbers, I would like to take just a minute and give you some statistics. I know statistics sometimes discourage people. But Utah ranks No. 1 in the United States in the highest percentage of the population under age 18. Almost a third of our state's population is our children. The national average is 24 percent, and the next highest state to Utah is Idaho at 27.4 percent. So we have a lot of children in Utah. Between 2000 and the 2010 census Utah's population of children grew by 21 percent.

As I said, we have a lot of children in Utah, but we also have strong family values and a commitment to our children's well-being. Even though we have one of the lowest fatality rates in the country, we believe and strive to lower that rate because we believe one child fatality is one too many.

Philosophically, at the department we believe that children, when it can be done safely, are best served in their own homes, in their schools, and in their communities with the community having ownership of those children.

And currently our department -- we're really excited because we're working on two major initiatives with our new department leadership. And the first is focused on early intervention and prevention. We know as -- as a department that the further upstream we can be when families -- children and families are experiencing crises, the better we're able to intervene and the more successful the outcomes will be, not only for the children and families but for our communities as well.

The second intervention or initiative that we're focusing on at this point is for those children and families who are in severe crisis who have made it into the system, if you will. Our approach is going to be, moving forward, a System of Care approach. Utah has had -- has been involved with System of Care almost since its inception in the -- in the mid-'80s, but we have never moved forward with an initiative that involves our entire state.

And so we are in the process of actually implementing a System of Care model across all four of our major child serving divisions, and that is child welfare, juvenile justice, substance abuse and mental health, and our division for services for people with disabilities.

So we're -- and we are fortunate in comparison to some other states because all four of those agencies sit under the umbrella of the Department of Human Services. So we're initiating a statewide System of Care initiative. We believe, again, that children should be and are best served if we focus on their individual unique needs and that our service delivery is individualized and child specific as opposed to being program based.

And we also recognize, as many of you do that the child welfare services system for many years, children are often complex. They don't come typically to the attention of our department with a single problem as we well know. And to operate in silos within our department does not serve those children and families well, so we're beginning this initiative.

From our perspective it's a common sense service delivery approach that really connects Utah's children and families to the services and supports that they need in their communities so that they can be successful. As you -- many of you may know, the core values of System of Care is first and foremost community based, and so we're moving our system away from more group and congregate care settings to more community based and in-home supports.

We are adamant that our new System of Care approach must be family driven. We believe that families know the needs of their children and that they must have a seat at a table -- at the table and a voice in the plan of care for their children.

We have to be individualized. The plans have to be individualized. We have to coordinate across not only our own department, which is -- this is a culture change within our department as well as with the way we do business with our partners. But we have to coordinate within our own department and also across the other agencies in the state that serve children.

Youth guided, we have been -- heard many times children coming out of foster care who say I had no voice in what happened to me and we want to make sure that we recognize that youth voice.

Trauma-informed, I think we're all learning much more about what -- the impacts of trauma on children. And I believe that in many cases we're trying to medicate trauma as opposed to figuring out the roots of that trauma and trying to focus on how to work with behaviors as opposed to using medications.

We also have to be culturally competent. Utah has a very diverse population. We have eight federally recognized tribes in Utah. We have a large Hispanic population in Utah as well. And so we want to make sure that we understand the culture and that we value and appreciate the culture that each of our families brings with them and that we're evidence based.

And so we believe that by putting children and families first we're allowing them to drive the process. And instead of our department finding programs that meet their needs, the System of Care approach for youth and families really will help them identify and self-select the resources that meet their needs.

We're already starting to provide services to families in our western region under the System of Care model. Those counties are Millard, Juab, Utah, Summit, and Wasatch Counties. And Millard and Juab, in case you have -- know nothing about Utah's geography, very rural, frontier communities, Utah County is urban, and Wasatch and Summit are more suburban. So we -- we've got a nice mix of counties to begin our process.

By 2017 we will have rolled out System of Care statewide in all 29 of our counties. And I think we're -- there's very few states in the country that have been ambitious enough to try to move System of Care from geographic areas to a statewide model, but we believe it's the best thing to do. And we also know that successful Systems of Care involve partnerships, and we are all about partnerships and connecting with other resources.

In addition to our amazing leadership across all four of our major child serving divisions -- and Brent's sitting here. He is an amazing leader for our child welfare system. But we also have a statewide Governance and Oversight Committee. That committee is made up of representatives from the Utah Family Coalition, Youth Move Utah. We have the state superintendent of education on that committee. We have the director of the Department of Workforce Services, the Director of the Department of Vocational Rehabilitation, the Juvenile Court Administrator, representatives from local -- our local mental health and substance abuse authorities.

So we've really reached out to basically every child-serving agency in state government, and they've come with us to the table, including the Department of Health and Medicaid. So we're really excited about the commitments that we have received at this point. The commitment that the state leaders at the Governance and Oversight Committee level is making, they're also making that same commitment for their staff and their resources at the regional level as well.

So in summary, not only do we believe that System of Care is the best approach, we also believe that it's -- it's a good policy decision for our state leadership because ultimately safe and healthy children grow up to be safe and healthy and productive and successful adults. And so I really appreciate the opportunity to welcome you here today, to tell you how excited we are about both of our initiatives in terms of early intervention and prevention and also our System of Care initiative.

It is going -- I kept -- I keep telling our leadership and staff it's going to be messy and it's going to be hard and it's going to take a whole lot of time, but if we truly believe that this is in Utah's children's best interest, we'll stay the course and we will get this done. And so I'm really excited to be a part of this new and strategic vision for the Department of Human Services. And we look forward to your visit and if there's anything we can do to make it more successful, please let us know. Thank you.

CHAIRMAN SANDERS: Thank you. And would you like questions after each presentation or would you prefer to --

LANA STOHL: It's up to you, whichever you'd like to do.

CHAIRMAN SANDERS: Okay. We'll -- we'll hear all three and then we'll raise questions then. So thank you.

BRENT PLATT: So Commissioner Bevan, Commissioner Bevan, you're not -- you say you're not the brightest bulb up there? He just had to train me on all this stuff so I'm -- we're both dimwits or whatever. I'm not sure. My name is --

COMMISSIONER STATUTO BEVAN: Thank you.

BRENT PLATT: I've just offended one member of the commission so this is -- I'm doing good.

COMMISSIONER STATUTO BEVAN: You're it.

BRENT PLATT: Well, my name is Brent Platt, and I'm the Director of the Division of Child and Family Services. And we're one division under the Department of Human Services as Lana mentioned. I apologize for my voice. I'm -- I have this nagging cough I'm trying to get rid of, so forgive me.

We are, we're the -- we're the state agency here in Utah. We're responsible for investigating allegations of abuse and neglect for children and keeping with the -- with the goal of -- of making sure that once we get involved these kids aren't abused or neglected again. I mean, that's the scary thing for our caseworkers is they go out into these homes and they make decisions and they -- they gather their information, they make decisions and then have to do their very best to -- to -- to figure out what's right for these families, what's right for these kids, what decisions they need to make that will best protect these kids. And so just my hat -- my hat comes off to the -- to the amazing caseworkers that we have in this state and really throughout the country. I just -- I'm very grateful for them. It's a thankless job, and they do amazing work.

Just quickly I -- so you know, I'm confident that if -- among all the questions you might have, I'm not -- we're not going to have all the answers to, so I'll work with Amy or whoever to make sure that -- that we -- you know, we document those and that we get you answers. We want to make sure that you -- you know, that you have the information you need from Utah.

And I also want to thank the commission for kind of stoking the fire here in Utah, especially for me around the issue of near fatalities with children. We -- this is an area where there's kind of a renewed energy and a focus, and I've talked with Dr. Campbell. I've talked with Rob Parrish. These are folks represented today, and -- and they're very interested and hopefully not frustrated with the division, but they're very interested in seeing what they can do and what we can do to move this process forward and kind of figure out how we can move upstream and -- and learn from these near fatalities and then, you know, ways that we can eliminate those as well in our state. So I appreciate their willingness and their -- their expertise and their willingness to work with the division.

So just quick -- just about child and family services, we're a state-run agency. We're state administered, so it's not a county-based state -- or agency. About a thousand employees. We had 1100 in January, but we've had a hiring freeze, so we've dropped a few. About a thousand employees statewide, about 34 offices from -- you know, from the most urban areas to the most rural areas of the state.

We're divided up into five regions so it's -- one of the regions is -- is the four corners area of Utah, and it takes in one of the - - some of the most -- the most rural, sparsely populated areas of the -- of the -- of the continental United States. There are -- there are days when caseworkers have to drive into Colorado or New Mexico or Arizona just to get back into Utah to see some of the families they're serving because there's just -- there's just so few roads. Then, of course, we have -- you know, we have Park City with the Sundance Film Festival, so we are -- we are a very -- we're a very diverse state and very complex state. It's a great place to live.

In 20 -- in 2014 DCFS received more than 38,000 referrals with alleged abuse and neglect. We conducted approximately 20,000 child protection investigations throughout the state. And of those investigations we confirmed more than 9800 child victims of abuse. And of course those are just the victims we know about because there are -- there are things going on that aren't reported.

In 2014 we served about 4600 children in foster care. So at any given time in Utah we have about between 2600 and 2700 children in foster care, but over the course of the year we served over 4600 children. We also served approximately 9000 children in in-home services, so that's not 9000 families, but 9000 children. And in Utah that might be, I don't know, 2000 or 3000 families. Who knows? We have a lot of kids.

So I thought -- I know you guys -- this is a very heady topic and a very -- very heady responsibility that you guys have to kind of fix the country. I mean you're -- you're touring the nation and you're trying to figure out what you can do to -- to help reduce and -- or to eliminate child abuse and neglect fatalities. And I'm here to tell you we don't have all the answers, and you know that.

But what I thought I would like to do is just -- is just focus on three areas that I feel like that we are doing well, focus on one area that we -- an initiative that we've had in place for many years that we feel like is very effective in engaging in families, and then -- and then an initiative that we're in the process of rolling out and then one that we're just at the beginning phases of. And then, of course, we'll take questions.

The first area that I wanted to just share with you that I feel like is just fundamental to child welfare -- and many states are embracing this, and we've had actually several states come to Utah to learn about it, and that's our child and family team process. We really feel like -- our philosophy in Utah is that, you know, for the most part families know best. They -- whether it's the parents, whether it's relatives, whoever it is, they know if -- given the right circumstances and the right opportunities, they're going to know how to help protect their children, their nephews, their nieces, whoever it is.

And so we -- it's a requirement for any case and not just in foster care. I think in the -- in the Utah report it mentions we're -- we have child and family teams in foster care, but we also -- these teams are required for our in-home cases as well, and I just wanted to clarify that. That's important to us.

And these teams, they'll include, you know, parents, educators, clergy, neighbors, relatives, friends, mental health. You name it, we'll include it. It depends on -- it really depends on the

family and what their needs are and what their culture is. Typically at the beginning of a case, the casework is going to drive this process. Right? They're going to sit down with the family and say, okay, who needs to be involved. And oftentimes the family might say, well, I don't want them and I don't want them and I don't want them. And then we have to kind of negotiate with them and say, well, hang on, let's talk about this for a minute.

And so it's important for us. It's important for our caseworkers to really know how to engage with these families and kind of learn how to negotiate and work with them so that they can encourage these families to start taking responsibility. And we feel like it's a very important process because -- because by the end of the case oftentimes the family is driving that team. So they very much are in charge, and the caseworker is simply a member of the team.

And so this is something we're very proud of and it's something -- the teaming process has been a part of Utah's child welfare for 15- plus years and it's still very alive and well. And we feel like that's just fundamental to the work that we do. It sets the tone at the beginning of the case, throughout the process -- or throughout the life of the case, even to the point of having the really difficult discussion sometimes with family -- with parents about this isn't working, you know, we've been working with you for -- you know, we've been involved for, you know, 18 months, two years, you know, a year, and it isn't working, what are our options here, you know, and so having those really difficult discussions with the families. It also includes foster parents and whatnot. It just depends. But we feel like that's a very important component to Utah's child welfare.

Another -- another area that we're -- that we're currently rolling out is -- and has to do with our IV-E waiver. We've -- we did a -- we kind of looked around the country to try to find some good in-home programs that are more broad, more robust than just an intensive family preservation program. Those are key, but we serve a lot of families, and not every family needs four visits a month, you know. It just depends. So we -- we came up with our own version of an in-home model that we call HomeWorks.

COMMISSIONER COVINGTON: Home plans?

BRENT PLATT: HomeWorks. HomeWorks. One of our caseworkers actually came up with that name, and I thought it was a brilliant name because home does work. That's where -- that's where it needs to start and that's where it needs to end. This is a program that we rolled out -- we started rolling out about a year and a half ago. We started developing it two years ago.

And we decided that as we would roll this out across the state, we wanted to make sure we did it slow and we did it right. So with our five regions we started up in the northern part of the state. And basically -- anyway, by the end of this year, by the end of 2015, it will have been rolled out for the -- throughout the entire state.

There's three basic kind of tenets of HomeWorks that we emphasize. One is enhancing -- making sure that we're using evidence-based assessments when we work with our families. The other piece is giving caseworkers skills and helping them to develop the skills and also giving them kind of resources that they can use to really meaningfully engage with these families. It's one thing to go into a home and say, hi, how are you, how's your kid, thanks, see you next month. It's another thing to go into the home and visit with the family and talk

about the importance of sitting around the table together, the importance of supporting the kids with homework, the importance of looking up -- you know, making sure that we're tracking grades, the importance of dealing with mental health issues, et cetera, et cetera, everything from -- from those issues to domestic violence to -- to whatever -- whatever you can imagine.

The third piece to this is building better collaboration amongst the community with our community partners. And we're not just talking about the providers who we contract with but really engaging the community. The reality is we're one piece to the puzzle. We're not going to fix everything. We don't even get involved until damage has already been done.

and I've got to say, that's the hardest piece for us: How do we engage in the community? And that's -- that's the piece that we're struggling with.

So I have caseworkers who are super excited about this. They feel like, oh, my, gosh, this is great, we're going into the home and we're doing real social work. But wait, this family needs substance abuse treatment and there's a three-month wait. So that's where System of Care comes in, and that's where System of Care is really going to help to kind of help create the safety net for these families. So we're excited about the HomeWorks process and we're really excited about the department's System of Care initiative that really is going to run hand in hand with -- with this program.

A key component to HomeWorks is an -- is an assessment tool that we've developed with -- it's CANS-based assessment, but it's unique to Utah, and it's called the Utah Family and Children Engagement Tool, so UFACET, that's what I'll call it.

UFACET assists caseworkers in identifying the underlying needs of families which when not addressed lead to recidivism and repeat maltreatment. It allows caseworkers the opportunity to address the factors that resulted in the risky or dangerous behaviors that lead to their involvement with DCFS rather than kind of using this Band-Aid approach, you know, like, well, it's -- hopefully it will be all better addressing just one incident or behavior without addressing the underlying cause.

We also are using the strengthening families protective factors, and so we're braiding those into the UFACET. And it works to -- the goal is to achieve long-term behavioral change that will reduce risks with these families. So we want to get in, do our work, and get out, and we don't want to see these families again. We want them to be healthy and we want them to be, you know, in a place where they can -- they can take care of themselves.

UFACET is completed during the child protection investigation, so it's very early on in the case. It focuses on building relationships with the family, identifies the family as the experts. It includes a caregiver manual that allows the family to see exactly what's on the assessment, so they see what we see. It's used -- the child protection workers use it to gather information that's passed on to the ongoing worker. An area where we struggle, and I'm sure other states struggle, too, is transitioning a case from one kind of program area to another. And this -- this assessment, the UFACET, helps us to kind of make a more seemly process. It guides workers to better address family needs, and it's also being used as the assessment tool for System of Care.

So since October of 2013, we've had 1100 -- probably more than 1100 assessments that have been completed with families as we're rolling out the HomeWorks model. Right? So it's being evaluated by the researchers at the University of Utah. We've seen very positive results anecdotally at the family level and at the caseworker level. I mean, families -- we have families who are willing to testify in front of our state legislature, and you don't get a lot of families who are willing to air their dirty laundry, but we get families who are saying this really helped. And that's big to us. That's important to us. We have caseworkers who are very excited about it. So that's the second area.

The third area -- and this is something that we're just working on right now since about November of last year. In Utah we have a lot of great advocacy groups including child -- including DCFS, I mean, A lot of organizations, a lot of individuals who are just passionately involved and passionately invested in protecting children. But really what -- what I don't think the division has done a good job of is bringing these groups together so that we can look at all of the issues more globally. So we have different groups doing different things, and there really hasn't been a coordinated effort, at least not from what I've seen.

And so we're in the process of developing a statewide coalition of sorts where we're bringing together these child advocates. This coalition is -- it includes adult survivors of child abuse. It includes -- just as of a couple weeks ago, I forced Dr. Campbell to be on it. We have several other individuals and groups from family support centers, children's justice centers. We have legal folks and we have some mental health folks. We're working on bringing in the clergy as well because we know -- I know I'm a child welfare agency, but there's only so much I can do. This really is a community effort to eliminate child abuse and neglect and certainly to eliminate child abuse and neglect fatalities.

So we're excited about that. I can't report much on it other than, you know, I'll be happy to send you information next year. But I'm confident that we're going to be able to -- that we'll be successful and that we'll work on very meaty issues around child abuse and neglect and that we'll be able to do a better job getting the message out to the communities in Utah on the importance of prevention, getting the communities involved, and just the bottom line is that child abuse is not okay.

Thanks. I'm glad you're here. Like I said, you've already kind of stoked the fire for us and I -- and I'm really, really grateful for that. We know that we are not -- we're not where we need to be. We never will be. When I'm where I need to be, it's when I'm pumping gas somewhere because there's no need for child welfare in the state because families are healthy and happy. But I really appreciate you guys being here.

And I know, you know, you're looking for recommendations, what do you want to tell Congress or whatever. I don't know. But here's the deal. Whatever it is you guys come up with, this commission, and I -- I know I don't speak very well, but I'm being very serious when I say this. Whatever it is you guys come up with, whatever recommendations it is that you come up with, it would be wonderful if you could somehow braid that in with kind of this -- this other discussion about child welfare finance reform.

Because whatever changes you're going to want to make, whatever changes you're going to want to recommend, it's -- it will probably mean an adjustment in how funding is going to be

allocated. And so I would just really appreciate if you would just kind of look at the roadmap overall and make sure that this fits in nicely with that so that we're not siloed -- that you're not siloed in your recommendations versus what everybody else is doing. I think that's really important.

And I realize you guys know this. I hope you don't think I'm preaching to you. But as states that would be really helpful. So I, again, thank you for your time and thanks for coming to Utah. I've got to say this is just an amazing place to live and I hope you enjoy your time here. Thank you.

CHAIRMAN SANDERS: Thank you very much.

Last presenter?

CHERYL DALLEY: Yes. I'm Cheryl Dalley. I am the Fatality Review Coordinator for the Department of Human Services.

Children are among the most vulnerable in our population. Unfortunately, when they -- we see them in our committee, they've come to the ultimate sadness, that of -- that of death. The Child Fatality Review Committee Act was proposed to the Utah State legislature in 1996. And although the bill was not codified, the Department of Human Services began holding child fatality review -- reviews at that time.

Then in 2010 the Fatality Review Act became part of Utah State statute, and then it was amended again in 2011. The purpose of our fatality reviews is, first of all, to develop ways to prevent future client deaths, to improve department services, to assess if best practices were followed in casework, and to recommend modifications to procedures, policy, law, and training when necessary.

The way we determine eligibility for a fatality review is if the family has had services through the Division of Child & Family Services within 12 months of the child's death. Some of the things that might qualify would be that the child is in the physical or legal custody of the department or a division of the department. It could be a CPS investigation. It could be a foster care case, in-home case, or a child in substitute care. The child could be a resident of a facility or a program that is owned or operated by the department or a division of the department.

Notification is an interesting subject because many times there's not an open case through DCFS at the time the child dies. The family may have had services within 12 months, but there's not an open case. And so I'm provided by the Office of Vital Statistics with the death certificates of all children between birth and 21 years, and I compare those death certificates against the DCFS database which is called SAFE to see if those families have had services. And if they have, then that child qualifies for a fatality review.

After that -- the individual has been identified, then I request records or actually now with the SAFE database I can access all of the case records through that database, which has made it very, very convenient. We have timelines for the way these things are -- happened. I'm supposed to be notified within seven days of the division's learning about a death, and then there are different timelines for the different portions of the review.

The Child Fatality Review Committee meets on a bimonthly basis. At this time we have 18 members, and that includes the Director of the Guardian Ad litem's office, a director or a designee from the Attorney General's child protection unit. We have a physician from Primary Children's Medical Center. We have representatives from three of the five DCFS regions. We have representatives from the DCFS administration office, including program and administrators over intake, Child Protective Services and training. We have a representative from the department's risk management office. And we also have the director of the Child Protection Ombudsman Office.

As I go through the record of the family services, I write a chronological summary of those services in a report. And then those reports are sent to committee members approximately a week before our meeting so that the committee members have time to read the reports and spotlight or focus on those things that they want to discuss, whether it's weaknesses, strengths, practice issues.

Then we look at an analysis of systemic issues. We look at did the DCFS caseworker follow policy related to the essential issues of this case and are there significant system weaknesses related to the death of the child. We also -- the committee may pose questions and concerns for region response and make recommendations. And then the completed report is sent to the Director of DCFS -- that would be Brent -- to our Executive Director of the Department of Human Services, to the director of the region in which the fatality occurred, and also to our constituent service person and our training program administrator.

Our reports are classified as protected. The body of the report, the summary, is confidential, but the actual analysis and recommendations is classified as a protected document. So they are not admissible as evidence in a civil, judicial, or administrative proceeding. They're not subject to discovery, subpoena, or similar compulsory process in any civil, judicial, or administrative proceeding. And no individual or organization with lawful access to the data can be compelled to testify with regard to report or response to a report. And because of this committee members are free to express their views and discuss issues without fear of being the subject of legal proceedings, so it promotes open discussions in our committee meetings.

We have waive reviews. After I've written a report and it appears that there are no systemic issues or no culpability on the part of DCFS, I submit that report to my supervisor, who is the Director of Office of Services Review. He reads and reviews it. If he agrees, he signs off. And then we also commit a complete report to the chairman of the committee who also reads the complete report. And if he agrees, he or she agrees, they sign off on it. So if all three of us agree that there's no reason for this full report to come before the committee for a formal review, then we recommend that formal review be waived.

However, the committee does receive the analysis of systemic issues and the findings. And if they feel that there are issues that need to be brought up in the committee, then the case can -- will be brought before the entire committee, and they will receive the full report. But it was a way of saving time for committee members and not having to read -- read full reports on things when there might not be issues.

The region has 20 days within which to provide a written response to the executive director of the HS and to the fatality review coordinator. They address the committee's concerns and

questions and recommendations and include a plan of action to implement any recommended improvements within the division.

When everything is completed, the report, as I said, is given to the executive director of DHS, Brent, and so forth, and a redacted version of the report is sent to the Office of Legislative Research and General Counsel who provides copies to chairs of the Health and Human Services Interim Committee and to the Child Welfare Legislative Oversight Panel.

By statute I must prepare an annual executive summary or annual report, but we term it executive summary, each year. And that is sent to the Office of Legislative Research and General Counsel who then distributes to the Child Welfare Legislative Oversight Panel.

And then on an annual basis I give a verbal report to the Child Welfare Legislative Oversight Panel that this report includes the number and type of fatalities, qualified individuals, number of formal fatality reviews conducted, categories of qualified individuals who died, whether they were receiving CPS, foster care, in-home, et cetera, gender, race, age, and other significant categories, suicide fatalities, action taken by the Office of Licensing or of Bureau of Internal Review and Audit in response to a fatality of a qualified individual. And the executive summary is a public document. And the annual report is -- on the verbal report is open to the public. However, a discussion with the panel on individual cases is a closed meeting that is confidential and private.

We have a relatively small population here in Utah. We have few large metropolitan areas, but we do have a strong emphasis on the importance of families. So we have relatively low numbers of fatalities. During the last five years we have -- the committee has reviewed 206 known fatalities of children eligible for review. In fiscal year 2014 we reviewed 37 fatalities. As far as abuse and neglect fatalities, in the past five years we have reviewed 36 cases in which abuse or neglect was the -- or the fatality was a direct result of abuse or neglect. And in the fiscal year 2014 that number was seven.

But throughout the history of DCFS, the child fatality reviews, there have been no abuse or neglect deaths of children who were in substitute care. Children have died in substitute care, but it has been from natural causes, illness, or accident, but we've had no abuse or neglect deaths while children were in substitute care.

Value of the process, we've seen great improvements in the practice in DCFS, and hopefully the child fatality review process has contributed in some small part to that improvement in conjunction with the other review processes that are in place. In most cases it's impossible to definitely say that a fatality was a direct result of casework practice; however, it is possible to identify systemic weaknesses and to make recommendations that will hopefully improve services to the children and families of our state with the ultimate goal of preventing future death.

I appreciate the opportunity to share this information with you today. Thank you.

CHAIRMAN SANDERS: Thank you very much. That was very informative to hear about the system.

Are there questions?

Commissioner Dreyfus.

COMMISSIONER DREYFUS: Hi, thank you very much. Couple quick questions for you all.

Cheryl, you talked about the services -- how you define those cases that you will be reviewing in terms of 12 months had they received services. Does services include reports to CPS whether they were screened in or screened out? Does --

CHERYL DALLEY: If it was only an unaccepted referral we do not consider that a service. If a division received a referral --

COMMISSIONER DREYFUS: Within the 12 months of the child's death.

CHERYL DALLEY: -- within the 12 months, yes.

COMMISSIONER DREYFUS: So if there is a report in within the 12 months and it was screened out, it wouldn't be --

CHERYL DALLEY: It wouldn't qualify. The case wouldn't qualify.

COMMISSIONER DREYFUS: Okay. Great. Thank you.

And then does your report identify cross-system issues? Does your report help the legislature or your own leadership to see whether it's an education or law enforcement or health care or other systems that intersect with your agency's ability to be successful? Does your -- does your report start identifying gaps or issues that need to be brought to their attention?

CHERYL DALLEY: As I summarize the case -- the history of the services, sometimes those gaps become evident and the committee identifies those as they read through the summary of services. And, yes, we do -- we do make recommendations regarding -- regarding accessing those services or better communication with other agencies. We --

COMMISSIONER DREYFUS: Okay.

CHERYL DALLEY: We have no authority, of course, over other -- other agencies. But, yes, those are identified.

COMMISSIONER DREYFUS: Did you want to say something?

BRENT PLATT: I was just going to say like Cheryl mentioned, they have no authority to kind of -- to require other agencies to get involved, but it's helpful because they will identify areas where maybe we can reach out to those agencies. So it's helpful for us because we're in a position to where we can really --

COMMISSIONER DREYFUS: Right.

BRENT PLATT: -- build partnerships that we haven't had.

COMMISSIONER DREYFUS: Thank you. And then, Brent, just one last question for you. I just think it's wonderful what you're doing.

BRENT PLATT: Thank you.

COMMISSIONER DREYFUS: It's fabulous. And I love this clear articulation: Early intervention and prevention and System of Care. That's perfect.

So to achieve that, you said something at the end that struck me. You said to the commission, at the end of the day all the greatest recommendations in the world if the fiscal lever is not aligned to it, the federal fiscal levers are not aligned to it, you can't be successful. And I think about what you're doing here and we're not going to have waivers forever. Right? I mean --

BRENT PLATT: Oh, absolutely not. That's right.

COMMISSIONER DREYFUS: And we can't waiver our way out of this thing. So tell me, from your perspective what would be some of the key principals that you think need to be sitting behind that federal fiscal leveler.

BRENT PLATT: Oh, my. So to be clear, now Utah is -- I think we're different than a lot of other states. The bulk of our child welfare funding actually comes from general funds within the state. So we're -- I think we're about -- out of our budget $114 million of our budget is state funded and 57 million is federally funded. But I would say -- actually I have a handout that I wasn't prepared to hand out but with the information.

I think that there needs to be accountability wherever we're at. So we know that the feds have funded foster care and that's needed, it's necessary, but it's way too far downstream. I would think that the feds in working with the states -- we should be able to figure out a way to -- oh, my gosh. You know, I'm not going to be able to be very clear on this.

We have processes in place that we know work in foster care. We need to put the same emphasis and the same -- the same focus on keeping families together. So -- so -- so there are evidence-based processes, there are evidence-based assessments, there are evidence-based programs out there that are proven for the most part to keep families and kids together and safe. And I think states need to come together and identify those in a way that is meaningful and in a way that we're - - oh, my gosh, that we're connected so that -- so that by going to the feds and saying, hey, we need this funding upfront, we need this funding for prevention and early intervention. We can also show the feds that we're going to be accountable to that, because I think that's what they're afraid of. It seems like they're afraid that, you know, we're going to throw money at this problem and we're not going to have any way for you guys to show us that it works.

And just like with my state legislature, every year I have to ask for my funding. So we need to come together and identify ways that we can say, look, federal government, if you put money here, this is what we're going to show, this is what we're going to have to show for it. It can't just be state by state. It needs to be a collective effort I believe.

I don't know if that answered your question at all because I have some specifics that I can give to you. But for me just in my mind that's what needs to happen. I need the feds to give me money upstream, but in return I need to be able to show the feds that it's an investment that's worthwhile to them.

COMMISSIONER DREYFUS: Thank you.

CHAIRMAN SANDERS: Commissioner Petit?

COMMISSIONER PETIT: I have a number of questions, and let me speak to what the nature of them is. First I need to establish -- what we're trying to figure out is how to actually reduce fatalities. We know if we could actually figure out a way of effectively reducing mortality rates, you'd have to reduce morbidity rates. But we're coming at this from the perspective that the kid is killed or is about to be killed.

So just in terms of the uniqueness of Utah in the first place. You mentioned that you're by far the highest number of children as a percentage of population. What's your out-of- wedlock teenage birth rate, do you know?

LANA STOHL: Pardon me?

COMMISSIONER PETIT: Do you know what your teenage out-of-wedlock birth rate is?

LANA STOHL: Not off the top of my head.

COMMISSIONER PETIT: I'm going to guess it's very close to being near the top in terms of one of the lowest rates in the country. But can you -- does somebody in the audience know the answer to that?

Do you know where you come out on the annual kids count reports?

BRENT PLATT: You know, I -- I have that report. I don't have that information with me, but we certainly can get it to you.

COMMISSIONER PETIT: But I think the high school dropout rates here are very low.

LANA STOHL: They are.

BRENT PLATT: They're low.

COMMISSIONER PETIT: I think the number -- percentage of children insured is very high. Am I correct on that?

LANA STOHL: Yes.

COMMISSIONER PETIT: And the poverty rate is low. So when I look at going from 12 -- well, low in a -- if you -- if you put it up against income, it's -- incomes are not high. It's a different situation than some other places.

So in trying to figure out how to you -- how you went from 12 to seven, whether that's statistically significant or not, you know, I'm just trying to see. So you've had two years where you've gone from an average of about 12 deaths a year to the last two years you've had seven. But in both cases it looks like the deaths that were classified as abuse and neglect were open cases with the department.

And there were no other abuse and neglect cases that came in other than those that were open CPS cases? Do you know the language I'm referring to in the report that you guys have given us?

CHERYL DALLEY: Right.

COMMISSIONER PETIT: It said -- first, the child fatality rate, the national rate is triple Utah's. It's triple Utah's. But in this document that I'm looking at that was prepared for us, in FY 2014, seven children who had an open case with Utah DHS died. Were there abuse and neglect cases that a child died that were not open CPS cases?

CHERYL DALLEY: That was seven children total whose families had had services within a year of their death. They may not have been open at the time the child died.

COMMISSIONER PETIT: Seven children had an open case died in 2014. And it says they were all open. But if they weren't open within a year, they were open at some point.

CHERYL DALLEY: At some point during the 12 months, yes.

COMMISSIONER PETIT: Did you have any child abuse or neglect deaths that were not known to the department? Was there a group of children besides these seven in each year -- and the first year there was six that were open CPS cases and one was family preservation case. So I'm reading this. It says all 14 children that reported abuse and neglect were open or known to the department.

CHERYL DALLEY: Right. Well, because of the fact that I compare all death certificates of every child who dies in the state between birth and 21 years with the DCFS database, I think we do a pretty good job of identifying those -- those children who are eligible for fatality reviews who have had -- whose families have had services within 12 months of the child's death.

COMMISSIONER PETIT: Yeah. One of the things that we've been dealing with is what percentage of children that are killed from abuse and neglect are known to a department and what are not known. And as I'm reading this as it's written here, I'm not -- you know better than what is written here unless you wrote it.

CHERYL DALLEY: No, I didn't.

COMMISSIONER PETIT: This is saying that all of the children in the last two years who died from abuse and neglect were known to the department is the way this reads.

BRENT PLATT: Does that make sense?

COMMISSIONER PETIT: That's what this reads. If that's not true, I'd like to know it's not true. You may not know. Maybe --

CHERYL DALLEY: I guess I'm not understanding this.

COMMISSIONER PETIT: -- you could find out before we leave or later. But for me that would be a significant thing, the only children that are dying from abuse and neglect are already open. And I don't view that as a negative necessarily.

BRENT PLATT: Right.

COMMISSIONER PETIT: I'm just -- you know, what it says is not -- you're seeing a lot of cases. You're preventing a lot of stuff that's happening, and the kids that do die you already know, so they're not dying from someplace else. They're dying well known to the department. But is that true?

BRENT PLATT: Well, I -- and I don't know the answer to that. I want to be sure that we understand the question. The question is -- so in this report it says that fiscal year '14 seven children who had an open case with DCFS -- or with Utah DHS died from abuse or neglect.

COMMISSIONER PETIT: Yeah.

BRENT PLATT: Your question is: Are there other child abuse/neglect fatalities that weren't known to the department.

COMMISSIONER PETIT: Yeah.

BRENT PLATT: Right? So we have this cohort.

CHERYL DALLEY: Right.

BRENT PLATT: Are there other child abuse and neglect fatalities that weren't known to the department, no open case, that would have received from --

COMMISSIONER PETIT: Not reported in, not investigated.

BRENT PLATT: Yeah, just not known to our system.

COMMISSIONER PETIT: Are there any?

CHERYL DALLEY: Well, there are obviously other children who died of abuse and neglect, but they may not have had services through the department within 12 months.

COMMISSIONER PETIT: Okay. Well, that--

BRENT PLATT: That's what he's asking. Do we have those numbers?

CHERYL DALLEY: No.

BRENT PLATT: I don't know what that number is, but we can try to find out.

COMMISSIONER PETIT: What I'm saying is whether they died known to you or not -- I mean at one level it doesn't matter. At another level it matters a lot.

BRENT PLATT: Right.

COMMISSIONER PETIT: So the question -- so it would just be useful to have a complete picture as to how many children in this state are dying from abuse and neglect.

CHERYL DALLEY: Oh, I see.

COMMISSIONER PETIT: It's one thing to say there's six or seven, but they only meet that level -- rise to the level of being declared such if you've been involved with them. If there's 50 other kids that were killed that were not known to you --

BRENT PLATT: Right.

COMMISSIONER PETIT: -- and they died from abuse and neglect, that speaks to something else as well.

CHERYL DALLEY: Sure.

COMMISSIONER PETIT: Right?

BRENT PLATT: We'll get back to you on that, those numbers.

COMMISSIONER PETIT: David, I have other questions, but I'll stop and let others ask them. But if we can before we --

CHAIRMAN SANDERS: Come back to you.

COMMISSIONER PETIT: Yes, come back to me, please.

CHAIRMAN SANDERS: Commissioner Covington?

COMMISSIONER COVINGTON: That was one of my questions, too, actually. Because I -- I'm sure there's more kids that don't just come to the attention of the system. It would be an interesting number to read. Because one of the questions I had is is this the number you submit to -- I'm asking this because I'm on NCANDS. I'm asking this because I'm on -- we have a measurement committee that's trying to get a better handle on how to better measure child abuse and neglect fatalities. So how do you -- what number do you submit to NCANDS and how do you make that determination when they submit to child fatality reports? Do you know?

CHERYL DALLEY: Brent will have to answer that because the division submits that report.

BRENT PLATT: Could you repeat the question?

COMMISSIONER COVINGTON: Well, we're finding great disparity around the country in terms of -- and I'm not trying to judge you on this, trust me, because every state has a different number that they submit to NCANDS and different criteria. Do you know what the criteria is from Utah when you submit a number in to NCANDS for fatalities?

BRENT PLATT: I don't know, but I could get that for you.

COMMISSIONER COVINGTON: Okay. Just curious about it.

And I know that there's another -- you have a broader base child fatality review program in Utah which is -- that reviews all deaths.

BRENT PLATT: That's right, yeah.

COMMISSIONER COVINGTON: They may have the number, Michael, that would be all child abuse and neglect fatalities including those that don't come to the --

BRENT PLATT: And that's actually where I would go to, go to that committee.

COMMISSIONER PETIT: If there were other kids that are dying from abuse and neglect that aren't added in here, when the national numbers are put together, it's all children that are dying from abuse and neglect is what's supposed to be reported --

COMMISSIONER COVINGTON: Well, that's not true.

COMMISSIONER PETIT: -- not just the ones known to the department. Then of course --

COMMISSIONER COVINGTON: That's not true.

COMMISSIONER PETIT: -- it begs the question. It the begs the question if there were 10 or 20 or five other children killed, why weren't they known. And I phrase that in a manner not critically, but in terms of you're seeing a group of children, but there's another group of children that are obviously equally in trouble that you're not seeing. And what is it that interferes with your being able to see them? Why don't we know about it?

COMMISSIONER COVINGTON: Yeah, that's a good question.

I had a question. It -- it seemed to me -- and I was curious. When you were describing, Brent, your child and family team process and the role of the caseworkers, it seemed like a really sophisticated role for a caseworker. Do you have special guidelines for who can become a caseworker in Utah?

BRENT PLATT: Yeah. You have to have a bachelor's degree in social sciences and then you --

COMMISSIONER COVINGTON: Okay.

BRENT PLATT: -- need to be licensed as a social service worker.

COMMISSIONER COVINGTON: You do, okay.

BRENT PLATT: Yeah, that -- you -- you don't have to have that license when you're hired, but we expect that you'll be licensed as a social service worker.

COMMISSIONER COVINGTON: Is that a Utah licensing process or --

BRENT PLATT: It's through Utah but it's through -- it's a national licensure, yeah.

COMMISSIONER COVINGTON: NCAW -- yeah, okay. Good. I was curious about that because we've heard in other states that the level of training and support -- you know whether people have to be social workers or not and the level of training because it is a difficult job.

BRENT PLATT: Yeah, and we have our own -- we have a pretty comprehensive training program for our own caseworkers. It's about 120 hours of training just within the division.

COMMISSIONER COVINGTON: The other question I had is a lot of what you presented -- your early intervention prevention and systems of care. What work is going on in your department around super early intervention before families even come to the attention of the system? Is that work that you're doing in Utah or is that being done elsewhere in terms of that really early upstream child abuse prevention?

BRENT PLATT: Department of Health has several programs. I think they may be speaking to that. I'm not sure. But they have several programs that they run through the counties that are very early intervention prevention programs. We do tag-team with them. So if they feel like there are concerns, they'll contact our local folks and we can tag-team those. But I don't have specifics on that. But, yeah, there are plenty of programs, but they're not run through --

COMMISSIONER COVINGTON: So your.

BRENT PLATT: -- at least not through DCFS.

COMMISSIONER COVINGTON: Your programs that you've really described are once families are known to the system or a report comes in.

BRENT PLATT: And that's why I'm focusing on the child abuse and prevention -- the Child Abuse Prevention Coalition --

COMMISSIONER COVINGTON: Yep.

BRENT PLATT: -- that we can move upstream as a state.

COMMISSIONER COVINGTON: I'm good for now.

CHAIRMAN SANDERS: I have some questions, but go ahead Commissioner Martin.

COMMISSIONER MARTIN: First of all, thank you so very much. I was here some years ago with Judge Macaulay and did some training here in Utah, and you have succeeded in continuing to progress since I was here. So it's nice to be back in Utah.

I think I understand the answer to my question, but let me be clear. First of all, I don't want you to think that the questions we're posing to you are any way questioning the work that you're doing. What we're trying to do is make a clear understanding and a distinction between what we've heard in the past in other places. So I hope you can take that in the spirit in which the questions are asked.

My question is: Do you have any information about the four federally known or recognized tribes here in Utah, about their fatalities? I know they're sovereign nations and there's no real requirement, but do you have any information about their child abuse and neglect fatalities?

BRENT PLATT: I actually think we have eight.

COMMISSIONER MARTIN: Oh, eight? I apologize.

BRENT PLATT: Yeah, we have eight federally recognized tribes --

COMMISSIONER MARTIN: Okay. I apologize.

BRENT PLATT: -- not four.

COMMISSIONER MARTIN: Do you have any information about their fatalities?

BRENT PLATT: So this -- I don't, not specifically to how -- what processes they have in place to review fatalities. I don't have the information on that.

What I know is that we work with all the tribes in Utah. And so if we're involved with a child fatality that's associated with a tribe, it would go through this process. But as far as specific to the tribes, I don't know their process.

COMMISSIONER MARTIN: So if I understand correctly, they would be in your database data system, and so when they're checked against the death certificates, you would capture them that way. So technically the numbers that you provided for us may include native children as well.

CHERYL DALLEY: That's correct, yes.

BRENT PLATT: Right.

The problem with -- and I don't know -- I don't know if it's a problem or not but the problem is the jurisdictions in the tribes include more than --

COMMISSIONER MARTIN: Sure.

BRENT PLATT: -- one state. So we would only --

COMMISSIONER MARTIN: Sure.

BRENT PLATT: -- be talking about the membership in our -- within our boundaries.

COMMISSIONER MARTIN: Sure. And on your death certificate, your state death certificate form, is there indication or anywhere to indicate that the deceased is a member of a tribe?

CHERYL DALLEY: Yes, there is.

COMMISSIONER MARTIN: And do they identify which tribe or just that they're native?

CHERYL DALLEY: They usually identify the tribe on that.

COMMISSIONER MARTIN: I apologize. I'm sorry.

CHERYL DALLEY: They do identify the tribe --

COMMISSIONER MARTIN: Great.

CHERYL DALLEY: -- on the death certificate, yes.

COMMISSIONER MARTIN: Great.

My second question is more broad, if you can tell me what Utah means by Systems of Care. We've heard this term. I think all of us have some sense of what it means in different places, but I kind of want to have a clear understanding of what Utah means by Systems of Care, if you can, for me.

LANA STOHL: What Utah means by Systems of Care -- System of Care from our perspective is a philosophy. And it's based in those core principals that I outlined in my presentation. The implementation of System of Care -- as we start down the road of System of Care implementation, the goal initially is to focus on those children and families who are most in crisis who cross multiple systems within our department. So they are already involved with

juvenile justice and/or DCFS. They're involved with substance abuse and mental health and/or juvenile justice services or services for people with disabilities and two of our other divisions. So they must -- they're individuals and -- children and families that are in multiple systems.

Our goal as a department is to really have System of Care become the philosophy and the culture with which we do business as an agency so that all of the services to all of our children are provided in that context where it's not program based but individualized. The child and the family is at the core of that service or that -- I can't think.

But if you think about the circle here, the child and the family are the center of the circle. And all of our services instead of being families having to qualify for DSPD services, child welfare services, or juvenile justice services, we identify the unique needs and we bring the service from that particular agency into that family without having them have to go through four different doors and qualify, if you will, for that service.

One of the questions earlier, Brent was talking about the need for federal funding to align with the way we're trying to do business for all of our agencies within the department, the need not only at the state level but the federal level for us to be able to braid funding and to move more -- move away from more of a categorical way of looking at eligibility to a specific need--

COMMISSIONER MARTIN: Need based.

LANA STOHL: -- based on the child and family. That's what System of Care means to us.

COMMISSIONER MARTIN: And when you have that implemented statewide, do you anticipate, then, when looking at the CAN fatalities, child abuse and neglect fatalities, that you will then start looking at all the system databases like you do DCFS now?

LANA STOHL: Yes.

COMMISSIONER MARTIN: Okay. So then they will capture, Mike, the other cases that aren't known to DCFS at that point. Okay. Thank you so very much.

COMMISSIONER STATUTO BEVAN: I have -- I have a question related to the seven children that were infants that were killed in Utah. I'm also interested to read that in the "Deseret News" today there's, what, back to back stories?

BRENT PLATT: "Deseret News," Saturday and Sunday.

COMMISSIONER STATUTO BEVAN: Saturday and Sunday on -- just on the boyfriend, just on the issue of --

BRENT PLATT: No.

COMMISSIONER STATUTO BEVAN: Was it just on the issue of mothers and the negative impact boyfriends can have on --

BRENT PLATT: Yeah, it was more broad than that. It was looking at different prevention efforts that are going on and -- it was more broad than that, yeah.

COMMISSIONER STATUTO BEVAN: One of the things it brought up was that the services are free, so I wanted to bring that up again because it said there were some questions about services being free, and that's something that we should always publicize.

But my issue -- my question has to do with the seven children. I've been reading the reports.

One media report said that the family received an anonymous phone call re: Maternal -- regarding the mother's drug abuse. And another report from the police said that there was never any referral.

Do you know, since it's public information, what -- was there referral on these seven babies or was there no referral on these seven babies?

CHERYL DALLEY: The seven who died during the fiscal year 2014?

COMMISSIONER STATUTO BEVAN: Yes.

CHERYL DALLEY: They -- there would have been referrals because they were all -- their families had received services within 12 months of their death. Whether there was an open case at the time of their death or not, the family had received services through DCFS within 12 months of the child's death.

COMMISSIONER STATUTO BEVAN: They had?

CHERYL DALLEY: Yes.

BRENT PLATT: That's how they're known to our system --

CHERYL DALLEY: Right.

BRENT PLATT: -- and that's how she would know about the fatalities. Within 12 months of the death they had received some service through DCFS.

COMMISSIONER STATUTO BEVAN: Oh, okay. And my other question has -- well, thank you very much. I'm glad to -- I'm glad to know they were identified.

BRENT PLATT: Did that clarify or are we--

COMMISSIONER STATUTO BEVAN: Yes, yes. Because media reports were different, and I couldn't tell.

My other question has to do with the definition of child abuse and neglect in Utah and the fact that it includes fetal exposure to substance abuse. I'd like to know what the strategy is for responding to that definition. How do you -- how is there a strategy around the definition of infant exposure, or fetal exposure, I guess it's called here?

BRENT PLATT: I think that I would have to get one of my -- one of our attorneys to help with that discussion because I think I'm not going to do it justice, but we can probably do it offline or --

COMMISSIONER STATUTO BEVAN: Okay.

BRENT PLATT: -- if that's okay.

COMMISSIONER STATUTO BEVAN: Yeah, maybe we could do it offline. Thank you.

CHAIRMAN SANDERS: I have a few questions and then Michael and Jennifer.

First, you talked about the approach that you use in Utah and an evolving approach and certainly Systems of Care being part of that, and it really included a philosophy of family knows best and so forth. The rate -- the fatality rate in Utah has been low for a number of years. Can you say a little about your guesses as to why that's the case? Because it seems like the changes that you've talked about in practice have -- that the low fatality rate preceded those changes. I'm just curious, do you have any sense -- are there things the culture? Has there been a long term investment in certain effective strategies? What's your sense of that?

BRENT PLATT: Well, so -- so the changes - - I think significant changes that DCFS has made really have been over time: Child and family teaming, engaging with the community, engaging with families. So those aren't new -- those aren't new to the division.

So I can -- I think I can only speak to what we're doing. I think we're -- I think our database helps us track history with these families. It's a very -- it's a really robust database where you can, you know -- we track history of unaccepted referrals, unsupported -- you know, child protection investigations. We track contributing factors, everything from substance abuse to poor parenting to whatever.

And so I think within the division we -- the expectation is that when caseworkers go out and they meet with these families that they -- that we look at the history, we look at history of the family, and we really -- we try -- we try very hard to -- to connect them with services so that when we're out they have supports in place, because I think that's really important.

As far as kind of the broader discussion about, you know, approach to child abuse fatalities, I would probably defer to the Department of Health as well because they have a huge number of programs that they're working with -- within the communities. And so I would probably defer to them to speak to that.

But I think -- I think within the child welfare system -- I mean, we -- we do a good job getting families connected with formal and informal supports when we get involved the first time so that we're not seeing a lot of -- we're not seeing a lot of fatalities within the division. Of course one is too many. I don't know if that answers your question. I really can only speak for DCFS right now.

CHAIRMAN SANDERS: Let me add a second piece to that. The comment about zero fatalities in substitute care, do you have a sense of how long that's been the case and is that -- is that related to the first question? Is substitute care such an important part of the service continuum that you feel that's one of the ways that you've been able to assure -- continue to see a low fatality rate?

LANA STOHL: First let me take a stab at answering your first question. I think that, as Brent indicated, over the past 15 years our department has -- and our state has invested a significant amount of resources in helping to build a very robust child service system for both children in the custody of not only the department of child and family services but also the division of juvenile justice services.

So they -- those two systems basically have access to the mental health, the physical health services, and those families as well. So we -- we've invested and developed an incredibly robust array of services and supports for children and families who are not -- who come to the department's attention. And I think that's one of the reasons that we have been able to do as good a job as we have done at not only reducing the number of fatalities but also being able to keep children safely in their homes and in their communities.

In terms of the provider -- our provider system, we also have developed and take the responsibility of oversight of our private provider system very seriously and office of -- we have -- within the Department of Human Services an office of licensing that have very strong standards of care for all of our provider system at the various levels and license those systems, and we do ongoing contract monitoring both not only for just the basics in terms of life safety, but also programmatically for those providers to ensure that children that are in substantive care and the responsibility of either the department or this particular division are really getting the highest quality of care that we can provide. So I think those are two of the things that we have done over the last 10 to 15 years. I've been involved at some level with both divisions of juvenile justice and child welfare for a number of years, and I think those are some of the reasons.

CHAIRMAN SANDERS: Thank you.

Let me ask one final question about the reviews that you do. You indicated that the reviews were important in providing information particularly to supervisors about overseeing practice, and you also talked about the reports being protected, so a couple of things. One is: Can you say a little bit how supervisors are using information from reviews to impact practice and can you also say a little about the decision to protect the reports?

One of the conversations that we've had is the issue of openness and it sounds like you made the decision to protect the information in reports probably for a number of very good reasons. But can you say how you balance some of the issues of openness with that?

CHERYL DALLEY: It was felt that it was important to have open and honest discussion during our Fatality Review Committee meetings, and we did not want committee members to have the fear that they might be called to testify in some judicial proceeding or something like that.

So the analysis of the body of the report is the protected part. The body of the report is whatever -- the information in SAFE would be confidential. I suppose it would be have different classification. But just the analysis and the recommendations are protected. That information is sent to Brent as Director of DCFS, to the director of the region in which the fatality occurred. And then from there it is shared with -- I'm sure with the supervisors. Additional training goes on. If action needs to be done with a particular caseworker, that -- that action is taken in the region. Perhaps Brent can speak more completely to that issue.

CHAIRMAN SANDERS: Thank you.

Commissioner -- Mr. Platt, did you have --

BRENT PLATT: Yeah. We -- I don't know that I can speak too much more to that, but that - - that's exactly how it happens. There are oftentimes recommendations at a caseworker level. There are times when the recommendations are at the state level as well when they're requesting that we make change and they're requesting that we look at an existing practice guideline. So we take that very serious.

The regions have to report back when they've completed that task or that action item. That's how we kind of keep on track. I will see that during -- we have our own child welfare legislative oversight panel in Utah. There's a couple of state senators and -- I think two state senators and three state representatives. So they meet several times during the interim between sessions, and one of the processes -- it's actually pretty rigorous -- is they have access to all of the information.

So all of the information in these fatality reviews offline. We have a discussion with them, and they find out exactly what's going on, how are we responding, what are we doing to correct the issues. That's offline. That's protected. But it's a critical piece of the process for us because we're answering to our funders. We're answering to the lawmakers.

CHAIRMAN SANDERS: Commissioner Petit?

COMMISSIONER PETIT: There was a number of exchanges with myself and Commissioner Martin and others. For the -- can you just go back to the number of kids killed for a minute? You're showing seven for each of the last two years. But was there some consensus that there's some number that's roughly known or not known of children who were killed that were not known to the department in your reviews.

CHERYL DALLEY: Yes.

COMMISSIONER PETIT: So how many is that a year? Is it two? Is it 20?

CHERYL DALLEY: I have no idea. My -- my scope is directly with the Department of Human Services and with individuals who have been served there within 12 months of their death, so I have - - I don't know.

COMMISSIONER PETIT: But I guess the reason -- there's several studies nationally that you may or may not be aware of, you probably are, but that speak about the under-ascertainment of child fatalities due to abuse and necessity. Right? And it speaks of them being 50 percent under-ascertained, more even than that. In other words, they would say that a figure of six is really closer to nine or 12 or 15. But at this point they have not been so classified by you within your fatality review process: These children died of abuse and neglect not known to the department. That's not a category.

CHERYL DALLEY: That's correct.

COMMISSIONER PETIT: Okay. Yeah. No.

BRENT PLATT: I have some information here that says in the calendar year 2013 there were an additional six child fatalities that were not known to DCFS. So I don't know if that helps at all but --

COMMISSIONER PETIT: No, no, no. It does help. I mean, I think it helps all of us. What it speaks to, again, is the mere fact that they're not so classified, doesn't mean that they didn't occur. They did occur and they --

BRENT PLATT: That's a great point.

COMMISSIONER PETIT: -- they were known to somebody out there. And it sounds like you have a lot of things going -- and, David, in response to one of the questions you had, I mean just bluntly, Utah starts out with a stronger situation to begin with. It has a very low out-of-wedlock birth rate, has more lower rates of poverty, has much more intact families, and it's got a social safety net that is actually stronger than in most places. It may not be all that you'd like, but it's stronger. So I don't doubt that they have all the problems anybody else. They just don't have it with the same intensity as some other places have.

But I did want to ask, what are your worker caseloads and what are your worker turnover rates?

BRENT PLATT: So for Child -- DCFS I'm a little bit embarrassed to say this, but our caseloads are right around the national average. So for CPS they're, you know, between 12 and 15, 12 and 16 cases that they're assigned a month.

COMMISSIONER PETIT: You said national averages. Do you mean national standards?

BRENT PLATT: I'm sorry. National standard, not national average. Yeah, this is not the average --

COMMISSIONER PETIT: They're not national average, no.

BRENT PLATT: -- the national standard.

COMMISSIONER DREYFUS: Case is family?

BRENT PLATT: I'm sorry.

COMMISSIONER DREYFUS: Case is family.

BRENT PLATT: A case is family -- so a child protection worker works with 12 to 15, 12 to 16 cases per month. In home -- for home-based services we're actually in the process of weighting our home-based caseloads because with HomeWorks there's some expectation based on this assessment that a caseworker might spend three or four visits a month out there at the home. But they're around -- right around 15 to 18 cases. Some regions are a little bit lower, some are -- anyway, right around there roughly. And then foster care is around anywhere between 12, 15, 16, 17 cases. Of course rural areas they may be a little bit lower, but we still need the staff to - - you know, we need the presence.

We're -- were fairly comfortable. I will say that our caseworkers, they have quite a bit to do with the UFACET, with teaming, with reports, with -- you know, with coordinating services, but I can't complain about our caseloads.

Our turnover rate, this is probably a year or two old. It's around -- so turnover like leaving the agency.

COMMISSIONER PETIT: Yeah, leaving.

BRENT PLATT: I'm going to say it's between 12, 15 percent.

COMMISSIONER PETIT: We've been in jurisdictions where it's 40 to 50 percent.

BRENT PLATT: Oh, yeah, yeah, yeah. We're very --

COMMISSIONER PETIT: David, may I ask one last question?

BRENT PLATT: -- very happy.

COMMISSIONER PETIT: Can I ask -- it isn't clear to me that I could assert that you going from 12 to seven was the result of anything specific that you did. It could be -- you know, because it hasn't happened long enough, the numbers aren't big enough.

But let's ask, do you think there is anything that has caused that specifically to happen? And I'm speaking especially with law enforcement, with prosecutors, with cops. Have you been in situations where a relationship that you've had with them through some kind of memorandum of understanding or whatever that would cause you to go into a situation and basically preempt a kid at high risk of being harmed or killed in a situation? What kind of a specific relationship do you have with them on high -- high risk cases?

BRENT PLATT: It depends on the jurisdiction. We -- overall we have a really good relationship with law enforcement, but I will say that's also probably one of our weak spots. And I don't know if you'll hear about that today, but that's an area where I think we need to do a better job working with prosecutors and also working with law enforcement to make sure that we're sharing information that's -- when we're not in the crisis.

But we have -- we have different teams - - depending on the jurisdiction, we have child welfare, child protection workers who are -- they are assigned to a team of law enforcement folks to go out and investigate these cases. They work together to get kids interviewed at the Children's Justice Center, et cetera, et cetera. So I will say it's more hit than miss, but there's plenty of work that needs to be done from DCFS's perspective to do a better job partnering with law enforcement and prosecution.

COMMISSIONER PETIT: Thank you.

CHAIRMAN SANDERS: Thank you.

I know we have a few more questions, but we also are just a bit over so I'm going to suggest that we move to our next presenter. And will all three of you be here for any length of time, at least through the next break?

LANA STOHL: Through the next break.

BRENT PLATT: I'm really anxious to hear Kansas, so I'm going to be here through the morning actually. I really want to hear what they're doing.

LANA STOHL: And I will be here through the next break.

CHAIRMAN SANDERS: Great. So --

CHERYL DALLEY: I can stay.

CHAIRMAN SANDERS: So maybe if there are questions, we can catch you over the break. Thank you very much.

COMMISSIONER DREYFUS: Thank you very much.

COMMISSIONER COVINGTON: Thank you so much.

CHAIRMAN SANDERS: So we next have Kristine Campbell who's an M.D. and associate professor at the Department of Pediatrics at the University of Utah. Dr. Campbell.

DR. CAMPBELL: Can I clarify how I control the power point?

Hi. So thank you so much for the opportunity to come and speak with you guys today. You told me to do that. Sorry.

So I'm -- is that too loud? So I'm an associate professor in pediatrics here at the University of Utah. And in that capacity I work as a general pediatrician, as a child abuse pediatrician, and also as a clinical researcher. My clinical research that I'm going to be presenting today in particular is really focused in trying to understand how we can improve outcomes for children and families who have a history of CPS involvement.

So I think I first started to recognize this interest while working as a general pediatrician on the Navajo reservation in Chinle, Arizona, right after residency. As a general pediatrician in this setting with an emerging interest in issues related to child maltreatment, I found myself in a somewhat unique situation of serving as a primary care provider to families who really cycled in and out of CPS over many years.

The families that caught my attention the most were not the really disaster families. Right? They were the families that actually managed to change things, to turn things around emerging from years, maybe even generations, of abuse or neglect. The families managed to stop, as far as I could tell, which, granted, was a limited perspective, a cycle of violence and neglect which had really stigmatized and really hurt their families over many years.

The problem was I couldn't figure out what this critical change was. I couldn't figure out what triggered the change. And moreover from my limited perspective I couldn't figure out if that change really sustained the families so the kids five, 10 years down the line really had an improved outcome. So that experience of change in a few of the families that I really came to know for those years has continued to shape my research questions.

Today I'm going to try and present and sort of integrate findings and data from four different projects that I've conducted while here in Utah that relate to risk and to changing risk in families with CPS involvement. I'm going to be presenting three quantitative studies, so statistics and numbers, although I'm not going to get too complicated on that.

COMMISSIONER PETIT: Doctor, could you pull the microphone a little bit closer to you?

DR. CAMPBELL: Yeah, sorry.

CHAIRMAN SANDERS: Thank you.

DR. CAMPBELL: Intimidating. Is that okay?

COMMISSIONER PETIT: Yes.

DR. CAMPBELL: Okay. I'm going to be presenting three quantitative studies along with one qualitative study which gives us words and stories that highlight how we think about child maltreatment. I'd like to pause -- first I'm going to stop and I'm going to pause and think about the constructive risk, which I know is something you guys think about a lot. It seems like an obvious question, but I think we need to be really specific about what we say when -- or what we're thinking when we say risk.

Then I'd like to examine the ways in which we could try to measure risk in CPS-involved families and how we look at change in CPS -- change in risk in CPS-involved families, and then in sort of an ultimate circular argument try and figure out how -- whether risk reduction really reduces risk. In other words, if we reduce risk factors, do we reduce risk of bad outcomes.

Finally, sort of veering off way outside of my area of research, I'm going to start trying to identify some challenges and recommendations that I think may be more specific to the question of eliminating child abuse fatalities but certainly are things that I'm continuing to work on in my research as well.

So as I said, one of the research -- one of the research projects that I've recently completed is a series of qualitative interviews with CPS-involved mothers of children who have remained at home after a finding of child maltreatment, specifically physical abuse. The experiences of these women are not generalizable. It's not like statistics. But I think they do humanize the way that we think about these problems, and I know that for me their language has really changed the way that I start thinking about issues. So throughout the presentation I am going to include brief quotes, non-identifiable, of women that I think prove to point out more interesting facets of otherwise dry data.

So one of the things I took away from many of my interviews was the fact that woman women really do recognize that there's a lot of risks in their home, and they really do want to figure out how to change things. This woman, in fact, said I was hoping that it would be good when she recognized that CPS was becoming involved and that things would change and that we could all just get along better.

I also want to take time to point out a couple of caveats. First of all, my research describes what happens after a societal response to maltreatment. My research really doesn't focus on child maltreatment fatalities, which I know you guys are used to, but is worth repeating. And the goal of my research was really to expand our view of what might be accomplished in the moment that CPS enters a household, becomes involved with a family.

At various points in this research sort of pathway over the last few years the media has taken up some of the research I've published and decided that I hate CPS which is not the case. I work closely with them. My goal is not to scapegoat CPS in this process. It's really to say that they have a huge burden and it's not a burden that we should expect them to bear alone. Actually -- so that quote actually goes well with that. When I started the research I was

hoping that it would be good and things would change and we could all just get along better, and I actually came to know Director Platt when someone from the newspaper called him about one of my articles that had nothing to do about -- do with Utah.

So okay. So understanding risk. Let's talk about that. When we say risk what do we really mean? It's a term we don't use very carefully, at least I don't. Maybe you guys are better. And I think it feels like it gets very mushy around the edges sometimes.

Risk factors need to be used to stratify a population into groups in which an outcome of interest is either more or less probable, so high or low risk. And to do this, risk factors have to be associated, sort of statistically associated with that outcome, and they need to be present before the outcome occurs. It can't be just right as you enter the house. Right? So, for example, that child abuse fatality question that was being discussed earlier, it's not a risk factor if they die the first time that CPS enters the house.

It's important to recognize that some of the risk factors are really fixed traits -- so child age, child race, all of those issues, history of CPS involvement -- while others may be more malleable or modifiable conditions, such as poverty or intimate partner violence. And I am not going to try and argue that those are easy to modify or easy to change, but that -- that possibility exists.

And finally something that I know has been discussed here but we often forget is that risk factors in and of themselves are often not causal factors. And so we focus on them. We don't actually know whether changing them is going to really help things. Because, I mean, really if CPS involvement was going to be a directly causal factor in the cause of child maltreatment and fatalities, your job would be over, you could just actually shut down CPS and it would be over. But it doesn't work that way so -- it would be nice.

Okay. So I'm a sort of visual person and sometimes I also like to play with PowerPoints, so excuse me but -- so this is an example of what I'm talking about. So we know about one in 100 kids are found in their homes to be abused in a year, 99 out of 100 are not going to be abused. We know that a finding -- a CPS finding in the past is going to be associated with that -- that subsequent abuse and we know that finding by definition really has to happen before. And so in that respect it is a risk factor. Right? It's associated and it occurs before. But it's not a very interesting risk factor from my perspective because while it's great for identifying kids, it doesn't really tell me what I can change.

And so let's just say that we found some research that said that poor mental health was really a great indicator, a great risk factor associated with subsequent abuse. That suggests something we could change. And so say that we change mental health and then we can actually change the fact that perhaps abuse happens, because certainly that would be a really nice outcome.

But the fact is that much of the time we make those changes but abuse does still happen. And so then we're left with wondering, well, what are we supposed to do. I mean, it's a good thing to change a caregiver's metal health or to improve a care -- to improve a caregiver's mental health, and then we need to start looking at how other risk factors may be involved. Maybe in fact intimate partner violence is out there and is somehow not only directly associated with

abuse but may also moderate or mediate how mental health is expressed in that family. Obviously none of these are actually the solution and it's very complex, but I think it does point out how we really need to be cautious and thoughtful when we talk about risk factors.

And so why do I think that understanding risks and understanding what we mean when we say risk is important? Because changing outcomes, which is what I'd really like to see us do, requires that we use this term very carefully. Predictive risk, which I know has been discussed with this commission, is absolutely necessary, but it's also not sufficient. I think that something like 60,000 children under the age of six will be found to be victims of child physical abuse this year. And we know that those kids are at some increased -- actually high increased risk of fatal maltreatment over the coming years before they enter kindergarten.

But we need to understand how to change that risk because the fact is that we can't go and put all those kids into foster care. And despite, you know, the love of every helicopter parent in Utah, we can't wrap them all in bubble wrap. And so we really need to sort of start thinking about what changes are important and then how we make those changes.

So the research I've done begins with the premise that CPS involvement in the home is an indicator for risk. It's a risk for family disfunction and for poor child health outcomes and even for fatal and near fatal child maltreatment, but it is not a malleable risk.

CPS involvement is a unique window of opportunity because really in modern U.S. society there's actually very few sanctioned opportunities that I'm aware of where outsiders can enter a high risk home and really try to engage for good and really try to change things to improve outcomes for children and families. But it's really difficult to prove when that's been accomplished.

So for this woman who had an infant hospitalized with serious abusive injuries we wasted our opportunity. The perpetrator was removed from the home and she said, then, "Nobody has tried to talk to me about it. I got a call from a cop like three months after the incident. He just made me feel like he was accusing me of something. He said, Okay, we'll follow up with you, but I never heard anything from him, ever, not CPS, not the police, not the hospital, nobody."

And this woman recognized serious risk factors in her household at the time of CPS involvement. "I tried to be really honest and say there's some things I want changed, but she didn't take any notes and she didn't ask me any questions. She just went back to her office and wrote it up."

The injuries to her child were relatively minimal so she saw an investigating caseworker once and never heard back until she got a letter in the mail 30 days later explaining the case had been supported. She was still struggling with sort of a sense of simmering violence in her home when I met her six months later at this interview.

So how do we measure change in risk? And I think child welfare datasets, they certainly compile risks. And from a research perspective, however, it's hard to figure out how to use those. Because as noted in the last slide, identification of risk factors, at least in the vast majority of cases, can be variable and the definitions may not be standardized.

Another critical problem is that for families and children who remain outside the foster care or intensive family preservation system, risk may only be -- may only be measured at the moment that that family hits up against the system, which doesn't really provide us with a continuous picture of how these families are functioning when we're not right there.

So I think the other thing that I know that you-all have heard about and which actually excites me enormously is the idea of linked administrative databases and this idea of escaping data silos. And I myself managed like after eight years to get some linkage here, and I'm very excited. But I also have to say that those are also very limited.

So the administrative datasets when they're linked together do reflect risk. However, again these tend to be the fixed traits or really episodic events in a child's life so we know age, race, ethnicity, the neighborhood they live in, the doctor they go to. We know if they have a CPS report. We know if they have an inpatient encounter, school expulsion if we've got schools in there, births, deaths, and things like that.

But measuring change in those systems with that data requires us to make broad assumptions about why a family may or may not have had a finding of maltreatment, why they may or may not have gone in to see a therapist, and why they may or may not have graduated from high school. And so again that administrative data alone may not be enough for us.

And so we are stuck with the very clunky and challenging issues of research databases. And for many questions these longitude datasets are far more likely to provide granular detail regarding malleable risk factors than our administrative datasets ever will. They enroll children and families based on particular criteria and then systematically follow them over time with data collection that's really intended to look at research questions.

What's unfortunate is that these longitudinal research databases exist all over the country, there's tons of them, and none of them ask questions about child abuse because of perceived sensitivity. Believe me they ask a lot of really rude questions, but they don't ask that question. Okay? So I think that that's unfortunate. I don't know that I can change it.

Today I am going to be presenting research that draws from LONGSCAN, which was the longitudinal studies of child abuse and neglect, a consortium that came together. I think you all -- I think you heard from Dr. Runyon really when researchers around the country recognized common research goals that they were all doing independently and then brought them together under some common -- common measures in the early the 1990s.

And then I'll be presenting also some studies from NSCAW, which I think really grew out of the LONGSCAN projects but then tried to use a stratified survey sample that allowed us to make some generalizable estimates of national populations of CPS-involved children rather than just limiting it to those children who were recruited for the study.

So in this first study what we did was we looked at malleable risk factors for almost 600 children who were enrolled in the LONGSCAN study at four years of age. Using the LONGSCAN data we sort of followed -- well, we followed this group of children until they were about eight years of age. Some of these children had a CPS -- had CPS involvement. About 164 of them had CPS involvement during that four years, and the remainder did not.

We adjusted for static traits and past events that we were able to detect at the -- at baseline measurements, and then we looked at the change in malleable risk factors over time. And so then what we did was looked at the adjusted difference in change in risk factors over time between these two groups, between the groups that had CPS involvement and those who did not to try to define the change in risk that would be associated with CPS involvement.

This is a lot more information than we're going to go through right here. But what I can tell you is that we looked at social support, family functioning, household poverty, maternal education, maternal depression, anxious child behaviors otherwise known as internalizing, child behaviors and externalizing or aggressive child behaviors.

And what we found if you look in that final column is that for the most part there was no difference. These two groups of children, you know, all high risk really in the LONGSCAN studies, some with CPS involvement, some with not, really had no difference in the way that those risk factors changed over time. The only difference was that in maternal depression they actually -- the kids who had CPS involvement there was much higher chance of having maternal depression or higher rates of maternal depression in that group as we went along over time.

So now one way that you could interpret this in a positive light actually is that CPS involvement right there, that dot on that line, represents rock bottom. Right? So really because I'm only looking at four and eight years of age, maybe we're seeing really a positive, maybe they're rebounding. Okay. And I think that's a really hopeful and legitimate question.

If true, the difference in risk should be most notable close in time to the CPS -- the time of CPS involvement. So we reran the analysis really looking and comparing families that had early CPS involvement versus late CPS involvement over those four years, but what we found actually was the opposite, which was that the farther away you got from CPS involvement the worse off you were. So really these families just -- there was no change and then they continued to decline over time from CPS involvement.

Then we looked at whether risk changed after CPS involvement using the NSCAW dataset. And in this way we could look at how it was reflected in the national population of CPS- involved children. Remember that -- well, I don't know -- I was going to say remember. But in NSCAW there is no non-CPS-involved population. These are only kids who had CPS involvement.

And so what we did in this case was we looked at children who had some baseline risks, and then we simply coded whether those risks were present or absent and then looked at them at 18 months and at 36 months and simply tried to describe how those risk factors changed over time since CPS involvement. We also -- yes.

COMMISSIONER PETIT: Does any of this allow for what CPS is actually bringing to the table, you know, small caseloads, big caseloads, training access to services? I mean, what's the CPS variable? Wouldn't surprise me that the first out you get from CPS the worse your problems get. While they were involved something constructive was happening perhaps, and then as the move -- but what's the CPS variable? Is there one?

DR. CAMPBELL: So in the LONGSCAN study we only had -- were only able to use the CPS variable itself. There was no -- unfortunately the way that LONGSCAN was collected --

COMMISSIONER PETIT: There's no qualitative assessment of the CPS intervention.

DR. CAMPBELL: No, not in the LONGSCAN.

COMMISSIONER PETIT: We just heard a state that says they have 12 to 15 cases, and we've heard other states where it's 50 cases. I would expect different outcomes with 50 cases than 12 to 15. Right?

DR. CAMPBELL: Absolutely, and in LONGSCAN -- yes, definitely.

I will also say I think there's some other issues in those. Many of the risk factors that we looked at are things that particularly at the time of LONGSCAN and even, I think, at the time of NSCAW were not being as strongly viewed as sort of within the realm of CPS, so I don't know that anyone expects them to change poverty.

So then we looked at -- so in the NSCAW, although there's still limited CPS variables, we did try to look at whether or not families were referred for risk-specific service and then we also tried to compare to general population estimates for those risk factors for those factors that were available.

And this does not -- I was hoping it would look a little better, but it doesn't, but just look at the lines. So this first graph is poverty, and what we can see -- if you'd focus really just on that dark line that's sort of in the center of that graph, that's the main result. Almost 50 percent of children entering CPS for a first time -- and these are first time -- first time investigations for child maltreatment where a child remains in the home. Almost 50 percent of those children were living at the national poverty level, and that did not change in any significant way over time.

If you look above that, those are the ones who were referred for some sort of risk- specific services. In this case the variable that was available in NSCAW was -- I think it was mainly cash assistance or DWS work. And then down below the hash line is the national average, so you can see they're well above that, and there's no change whether or not they were referred for services.

Poor social support, it actually looks like it trends towards an increase. This is statistically insignificant. But basically about a third of women described their families as being extremely socially isolated at the start of -- at the time of entry into CPS, and this simply continued forward over time. There did not seem to be substantial referral for services on this. This was to crisis family support centers and things like that. And when it did, it didn't provide us significant improvement and in fact maybe reflected worsening over time.

One spot that was a little bit bright here was intimate partner violence. Twenty-two percent of women reported intimate partner violence in the year prior to CPS involvement, and that declined to 13 percent over those 36 months. And really although it was a minority of women who were referred for their -- for intimate partner violence support services, where they

were we saw a dramatic decline in that prevalence and so I think -- and our next study took off from that finding.

Corporal punishment remains unchanged. Maternal depression remains unchanged.

Drug or alcohol addiction was interesting. I think there's a relatively low reporting of prevalence. If you look at the bottom dark line, it falls below the national average. This obviously may reflect their -- some concern about providing this information in a research setting, although they were able to report a lot of other things they did. It also, I think, reflects that a lot of kids in these settings are removed from the home and therefore not included in my study sample because I was interested in kids who remained at home. Again, the positive note is that where they were referred for services, we see a decline over time.

And if -- I notice a leaning towards the microphone. I'm happy to entertain questions at any time if it matters.

Okay. Internalizing child behaviors or shy and anxious child behaviors, there was a slight --

CHAIRMAN SANDERS: I think we might -- do you have --

COMMISSIONER PETIT: No, I thought you had asked for questions, and I did have questions.

DR. CAMPBELL: I just noticed you leaning forward.

COMMISSIONER PETIT: Where you're saying no improvement --

DR. CAMPBELL: Go ahead.

COMMISSIONER PETIT: Where you say no improvement, no change, you could say no worsening.

DR. CAMPBELL: I could. You're right.

COMMISSIONER PETIT: Right?

DR. CAMPBELL: Yes.

COMMISSIONER PETIT: And that would be--

DR. CAMPBELL: No statistical --

COMMISSIONER PETIT: -- another control group over a period of time, big enough sample you'd say, gee, they kept going further and further down, down, down, kids died, whatever.

DR. CAMPBELL: That's true. I would say that if we -- so that's true in some of them. For example, in the poor social support, I think you could argue that if we had a big enough sample they would have gotten worse, worse, worse. And so it goes both ways.

COMMISSIONER PETIT: But let me just say --

DR. CAMPBELL: Yes.

COMMISSIONER PETIT: -- the question for us -- question for me. I won't say for us. A question for me on this thing is that you've got CPS all across the country being slammed. They're involved with three, four, five, six, seven, eight, ten notorious cases in which a kid dies. They're involved with 5000 other cases where a kid didn't die. So one of the issues is, is it possible to show what they're doing right as opposed to just what it is they're doing wrong?

I'm not defending them. I'm just saying that you could not abolish CPS today, I don't think, and say it doesn't exist and not expect to see a sharp increase in child maltreatment tomorrow.

DR. CAMPBELL: I absolutely agree with you. I also think, though, that it's important that we recognized where -- so again CPS is often very focused on immediate safety, and I think they do a great job. I think trying to make sure we understand not just where CPS can help but whether others can bring something to bear --

COMMISSIONER PETIT: Absolutely.

DR. CAMPBELL: Because they don't -- they don't work with the family for 36 months.

COMMISSIONER PETIT: No, exactly right. But is there a way to show what the positive impact is as well as the negative impact and all the other things that you're saying spin off of that? But have you seen any research, I haven't, that says look at how beneficial CPS is to the larger community in protecting all these children who didn't get killed or who didn't die? Is there anybody that's actually been able to control for that and look at it and say it did make a difference or it didn't make a difference?

COMMISSIONER RODRIGUEZ: That's what she was looking for.

DR. CAMPBELL: So I think -- well, I mean, I think -- so that's a good point. I was looking for it, although I think -- it reminds me most clearly of something -- of a conversation I had -- a conversation of a hypothetical experiment I had in -- in my master's program which was we -- you can't randomize children to receive CPS or not.

COMMISSIONER PETIT: Right.

DR. CAMPBELL: And so I think that, no, we don't have a way of doing that, and I think that the -- the expectations and the role of CPS have morphed so much over the time since, you know, child welfare began, you know, decades ago till now that even trying to compare before and after isn't fair. And so I do think they have a difficult job and I, again, do want to emphasize that I'm not at all trying to slam CPS.

COMMISSIONER PETIT: I'm not interpreting it that way --

DR. CAMPBELL: Good.

COMMISSIONER PETIT: -- but the 400,000 children that have been removed, they have been removed because they are, I suspect, believed to be the most at risk children of all. If you put them back on the table and said you're not in foster care, you're back at home, what would the outcomes look like? So before some -- some are rushing to say we don't need foster care. You know, you've got 400,000 kids in foster care. What would the alternative be to foster care?

DR. CAMPBELL: No, no, no. And I think that -- I mean, there is some research out there that suggests that children who -- you know, if you compare the children who enter foster care with the children would don't enter foster care, the outcomes for the children in foster care are generally -- are generally better. I think it's - - there's not a huge amount of research on that, but there is some. And I think the challenge is - - I mean I live in a state that for good reason but sometimes conflicted reasons highly values keeping kids at home even when there may be ongoing risk. And so -- I may get in trouble for saying that. And so I -- I think -- honestly. And so I think that understanding what we need to do when we don't put a child in foster care is important.

CHAIRMAN SANDERS: So I think we --

DR. CAMPBELL: Sorry.

CHAIRMAN SANDERS: I want to make sure - - I'm giving you a time check.

DR. CAMPBELL: Okay.

CHAIRMAN SANDERS: It would be important to go ahead and finish, and as commissioners why don't we let her finish and we'll have a chance for some questions afterwards.

DR. CAMPBELL: Okay.

CHAIRMAN SANDERS: So go ahead.

DR. CAMPBELL: And so then again sort of the aggressive and destructive child behavior problems did not change or did not get worse.

So the women who I interviewed did recognize that there was this sort of time limited aspect of CPS involvement, and they knew that they had priorities, but they sometimes worried about this. "Half my income just walked out the door," said a woman after her -- after her boyfriend had been put out. "I'm behind on my mortgage like four months so, you know, I would have appreciated more concern into that end of it. It was nice they wanted to make sure he was out of the house and my kids were physically safe, especially in the immediate. But looking at the long-term repercussions of what happened, I think that should have been a higher priority."

And then some women -- these are two separate women -- continued to have a sense of worry and anxiety not knowing whether or not there was adequate risk reduction to allow their children to be safe. "I'm still very wary of having to send them with their dad on his days when he has them. I get butterflies and sick to my stomach when I have to send them. I pay more attention to the stupid little things. His parents have a running joke like, oh, don't touch them, you might bruise -- don't touch her, you might bruise her. It's a big old joke. They just laugh about it. I try to laugh, but I take everything more seriously. I am very cautious. If he gets upset, I just always take precautions. I don't want things to be bad."

And so this final question -- final study was an attempt to answer that question: Can reducing risk improve outcomes? And we really did take off from the finding where we saw that nice drop in intimate partner violence in the NSCAW sample.

This time we looked just at children who were over two years of age remaining at home after a CPS investigation. And this gave us 320 children representing the experiences of almost 300,000 CPS-involved children. Although all the caregivers reported intimate partner violence in 12 months prior to CPS involvement, only 12 percent of them had caseworkers who reported referring to IPV services at the time of their involvement.

Forty-five of the women reported ongoing IPV at some point at 18, 36, or 80 months after CPS involvement. And what we did was we compared child outcomes based on the persistence of IPV. And in this case, the child behavior problems, which I've previously provided as a risk factor, become the outcomes of interest.

So what we saw here, and I think that this was encouraging to me, is that when we look at these anxious, shy, withdrawn behaviors, the kids -- although they start out the same, the kids in which IPV resolves in the home, the dotted line, we see a slight decline, 12 percent, from that baseline as the months from CPS involvement are extended.

More impressively perhaps is what we see in the aggressive and destructive behaviors, which I think is what we all believe sort of is something that happens in kids who witness ongoing violence. And for those kids where IPV really resolves, we see a dramatic fall even in that first section dropping 15 percent from their baseline. And in kids where IPV persists, we see a 10 percent increase from baseline, so that by five -- five years out -- five-plus years out from CPS intervention, kids with persistent IPV are 1.9 times higher -- have 1.9 times higher risk of having these -- these significant problems.

So I don't know why IPV stops. I'm not sure anyone exactly knows that. I think there's a lot of reasons. But one of the things I took was that women really were able to describe small actions that were taken by caseworkers, police officers, therapists, and medical providers that sometimes provided them with that extra push that they needed to make a difficult decision.

This was a Latino woman, so there's some sort of awkwardness of the translation, but she -- it took a lot to leave her husband. "My caseworker told me one or two things I have to tell you. First of all, I congratulate you on your decision and hope you continue to be firm. That is a very controlling man, very possessive. It's going to require a lot of hard work for you to get rid of him. I hope, my case worker said, for your sake and for the sake of your daughters that you continue firm. There are many cases in which women give in, and the ones that suffer the consequences are the children. It made me feel more certain of my decision and it gave me strength to continue forward with my decision."

She brought this up three times, just this little snippet, three times during a 60- minute interview. It made a huge impression on her. So I don't think we need to downplay the small things that CPS and others can do for woman who are in a situation of risk.

So the summary of what I've got to say today is simply that I do believe that the point of CPS involvement is a unique opportunity to identify high risk children and to support change for these children. The prevalence of malleable risk factors is high within the CPS-involved households. CPS involvement in the household does not really change the prevalence of malleable risk. It may be that it would increase or decrease without CPS presence, but we

can't do that randomized, controlled trial. So what I can say is that it doesn't seem to substantially alter it. The hint that I have is that when malleable risk factors resolve, I think the child well-being can improve, and that's a good thing to know.

So why then do we seem to miss that window of opportunity? And I think there's a lot of reasons, but part of it may be because we have historically set up our response system that essentially shuts the door at the moment that some modicum of safety has been achieved.

This woman said, "People that still have abuse" -- she was funny. "People who still have abuse in their family seem to get all this help from CPS. It's like, oh, CPS checks up on us every week because me and my boyfriend fight. I hear that from my friends all the time. CPS" checks up on this -- "checks up on this for this, for that." "Well, what about the families where there's no abuse left? I mean sometimes they need help too. Even though there's no physical abuse left, they still need resources and stuff to hold them. Sometimes you're not ready when you're right there, fresh wounds at the hospital, to get those resources. And then they just disappear and never come back, and I mean it's like they're punishing you for making sure your kids are in a safety environment."

So these are the words of a woman who had two children hospitalized with severe abusive injuries by the same person in two different years. We didn't support her after the first time and she didn't understand what happened because each time he left for a little while and then he came back. So she needed more than immediate safety. She needed someone to continue working with her even after safety had been achieved to really understand what had happened and the risk that she faced.

So here's the challenge, though. As I said at the outset, I don't -- I don't study child maltreatment fatalities. I think you guys have a really distinct challenge in preventing child maltreatment deaths because I can -- I think that we can probably find the malleable risk factors that are associated with child maltreatment deaths. And I think a lot of them are associated and even are causal -- I don't know that for sure, but are associated and causal for child well-being outcomes.

But I'm not convinced that they're really causal for child death, because poverty, maternal depression, and IPV may all be malleable risk factors associated with child maltreatment deaths, but poverty, maternal depression and IPV don't actually really cause child maltreatment except in some really rare cases. The cause ultimately is the action, the inaction, or the series of inactions of a person, and I don't think we understand what causes that.

So I'm going to just in finishing up -- I know I'm -- sorry, I'm probably running over my time. I'm going to run through some challenges, and I'm going to first say that I totally co-opted this logic model from a 2012 Milbank Quarterly paper by Leonie Segal, who I don't know, but who's written a great article trying to explain why we see varied results in the field of home visitation and child abuse prevention. It's actually got a funny title.

So to close today, I've sort of adapted this to think about ways that we need to move forward in thinking about how to reduce -- how to improve child outcomes but then also how to eliminate child abuse fatalities. So first of all, an important issue is defining objectives. Now

this commission already has an objective and that's to eliminate child abuse fatalities. I think that's really hard.

And so I actually would like to suggest that we maybe define the objective around what is our mandated response to suspected child maltreatment. And by that I don't just mean CPS, but what is the societal response? What are the priorities of that response? Are we more interested in investigation or mediation? And are we more interested in societal justice or child health?

And while I like to think, I think we all like to think, that those can operate in parallel, there are moments at which those priorities are opposed to each other. And I --

CHAIRMAN SANDERS: Dr. Campbell, I just want to step in for a second. You probably have about two minutes to finish.

DR. CAMPBELL: Okay. That should be perfect.

And then what are the resources that we can bring to bear once we've decided what those priorities are? Our subpopulations include who's at risk, and I know that this commission has already been trying to sort that out and understanding that we may need different approaches to each of these different subpopulations.

We need to develop and test a change theory, and I think this is where we sometimes fall down. We identify our populations at risk and then we try and do something without having a theory of understanding what changes are critical to achieving that objective. So it's sort of painful to acknowledge because I'm a huge fan of just trying things and seeing if they work, but we're talking about huge efforts to just try things. And so I think having a theory that we can really operationalize is critical. It requires hypothesis-driven research, breaking down data silos, and asking for input from those most affected.

And once you have that change theory -- or that theory of change, I think you can develop programs based on that that will be something beyond saying we need to provide parental support. There's not going to be one solution for every one of the conditions. We have to collaborate and innovate. And in addition to moving past data silos, we need to move beyond service silos and get all of the different providers to start working with each other.

We need to measure success and failure based on the components of that theory model -- of the theory of change because it's going to be really hard to pick up the signal of just the numbers of deaths or near fatalities also, I think. And I think that we also need to recognize when things aren't working because we can't just continue to fund things if they're not working.

So this was a way of celebrating success because this woman really made me both sad and she also made me laugh. Not everyone's going to recognize when we've done good, right, when CPS does change things. My interview with this woman was marked by complete shock. I couldn't believe she was actually still alive and sitting in front of me and that her child -- her children were still with us.

She was so angry at CPS I can't even tell you. She said, "My life today, I can't even believe that I'm sitting here and I'm okay because a couple months ago if you'd asked me if I would ever be okay again, the answer would have been no, and it all did start with CPS." And then she said, "But their involvement -- except it's not in there. And then she said after this, "But their involvement was just ridiculous. It was ridiculous." She was so angry.

She did not acknowledge the help that she had been given, but I could see that she'd been given help. And we're not always going to win that battle. But she'd had a enormous number of service providers from all different areas from first responders to police to jurists. Everyone helped her achieve that goal.

Thank you guys very much.

CHAIRMAN SANDERS: Thank you.

We have time for a couple of questions.

Commissioner Martin?

COMMISSIONER MARTIN: So one of the questions I have is -- first of all, thank you so very much for the work that you've done and presenting it to us and giving us an opportunity to try to understand it.

Other than the group of DV and the substance abuse to the extent that you saw reductions, can some of the results be explained by the services that were actually engaged? So sometimes I think -- as a judge oftentimes I will be asked to codify a recommendation for anger management, you know, and now talking to domestic violence advocates, you know, that may not be the appropriate service for a perpetrator, a alleged perpetrator. Right?

And so I often wonder whether or not the services we're actually requiring people to participate in are the things that are going to actually effectuate a change. And so I'm wondering if in fact rather than looking at it as CPS involvement whether or not it's actually the service that is not coming up to the line.

DR. CAMPBELL: So I think, first of all, in my research there's no way to figure that out. Trying to -- trying to sort out what resources people used or when they were involved is almost impossible even within these longitudinal databases. I do think that there are incredible challenges to trying to answer what I would view as really a critical question: How does the change occur? Right? Because if we're trying to change risk, how does that change occur.

COMMISSIONER MARTIN: Right.

DR. CAMPBELL: And what we've seen -- and I think you guys are probably familiar -- sorry for the familiarity. I think the commission is probably familiar with -- with research that has really tried to sort of pull this apart. Right? So if we look at people who enter substance abuse treatment or if we look at families who get ongoing services, do they get better or do they get worse compared to the families that didn't get services? The problem, of course, is they almost always look worse, but that's sort of why they got services to begin with.

And so it becomes incredibly difficult. And in my mind there's two ways to address this from a research perspective. Okay. So from a -- from practical perspective of what are we going to do today with the families that come to court today, I think we continue doing the best work we can. You can't stop.

COMMISSIONER MARTIN: Sure.

DR. CAMPBELL: Right? But so in terms of a research agenda, what needs to happen I think is this issue of a change theory. We need to -- we need to have people who are smarter than me, smarter than a lot of people come up with really strong hypothesis-driven research about what causes these changes, because I think you could then measure that. You could look at that. I don't think you're going to be able to randomize people to get good services versus bad services or even just services versus no services. No one's going to be comfortable with that.

But if we could have a theory as to why change happens, then we could look at whether the process really affected that area. And then we would be able to design programs that work to address that area of change.

COMMISSIONER MARTIN: During the break I'd like to hear your theory about protective factors and strengthening, as opposed to looking at and focusing on the risk factors of a family, looking at the protective factors and making concerted efforts to increase and strengthen the protective factors. Because I think from where I sit on the bench that's the difference.

DR. CAMPBELL: Okay.

COMMISSIONER MARTIN: You know, people come in with very similar looking families with risk factors, but the ones that make it, you know, whatever make it means to you, right, it looks as if they have this internal umph. Right?

DR. CAMPBELL: Right.

COMMISSIONER MARTIN: They have this thing that allows them the ability to rely on their resilience -- the resiliency and they make it. So thank you.

DR. CAMPBELL: No, I would appreciate the conversation.

CHAIRMAN SANDERS: Commissioner Covington?

COMMISSIONER COVINGTON: It's really a comment maybe and if you had some thoughts on it. As you were presenting this -- we're doing a lot of work on looking really upstream, and all I could think about is taking those graphs you've created and try to put in different types of other interventions before they even have to -- you know, families come to the attention of CPS. I'm thinking of, you know, the new intensive home visiting programs, et cetera, et cetera, where you can start making some of those changes occur.

One of the other questions I had for you, though, is: Did you do any weighting on any of the risk factors -- weighing -- weighting -- weighing on your risk factors to see if any of them were more causal, maybe not causal, but is domestic violence going to be a more important risk factor and have more weight on whether further abuse continued versus other pieces such as poverty or what have you?

DR. CAMPBELL: So the answer is no. One of the problems that NSCAW I think -- you know, one of those things that you recognize only too late in the process, at least the first NSCAW survey -- I know they're repeating it -- was that they didn't adequately capture repeat entry into the system. LONGSCAN did a great job of that but wasn't able to capture risk factors quite as nicely. So no dataset is perfect.

So we were unable to really look at that. I know that there's unpublished data from LONGSCAN which has attempted to look at what risk factors, what exposures seem to be most related to negative outcomes, not child abuse fatalities but negative outcomes for children. And I will say that my conversations with those investigators suggest that IPV, intimate partner violence, is -- is a big factor.

Now, I think that it really does seem to be driving a lot of the negative outcomes we see in kids. There is -- and I think this gets into the ACES work, the adverse childhood experiences work, of Vince Felitti and all of those. There is a paper by Finkelhor, et al., where he really did try to look at not just -- he looked at all of the data he has, which is a ton, and tried to pull out which adverse childhood experiences, not just limited to the original 10, were related more substantially to negative -- or to trauma symptoms in children. And he came up with -- I think it was about 18 or something like that, dropped out a few that I think many of us now wonder about, you know, divorce or something like that and added in some others. And so that would be a study I might recommend. I think it was in 2012.

CHAIRMAN SANDERS: Commissioner Rodriguez and we'll see if, Commissioner Petit, we have time for one last question.

COMMISSIONER RODRIGUEZ: I just wanted to say I really actually appreciated the frame. I think it's consistent with much of what we've been discussing about the need to sort of think about child protection much more expansively and how focusing on safety often is at the expense of focusing on well-being, that we've taken a one or the other sort of approach that hasn't in the long run served families and children well.

And I guess my comment is just I know that the story that your research tells, it definitely resonates personally with my own family's experience. I was removed and that was it, and both of my parents deteriorated even though the case was in reunification. And I think it's also -- it was my own experience in care as well, that removal was seen as that intervention and then nothing afterwards.

But I am really curious about the variables that you chose in there and why you didn't, for example, choose substance abuse or why you focused in on maternal depression as opposed to other types of mental illness. Was that intentional or was it the easiest to measure?

DR. CAMPBELL: So I think those are great questions, and although I sang the praises of research databases, they are limiting also when I'm not the person who created them.

COMMISSIONER RODRIGUEZ: Got it.

DR. CAMPBELL: So to a certain extent they --

COMMISSIONER RODRIGUEZ: They were the ones acceptable.

DR. CAMPBELL: -- they were there. They also do have some link to -- they have -- you know, they have been associated with child abuse and child well-being in other research, and so there was a sense that there was at least a research grounding for their selection.

And I'm not sure if this is what you were intending by some of that question, but at the time that these research databases were put together and also because of who tends to answer survey questions, the role of the father is overlooked not just in child welfare work and not just in, you know, pediatric engagement with families, but it's also been ignored I think a bit in the research database world. We still don't really understand the role of fathers and how important that may be.

COMMISSIONER RODRIGUEZ: Okay. Thank you.

CHAIRMAN SANDERS: Go ahead, Commissioner Petit.

COMMISSIONER PETIT: Just one quick question. You've mentioned, I think, but where was the sample drawn from for CPS? Which CPS agency? Was it a melding of CPS agencies or was it a single state's CPS agency?

DR. CAMPBELL: Okay. So -- and I'm sorry I didn't explain that very well. So the LONGSCAN study, the first one, those were five different regions around the country, and it's a bit of a mishmash. So there was an adjustment for what -- for where they came from. And in order to explain that I'd be happy to, but it's -- I think the best -- the best statement would be it's not generalizable. They chose -- they had five different existing studies. Some of the kids were CPS involved and some of them weren't.

COMMISSIONER PETIT: I think both Commissioner Martin and I raised the same question about what is the qualitative nature of what CPS was doing? Were they -- you know, is it the same across all the regions?

DR. CAMPBELL: No.

COMMISSIONER PETIT: And the answer is, no, it's not.

DR. CAMPBELL: No.

COMMISSIONER PETIT: So we don't know if it makes a difference good CPS, bad CPS.

DR. CAMPBELL: And then -- and then the NSCAW study, the subsequent studies that were shown, are drawn from around the United States. Not every single state is represented and in fact Utah is a state that wasn't represented in that. But they used a sampling procedure that was -- that they at least tell us and has been used in multiple settings to suggest that it is generalizable, with certain caveats, to the national population.

Now, whether they fully -- they have an entirely different dataset that is about CPS involvement. It's smaller because I don't think they got all of that information. But I haven't worked with that as much, and so I don't know whether you can judge quality on that.

CHAIRMAN SANDERS: Thank you very much.

DR. CAMPBELL: Thank you.

CHAIRMAN SANDERS: Very informative and different information than we've had before. Thank you very much.

So we are at the point of a break. We'll break for 15 minutes and reconvene with our next panel.

(A break was taken from 10:30 to

10:55.)

CHAIRMAN SANDERS: We are very fortunate to have this state's top prosecutor with us, the Attorney General, the 21st Attorney General of Utah, Sean Reyes. And we had an opportunity to talk a bit during the break, and I think the experience and commitment that he brings will be evident, and we're very fortunate to have him to testify.

Attorney General Reyes.

ATTORNEY GENERAL REYES: There we go. Thank you very much, Mr. Chairman. And members of the commission, welcome to the great state of Utah. We hope you've enjoyed your stay, and if we can do anything else to accommodate you, please let us know.

I looked briefly at the other witnesses today and saw that you had an incredibly distinguished panel of subject matter experts. And I wanted to add I thought it was wonderful that you didn't have any politicians coming and speaking to you today because I hate politicians. I'm going to tell you why. My definition of politics, and some of you may have heard this before, but the etymology comes from two root words, I believe, poly meaning many and ticks mean little blood-sucking insects. And if you combine the two, you kind of get a feeling for my view on politics.

But I believe politicians tend to ask the question what can a particular title, what can a particular position do to serve the individual. Conversely, public servants ask the question what can the individual do to serve the office, the position, and the people that it represents. And I can't think of better public servants in my mind than you-all and the work that you're doing and the many who've come to testify and who are represented here in the audience today.

I have many friends that we've worked with closely in my short tenure as Attorney General and have come to admire them greatly for the work that you do. So again -- that they do, excuse me -- thank you for what you've been doing over the past five years throughout the country and in Washington D.C., first as part of the national coalition to end child abuse deaths which led to the introduction and passage of the Protect Our Kids Act of 2012 and the establishment of the commission to Eliminate Child Abuse and Neglect Fatalities bringing us here today.

I might add that the acronym, I guess it's CECANF, is much better than when I served on one particular congressional presidential commission. It was the National Museum of the American Latino commission, and the acronym was NMAL, which any of you speak Spanish was particularly difficult to pitch people on the positive attributes of our of mission when the word "mal" means bad, and we didn't -- we didn't have the foresight to change that.

Last week I went to Washington, D.C. to testify before the House Committee on Foreign Affairs regarding human trafficking. And let me say, first of all, with no offense to those of you who are devoted beltway folk, after spending a week in Washington, D.C., it's great to be back in America here in Utah.

Why was I there? We -- there was an important international Megan's Law bill that Chairman Smith had put forward contemplating a regime under which HSI would be obligated whereas it's now just voluntary to notify our law enforcement partners internationally of any child sexual predators who've been identified in the United States who were traveling abroad. Perhaps they were traveling for legitimate reasons, but anecdotally we know that most of the time they're traveling to have child sex parties, create child pornography, abuse children in sundry ways.

And so I felt it was a very healthy policy to reach out, and if we have a Megan's law within our own borders that gives our citizens protection and notification of the whereabouts of identified child sexual predators, then why not have that internationally. And reciprocally our president would under this bill be encouraged to enter into MOUs allowing and encouraging our sister nations to notify us when their identified child sexual predators from within their justice system were traveling into the borders of the United States.

So anyway, it was a great opportunity to raise awareness about child sexual trafficking which is a subset of child sexual abuse which is a subset of what we're talking about today. So I don't mean to be particularly narrowly focused, but it is something that is of great interest and emphasis in my administration.

A little over a year, also to give you some context for some of the work that we've done in child trafficking and human trafficking, again with an eye towards getting back to some of the finer points of what our state has done in terms of protecting and trying to remedy the scourge that is child neglect leading to fatality or near fatalities.

But let me tell you a little bit on the trafficking side. A little over a year ago our office handled one of the largest, if not the largest, case in the western United States dealing with child human trafficking. And it was an international criminal from central America that through the bravery of some of our own minority communities came forward, helped us gather the evidence that we needed and helped us arrest this individual.

When our federal counterparts, law enforcement counterparts, found out about that, they said, well, that's great, we've had this guy on the radar for a number of years, every time we try to make the case against him, we can't get the witnesses that we need, they seem to disappear or are too intimidated. And so we asked them to illuminate that dynamic, and they said, well, we've deported him seven different times back to Central America, and apparently he just keeps coming back into the United States.

So we made the commitment to prosecute him here within the U.S. justice system, keep him here without deportation. And upon doing so, by the time we filed our charging documents, we had over 60 witnesses and victims who had come forward with their families. What this monster had been doing was raping little boys that he'd brought from Central America and also abusing children here in the Salt Lake County area and forcing them to mule, or carry,

sell his drugs, not into just high schools and junior high schools, but elementary schools throughout our community.

And when we did have this many witnesses finally come forward and feel empowered, during the pendency of the trial the defendant took his own life, and so in some ways there was absolute closure for these families on that side. And then we worked very hard to get the survivors the resources that they would need to begin the very long healing process to overcome the atrocities that they had just endured.

That experience opened my eyes to the prevalence of human trafficking in general, not just worldwide and far-flung countries, but right here. And if it can happen in Utah, one of our smaller population states in a relatively quiet and peaceful environment, then I propose it could happen anywhere in the United States and likely is happening throughout.

And so many of the most vulnerable in this enterprise -- by the way, it is the fastest growing criminal enterprise. It has now become the second most lucrative international criminal enterprise only behind drug dealing and leapfrogging arms dealing and counterfeiting, and those are themselves hundreds of billions of dollars industries. But it has become that -- that prevalent. And so many times the victims are children. And many times because of the lack of reporting I'm afraid that the victims not only suffer alive, eventually their lives taken and we just don't know about it.

So I believe that our efforts in human trafficking and thwarting child sexual trafficking and child predation all help bring awareness, help bring resources, help bring policy makers to the table a little more aware of the epidemic that there is regarding child abuse and neglect fatalities.

Another side note, and I -- my staff put this in here. Last October I joined a nonprofit organization based here in Utah called Operation Underground Railroad really with a desire to see up close and personally the inner workings of child sexual trafficking. I, along with other Utahns, posed as participants in a child sex party. We went down to Columbia and simultaneously in three different cities, including Cartagena where I was, we liberated 120-plus young girls and boys from the clutches of child traffickers, sexual traffickers, who offered them up like they were desserts to any paying customers, young boys and girls from the ages of 10 to 16 who'd been either abducted from their families or duped into believing that they were participating in some kind of legitimate enterprise, a modeling agency or other.

And in this particular case they had used a former Miss Cartagena to induce families to allow their young girls and boys to enter into what they thought, again, was a legitimate enterprise with no knowledge that their children were being prostituted out to primarily American and Canadian tourists who were, you know -- who were coming for -- for that purpose.

So working very closely with our law enforcement partners, we trained CTI, their version of the FBI in Columbia, their local law enforcement, their Coast Guard and worked hand in hand with their child and family services organizations. In fact, we refused to do any operations even at the request of their president and ambassador until they assured us that every available resource that they had on the child and family services side would be made

available, and in fact they were. They had 60 agents on the island when we -- when we helped liberate the 50- plus girls and boys who were in the Cartagena operation. Again, the 120 was cumulative from the -- from the three cities.

And organizations like Operation Underground Railroad and International Justice Mission, they are organizations that I would offer to you are ones that if you have not yet reached out to, that you should, if you have not yet correlated with, that you should. And our office would be happy to help facilitate those introductions. They do incredible work in many nations and continents throughout the world.

Just yesterday we had four representatives from Senegal -- judge, prosecutor, international humanitarian representative and government official -- specifically to address child sexual trafficking, child abuse and trafficking. Of course, the sexual aspect of it makes up about 80 percent. A lot of -- about 18 percent is hard labor, and so these children are put into circumstances that are atrocious that often lead to their demise. Sadly, again probably mostly unreported so we have no idea of the magnitude at any given time.

Other ways that they are abused, they're recruited to become conscripted, essentially, to become part of little military units for warlords or terrorists. Recent reports uncovered that many terrorist factions were buying up little boys for $100 a piece to strap suicide bombs to them and send them into the fray. Often the children are killed for their organs to be harvested on the black market and other, again, horrific consequences for being victims of trafficking.

So, again, I don't want to derail this testimony and overemphasize the trafficking aspects, but because we've done so much work and because we think your commission could be helpful in tying together some of the pieces with this component along with the many other groups that you work with, I offered that today.

Let me focus a little more specifically on what our state does here and particularly the Attorney General's Office in Utah. First, I know several organizations have addressed the child fatality reviews that are done annually here in the state. Our office participates not only in the state medical examiner's review but also the Department of Human Services review, and so as the Attorney General's Office we take an active support role in that.

Our office is absolutely dedicated to keeping families safe, and is particularly aggressive on crimes that involve children. As Attorney General I believe I have a legal and moral objection and responsibility to protect our state's most vulnerable which is why we've made a huge investment in the protection in children from abuse.

Our child protection division is our largest division within the AG's office. We have over 37 assistant AGs and management appearing in child protection cases in every county throughout our state. They work in tandem with their partners in the Division of Child & Family Services and are available 24/7 to seek judicial protection for a child who is in imminent danger of abuse or neglect.

And how do I know this? Because I've received phone calls 24/7 from my dedicated team saying, General, we have to make a decision quickly about this particular case, this situation,

we need court intervention or we need resources right away for this family. So I know that it's -- that it's true.

And as a point of personal privilege I'd like to highlight David Carlson, my division director for the child protection division who's here. He and his team were just honored by our governor, Gary R. Herbert, for being -- for a Governor's Award of Excellence. And I think it highlights the great work that's being done but also the state's commitment to recognizing work done in the area of child protection.

Administered through our office is also the Internet Crimes Against Children Task Force. It's -- ICAC, or ICAC, is a national effort with statewide components. And our statewide multi-jurisdictional task force investigates and prosecutes individuals who use the Internet to exploit children. ICAC for Utah includes 32 affiliate law enforcement agents -- that's a lot of different law enforcement -- 80 officers and three full-time prosecutors. And I just lobbied our legislator, lobbied hard and was successful in getting one of those additional prosecutors to help us with the backlog of cases that we have.

ICAC is very proactive, generating most of its own cases by going undercover on the Internet, working closely with organizations like Apple and Microsoft to leverage the resources of the private sector in creating tools for us to be even smarter and more effective against these predators.

There was a show a couple years ago: "How to Catch a Predator." While it made for great entertainment, it quite frankly gave away some of our best investigative secrets and started alerting all of the perps out there on how to avoid -- or at least the smarter ones on how to avoid getting caught up in this. And so we've had to also try to be smarter and come up with better -- better tools.

They investigate crimes involving sexual exploitation of children; possessing, distributing, manufacturing child pornography; enticing a minor over the Internet with the intent of committing sexual acts; and dealing in material harmful to a minor, for instance, sending porn to a minor and/or sexting.

We have invested in a mobile forensic laboratory which enables us to process forensics on site. Historically it took us sometimes six months or a year to get the evidence that we needed processed through our Rocky Mountain facility. And now that we have this, this is really making us a much more effective crime fighting unit. It allows us to identify immediately if the suspect is manufacturing child pornography and to separate children from the offenders right away.

Child pornography is not just teens who are 16 and look 18 or 20. But the child pornography that the task force targets involves infants, toddlers, and prepubescent children being sexually assaulted by adults.

Also in our office is the SECURE Strike Force charged with investigating human trafficking, document mills, criminal enterprises involving the trafficking, narcotics, and firearms. In 2014 agents opened 37 investigations involving sex offenses and human trafficking. Some involved minor victims, including a case where the defendant was sexually abusing young boys and

using their undocumented status to coerce them while they sold drugs for him. More than 62 charges were filed involving 40 victims, the majority of whom were boys ages 9 to 15.

This is -- also the cable station A&E just recently was out doing a program on this SECURE Strike Force team, and I'm proud to say that they told me afterwards that Utah has one of the best units of any law enforcement unit that they've covered over the last two years because they're so dedicated to eradicating abuse against children. And so, again, I'm proud of the efforts of our SECURE Strike Force team.

The Utah Trafficking in Persons Task Force is a multi-jurisdictional, multi-agency force launched two years ago by our AG victim advocate and two fellow advocates who were seeking to improve knowledge of and find resources for victims. It has grown to more than 50 members from local, state, and federal agencies as well as several non-profits.

In the 2014 legislative session our office helped pass two critical pieces of legislation to provide further protections for trafficking victims, including a safe harbor law that supports the diversion of minors to child services on a first offense instead of charging them with prostitution. And I've seen a sea change just in the last few years in a very positive way of treating victims truly as victims both in legislation at a federal level and in our own state. Instead of treating them as perpetrators, let's get them the resources and let's treat them as the victims that they truly are.

We owe a debt of gratitude to Commissioner Bud Cramer, a visionary who founded the National Children's Advocacy Center to improve the response to child sexual abuse. Utah Children's Justice Centers are modeled and based on that model administered by my office. Utah's 22 Children's Justice Centers not only handle sexual abuse cases but also serious physical abuse cases and other crimes against children.

In fiscal year 2014 13 percent of the cases brought to Utah centers were physical abuse cases. More than 5,000 children are interviewed annually at the CJCs, and approximately 13,000 people receive services. And as we add more CJCs, the number seems to be growing exponentially, which is a sad commentary, but also a good one. That means more are being reported, more cases are being handled in a proper and positive way. And hopefully that means that we can get more resources to those victims who are out there and whose voices have been silent historically.

More than 1000 professionals are trained through the program annually to ensure that they're using the most effective investigation and prosecution techniques in a uniform way and providing the highest quality of medical and mental health care.

The human toll of child sexual abuse is indisputable. It is impossible to place a value on the innocence lost and the lives shattered, but there are actually quantifiable costs to our country to the tune of $80 billion annually by conservative figures. Because of these astounding figures our CJCs in connection with our partner DCFS recently launched Utah's own version of One with Courage, a campaign with a remarkable set of PSAs and tools to build awareness about the silent crime of child sexual abuse.

Because serious physical abuse cases present unique challenges, a committee of local and state agencies recently convened at the Salt Lake CJC to identify problems and propose solutions for improving the response with a goal of testing a pilot project. Many from our office, including our director of child protection, discussed solutions including advanced training and development of rapid response protocols to improve coordination.

The information was shared with all CJCs to identify common problems and solutions for their respective areas based on community dynamics and available resources. And it's a brilliant dynamic at the CJCs to have medical professionals, law enforcement, health care professionals, counselors, child advocates, lawyers all working together in a very dynamic environment with the sole goal of keeping children protected throughout this difficult process of investigating, processing, and perhaps even prosecuting a particular case.

In addition to administering the Utah CJC program, the Utah Attorney General's Office administers the Children's Justice Act grant. As part of its latest assessment process, the CJAE task force -- excuse me, CJA task force opted to support these and other strategies for improving the response to serious physical abuse. Task force members will be examining the issues from several perspectives including CPS, law enforcement, medical, prosecution, and the CJC.

There are the immediate costs for the child and then there are long-range direct and indirect costs as that child moves into adulthood. Child abuse is a traumatic stressor that has been linked to many emotional and physical health problems ranging from depression to substance abuse to heart disease. Over the life of a victim costs include medical and mental health treatment, justice system costs, and lost worker productivity. And in 2012 Utah's estimated portion was a staggering $759 million.

There are many compelling reasons why child protection should be a priority for our state and our nation. It is a public safety issue, a public health issue, and an economic issue. But the only reason we really need to do this is because it is the right thing to do. Yet government alone will never overcome the scourge of child abuse, especially if we only focus on rescuing children and holding perpetrators accountable after the harm has been done. Intervention is only one piece of the response. For us to truly turn the tide on all types of child abuse prevention must be integrated across all settings serving children and families in our school, in our places of business and faith and other communities.

I recently spoke to a woman who runs a Children's Justice Center in a small Utah county. She has served the center for nearly 20 years and said that recently she is seeing many more children come to her center that are the children of victims that she'd served before. She wondered if the work that she's doing is worth the time and effort that she puts in, if she's done anything at all to help the children that might come through her doors.

Many of you have heard this story, but it's something that we all need to remember. It's one I share with my team often called "The Starfish Story." So if you'll indulge me, if you've heard it already, but it goes something like this. A mature gentleman was walking down the beach and saw a young man there at the shore throwing, frantically, starfish back into the ocean. The older man comes up to the young man and says, What are you doing?

And the younger boy says, Well, the sun's getting up high and the tide is starting to recede, and if I don't get all of these starfish back into the ocean they're going to dry out and die.

And the older gentleman says, But, son, look down the shore of this beach, there are hundreds of thousands of starfish. There's no possible way you can save them all. Do you really think you can make a difference?

The young man thinks about it for a moment, picks up another starfish tosses it back out into the ocean says, I just made a difference to that one.

And whether you've heard it before or not, the point is you are all making an incredible difference in your role as commissioners. All of these folks who are here to listen and offer testimony are making an incredible difference. And even if that difference is just one person, it's worth the time and effort that we are putting in.

As we address the underlying causes of abuse with this commission individually, in Congress, or in our states, we can each personally initiate dialogue in our respective circles of influence and learn about and promote the availability of prevention programs in our communities.

I apologize that I have another commitment to run to, and so I will offer up as a subject matter expert, if he'll join me here at the witness table, our division director David Carlson to answer specific questions about Utah's program. That's good. I thought maybe he wasn't going to come up for a second.

And just also thank you for allowing me to participate in this conference today and in your efforts. It's a privilege to serve our state. And, again, we'd be happy to help in any way, offer my office to -- and our resources to help you in your great work. Thanks and bless you in your efforts.

CHAIRMAN SANDERS: Thank you very much.

Questions for Mr. Carlson?

ATTORNEY GENERAL REYES: You okay? You've got to love that.

MR. CARLSON: We'll find out.

CHAIRMAN SANDERS: I have a couple actually. Can you talk a little about the -- the prosecution in child abuse cases, what -- what percentage of cases are you hearing? Is law enforcement reporting cases to you? What's the relationship between law enforcement, child protection in your agency? If you could talk a little about that.

MR. CARLSON: Sure. In the state of Utah the Attorney General's Office, we prosecute all of the child welfare cases from the state level. And so my division prosecutes all of the child welfare cases in the state statewide. And we have attorneys in 13 offices around the state that -- that appear in all the juvenile court -- in all the juvenile courts around the state. We've kind of allocated assistant attorney generals out on a -- here in Utah we use what they call the courtroom team approach, and so we have assigned one assistant attorney general, one guardian ad litem, and then we have public defender's and conflict public defender's who work as a team in each of the approximately 30 juvenile courts around the state. So we're

kind of -- I guess I would see us as we're kind of the engine that moves the child welfare cases through the system.

STAFF MEMBER: Excuse me. We have a phone caller that wishes to make a comment.

Go ahead caller.

CHAIRMAN SANDERS: Commissioner Ayoub? Yes, go ahead, Commissioner Ayoub.

COMMISSIONER AYOUB: Now can you hear me?

CHAIRMAN SANDERS: Yes.

COMMISSIONER AYOUB: And is it clear?

CHAIRMAN SANDERS: Yep, we can hear you.

COMMISSIONER AYOUB: Okay. I wanted to make sure the Attorney General knows that I thank him profusely for not only prosecuting with such intensity but also for going above and beyond his duties by going underground and doing even more good. So please convey that to him if he is already gone.

A couple questions. He mentioned that resources were offered to the victims after -- afterwards to make sure that they -- the resources they needed to be healed. So could you tell me what some of those resources are and who funded that?

MR. CARLSON: I sure wish I could, but I -- I didn't -- I didn't participate in the human trafficking side of things. I think one of the experiences he related happened down in Columbia, and then the other was a human trafficking case that was prosecuted here in the state. That was actually prosecuted through our criminal justice division, so I wasn't directly involved with that.

COMMISSIONER AYOUB: As a trafficking survivor myself (inaudible) interested in, so I have a couple other questions on that, but you wouldn't be able to answer anything about the trafficking. Right?

MR. CARLSON: I couldn't help you much on the trafficking side.

COMMISSIONER AYOUB: Okay. No problem. I will yield and email the Attorney General some questions. Thank you.

CHAIRMAN SANDERS: Thank you, Amy.

Any other questions? Commissioner Petit?

COMMISSIONER PETIT: Yes. When you say you prosecute child welfare cases, that's on abuse and neglect cases and a determination of whether a child is going to stay at home, lose parental rights or something?

MR. CARLSON: Exactly.

COMMISSIONER PETIT: You're not talking about --

MR. CARLSON: Criminal cases, we don't--

COMMISSIONER PETIT: Right, you're not talking about criminal cases.

MR. CARLSON: We don't do the criminal cases in my division.

COMMISSIONER PETIT: Okay. So the standard in civil proceedings is much lower than the standards for conviction in criminal proceedings. Right?

MR. CARLSON: It's clear and convincing evidence in our child welfare proceedings as opposed to beyond a reasonable doubt in criminal proceedings.

COMMISSIONER PETIT: And I think the Attorney General is, of course, to be commended. I share Commissioner Ayoub's position that what he's been doing in sex trafficking has been very important. My guess is if Utah is like the rest of the country, the greatest danger to children being sexually abused is in their own homes, and there's many reports that are made on that. I wonder if the prosecution rate reflects that so that if -- when CPS says we found 100 cases of child sexual abuse, they've called law enforcement, law enforcement confirms that something happened. Do you know what the record has been on successful prosecution of those cases involving very young victims? Is the evidence strong enough? Is there enough protocol? Is there enough training? What does it all add up to? Do you get more prosecutions? Do you know what the numbers look like?

MR. CARLSON: Well, the cases that my division are involved in are all in-home cases so -- and we do get a fair number of cases. I couldn't break down for you exactly how many of the cases that we file each year are sex abuse cases. We -- we file -- in my division we file approximately 1500 cases every year of child abuse and neglect cases, and any point in time we have about 4,000 open cases statewide.

The -- we do have pretty good -- especially in the area of sex abuse we have a pretty good working relationship with law enforcement that a lot of people have worked hard to develop over years. And the Attorney General mentioned some of that that revolves around our Children's Justice Centers that -- you know, that we have located around the state.

And so law enforcement -- the law enforcement side and the child protection side have learned to work pretty well together in the sex abuse cases. And we're trying to take that same success that we've achieved in the sex abuse cases and replicate it in the area of physical abuse cases, serious physical abuse cases, which is more, you know, what you're interested in. We haven't been as good in the past at coordination in the serious physical abuse cases as we have in the sex abuse, but we work pretty well.

Most of the Child Protective Services workers who investigate sex abuse are in specialized units. They develop relationships with detectives who are often -- except in some of the smaller law enforcement agencies, most of the larger law enforcement agencies have their special victims units, so they get really good at working together. And law enforcement does its part, collects evidence and, you know, brings charges on the criminal side. Child Protective Services is kind of -- that kind of leaves them to do what they do well which is short-term and long-term protection of the children, immediate protection of the children.

And it works -- it works pretty good when -- when everybody kind of knows their role and works together, communicates.

But we haven't had the same success, I'd have to say, in our serious physical abuse cases. We haven't developed the same teams either on the law enforcement side or on the Child Protective Services side, and that's something that we're trying to improve.

CHAIRMAN SANDERS: Thank you.

Any other questions?

Oh, commissioner Covington?

COMMISSIONER COVINGTON: You mentioned sort of like the sexual abuse you're doing really good and physical abuse you're trying to do something with, but what about neglect? Can you - - can you sort of give us a sense of some of the challenges? I mean when we look at fatalities in general, they represent about 70 percent of the fatalities, especially when you start looking at egregious lacks of supervision or, you know, failure to provide safety from known harm and what have you. How -- give us some perspective from a prosecutor's perspective what the challenges are for you in identifying and then actually working to prosecute those kinds of cases.

MR. CARLSON: Well, I guess I would say that the prosecution of the neglect cases isn't so difficult as it is what to do about the families, you know, once you get them under the juvenile court jurisdiction. A lot of it boils down to the resources that are available and how effective they are and how quickly you can get families engaged in the services.

It's -- you know, it's always -- every family is different. Every family situation is different. I think that's a lot of the challenge sometimes for us is to -- you know, working with our other partners -- with DCFS and the guardians ad litem, the courts -- is to try to identify, you know, what are the real risk factors in the family, what -- what should we focus on.

I'm not sure that we've -- you know, there's any magic answer there. It's just -- it's a lot of hard work, but I think that to the extent that we make a difference with these families it's by getting them engaged in services. I mean, there are certain things and we've all talked about them here this morning. Substance abuse issues, mental health issues -- those seem to be the two big stumbling blocks for families. And to the extent that we can get them engaged in effective services, that's probably the best thing that we can do for them.

CHAIRMAN SANDERS: So thank you very much for taking the time and for stepping in after the Attorney General had to leave. And please extend our thanks again to him. And we're going to move to the next panel. Thank you.

MR. CARLSON: Thank you.

CHAIRMAN SANDERS: And actually it's a good segue because our next panel includes a Deputy District Attorney as well as some law enforcement officials, so LaRene Adams and Chief Greg Butler, and Robert Parrish. And I believe Chief Butler has a couple of extra people who are colleagues who will be part of the presentation.

So we will -- LaRene Adams, if you want to come up and we'll actually get started with you. Welcome and thank you. Good morning.

LARENE ADAMS: Good morning. Thank you for inviting me to come and speak to you.

Okay. So what I'm going to do is give you an overview of our program and tell you how it all started. Back in 1994 the State of Utah was sued by the National Center for Youth Law, and so the primary concern of that lawsuit was that the well-being needs of children in foster care were not being met. So as part of the lawsuit -- as part of the lawsuit settlement, Utah came up with some new requirements and monitoring for the children in state foster care.

So then in 1997 a contract was written between the Department of Human Services, the Division of Child & Family Services, and the Department of Health, the Children with Special Health Care Needs Bureau which established the Fostering Healthy Children program of which we are.

And to note, that Fostering Healthy Children program contract is specifically for children in foster care, children that are in a substitute care out of their homes. Brent Platt, the Director of DCFS, and I have had conversations about extending our contract to cover CPS cases because we feel like it would be very beneficial to have that for the children, for caseworkers that are CPS when they're going out to do those investigations.

And some of the benefits of that would be that the nurses have the knowledge of normal childhood development. They also have the knowledge of diseases and conditions that the children may have, and so they would be able to let the caseworker know that if a child is looking a particular way it may just be that it's a normal process of that disease process. And also it gives the caseworker another set of eyes.

Okay. Our role as the nurses in the Fostering Healthy Children program is to oversee the health care needs of children in state foster care and to ensure that ongoing health, dental, and mental health care needs are provided for the children in DCFS custody. And this is done by maximizing quality and timeliness of health care services for the children and ensuring access to providers.

So why are nurses important in foster care? Children in foster care have higher rates of chronic medical illnesses, developmental delays, educational disabilities, behavioral disorders, and mental health problems. So my health care nurses identify the child's primary care physician that the child should, if all possible, continue going to and that would be their medical home. And the only time that we say that it's okay for a child not to return to their primary care physician is if they get moved quite a distance away from their home.

The nurses are consulted on health care questions. They participate and provide input for child and family team meetings, and this is extremely important on children that are -- that have special health care needs. And the nurse is an integral part of the child and family team from the beginning of the case to the end. And especially it's important for them to be a part of team because they're able to give input on the health care needs of the child and be able to discuss that with all the members of the child and family team: With the caseworker, with the parent, with the foster parent, the biological parent.

And as far as the biological parent, it's a really important time when they can talk to them, they can let them know who they are. And one thing is really helpful in the child and family team is the nurses -- when it's getting close for the child to go for a trial home placement, the nurse is able to talk to the team about whether the biological parent has been informed that they need to apply for Medicaid on behalf of the child. Because when a child goes home the foster Medicaid stops, and if the parent doesn't have insurance of their own to cover the child, then they need to apply for Medicaid so that they will have their medical needs covered.

They also talk to the team about what the child's health concerns are, if they have a special condition like diabetes or something, if the parent is going to understand that, if they're going to be able to meet the needs of that child, if the child is on medication so that they can understand that and whether the child is going to be in a safe environment medically when they go home. And they also talk about the ability of the parent to be able to meet the health needs and take them for required health exams when they get back home with their parent.

So Fostering Healthy Children today: I have 31 nurses statewide that are co-located with caseworkers in the DCFS offices so that they are accessible to the caseworkers, so that they're there to able to attend the child and family team meetings. There are approximately 2700 children in foster care. Each nurse has a caseload of 85 to 110 children. And it's especially important to note that every child in foster care has a nurse assigned to them. No matter -- even if they come into care and they're basically a healthy child, they still have a nurse over their case.

Fostering Healthy Children promotes an active partnership between the foster parents, the caseworkers, and the health care providers. And biological parent involvement is encouraged when appropriate at medical visits.

So when a child first comes into custody, the nurses gather, evaluate, and document the health history of each child. And this history is obtained from biological parents whenever possible because the biological parent knows the health of the child better than anybody else does. And whenever it's possible, my nurse likes to speak to the biological parents and start building a relationship with them.

We're able to explain to them why it's important for us to gather a medical history on the child and also a history of the family. We're able to let them know that we're there for them, that they can call the nurse at any time and ask questions about their child's health, and explain that we're an advocate for their child to make sure that their health care needs get taken care of, and that we're a soft place for them to talk to and that we're -- we can be there for them at any time so that they can come to us.

So we have developed a tool that's called the Health Status Outcome Measure, and this is an acuity tool. So when the child first comes into custody, we gather their health history and we take into account whatever conditions they may have -- if they're in mental health therapy, if they're on medications, whatever they have -- and then we assign an acuity score to that.

And then according to that acuity score we put that into the database and then this tells us how often -- the database prompts the nurse how often they're supposed to at a minute

contact the foster parent or the caregiver. And it also helps us track whether program interventions are making a difference from the time the child enters custody till when they leave custody.

So there's -- DCFS has requirements for the children when they come into foster care. Within 24 hours they're supposed to have an emergency visit if they're sick, if they have chronic medical condition, or if there are signs of abuse or neglect. And otherwise, within 30 days of custody they go in for a well child health exam, and hopefully this can be completed by their regular primary care physician. They go for a dental exam, and this includes x-rays, cleaning and prophylaxis.

And they go for a mental health exam if they're over five years of age. Children four months to five years we use the Ages & Stages screening tool. And this is a developmental screening tool, and it's sent out from my main office by my assistants to the foster parents. They complete the questionnaire. It's sent back into my office. It's scored. And if the children score abnormally, then we make a referral to early intervention or Head Start. And then they go out and they make a site visit to the home to see if they are accepted for further referral for services.

Okay. And then further health care requirements are annually. All of those same visits are required again. Oh, and also like teenagers like to sometimes go walk about and go AWOL, and if they go AWOL, they require a well child health exam again. And that's for the safety of them to make sure that something hasn't happened while they've been gone and to maybe do some lab screening and stuff to make sure that they're healthy.

This is a copy of what we call our health visit report form. It's a standard form that they -- the foster parents know to take to all health-related visits. Our providers know what it looks like. It's filled out by the provider and then sent back in to the nurse, and this is how we enter the inspection into our database.

SAFE, as has been mentioned, is the database that DCFS uses. The nurses also use that database, and the nurses are the only ones that enter the health information into the database on the foster children. This information -- from the time the child comes into custody until they leave, it stays in the system and it can be pulled at any time into a really nice report called the health data report. This report can be sent to the placements so that they have the health care information with their exams, with the follow-ups that are due, with all of their health conditions, with their health care providers. It's a very nice report.

And then talking about near fatalities. So when children first are -- CPS gets involved with them, my nurses attend what they call a 24- hour or a multidisciplinary meeting. It's where all the parties concerned come together, talk about why the child was removed, if it was a good removal so that they can go before the judge to see what's going to happen with this child.

So the nurse attends that meeting and then they will go back and they will request the hospital discharge instructions on this child to see what -- what diagnosis the child had, what is supposed to be done as far as follow-up. And then they will go to the initial child and family team meetings so that they can speak with the foster parent, the caregiver, wherever this

child is going to be placed to ensure that the outpatient follow-up is completed and that the child gets the services that they need.

I have an example of a near fatality that happened that my nurse was involved in. Baby Doe was admitted for a subdural hematoma, a traumatic brain injury, and fractures. And the discharge instructions were for seizure precautions, early intervention referral, multiple appointments to multiple physicians. This baby was discharged home to a kinship placement.

And then there was a child and family team meeting planned. Well, prior to the child and family team meeting the kinship had not kept the follow-up appointment and did not seem willing to do the other follow-up appointments. When they were in the child and family team meeting, she seemed overwhelmed, the nurse spoke with her at length trying to simplify the needed follow-ups in writing so that she would understand exactly what needed to be done.

And the nurse was very concerned she didn't quite understand what this baby needed. So the nurse spoke with the casework and guardian ad litem, and she voiced her concerns for the baby's needed care. The casework and guardian ad litem went before the judge who ordered the baby into a placement who was medically qualified. The foster mom was a nurse, and the foster father was a retired M.D. And so that is one way that my nurses can advocate for the children to make sure that their medical needs are taken care of and that the children are in a safe place.

CHAIRMAN SANDERS: Thank you.

I think -- Commissioner Dreyfus, did I see your hand?

COMMISSIONER DREYFUS: Yeah, just one real quick.

CHAIRMAN SANDERS: Sure. go ahead.

COMMISSIONER DREYFUS: Do your nurses -- first of all, it's wonderful what you're doing.

LARENE ADAMS: Thank you.

COMMISSIONER DREYFUS: But your nurses obviously have incredible experience now. Do they -- are they ever used in consultation with Child Protective Services?

LARENE ADAMS: They are. Child Protective Services are in the same buildings as the ongoing foster workers are, and so the CPS workers will go to them and will ask them questions. It's just that my nurses are so busy with their caseloads and where the contract is specifically foster care -- they can answer questions for CPS workers and they're happy to do that. They just don't have the time to spend a lot of time doing it.

COMMISSIONER DREYFUS: I think what it is for the commission is -- as we move around the country we -- we've been, you know, certainly intrigued with the idea of multidisciplinary teams. And we usually have them after the fact. Right? We do multidisciplinary team reviews when the child has died or there's been a near fatality or when things get really bad we put that team in place. Well, the thinking is for the -- for referrals that screen in at certain potential levels of risk, do we start thinking of teaming earlier, right, multidisciplinary teaming earlier on those investigations versus waiting till after the fact?

LARENE ADAMS: I think that's a great idea. That's why I mention that Brent and I have talked about extending our contract and having nurses there at the beginning with CPS so that they can be involved during the CPS referral and the investigation at that time. So we would really like to be able to do that if we could get funding.

COMMISSIONER DREYFUS: Thank you.

CHAIRMAN SANDERS: Actually if -- we're going to have the next panel come up, so maybe we should go ahead. If there are additional questions, please feel free.

Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: I'm just curious. Do the nurses work at all with -- since they're having conversations with the foster parents about meeting the medical needs, when a child is being reunified, do they work at all with the foster parent to get their sort of take or concerns about the birth parent's ability or capacity to care for the child so that that information is getting back to the --

LARENE ADAMS: Yes, they --

COMMISSIONER RODRIGUEZ: -- child welfare agency?

LARENE ADAMS: They will talk to the foster parents about it and see how -- you know, they can see how the biological parent interacts with the child, and then they will talk to the caseworker about that as well. And, you know, if they can see that there may be some kind of a problem or they have a concern, that's when they talk about it in the child and family team meeting and try to determine if it really is going to be a good placement for them, if they're going to be safe, if it's really the right time to reunite that child.

COMMISSIONER RODRIGUEZ: That's great. Because I think that the foster families often have more contact and a better sense of sort of the birth family's current struggles and strengths and that that information doesn't typically get back to the agency, nobody is really soliciting that from the foster family, so that's great to hear.

LARENE ADAMS: But just to note, it is actually the caseworker's final decision. It's not the nurse's decision.

CHAIRMAN SANDERS: Commissioner Martin?

COMMISSIONER MARTIN: First of all, Nurse Adams, thank you very much for your testimony.

I have two questions particularly around the near fatality protocol. You -- if I'm not mistaken, you indicated when the removal is good this protocol is put in place for the near fatalities. Did I understand that testimony correctly? So are there cases where you've made a -- or CPS has made a determination that the removal is not good? And if so, what happens to those children?

LARENE ADAMS: Well, in a near fatality it would probably always be deemed a good removal.

COMMISSIONER MARTIN: Okay. And with the protocol in place for the near fatalities, how many of those children do you serve on an annual basis roughly?

LARENE ADAMS: We do -- we do not have very many here in Utah.

COMMISSIONER MARTIN: Okay. Do you know how many of those have been successful so they have not resulted in an ultimate fatality?

LARENE ADAMS: You know, I don't have a number-wise, but to my knowledge the ones that we have served have had a good outcome.

COMMISSIONER MARTIN: Wonderful. Thank you so much.

CHAIRMAN SANDERS: Commissioner Bevan?

COMMISSIONER STATUTO BEVAN: Do you have an infant safe care plan in the hospitals here?

LARENE ADAMS: I'm not sure what you're talking about.

COMMISSIONER STATUTO BEVAN: When a baby is born prenatally exposed to substance abuse or - - and/or alcohol, there's evidence of fetal alcohol syndrome, is there any care plan at the hospital?

LARENE ADAMS: I believe that there is. I think that they -- I'm not sure because I'm not DCFS, but I do think that they do contact -- if they test the infant, I think they do contact CPS.

COMMISSIONER STATUTO BEVAN: Thank you.

CHAIRMAN SANDERS: I have a question. I wanted to go back to Commissioner Dreyfus's question for a second, and we have a chance -- I think Brent Platt is still here. Maybe we can ask him later. But the -- it sounds like there's a clear role for kids in foster care, and we heard earlier from Dr. Campbell that there's reason to believe that those children may be safer than others. And the children who have been investigated but not open it seems like are at much higher risk.

And so I go back to what Commissioner Dreyfus said, that this idea of the nurses being available during the investigation it seems offers more opportunity to improve safety conditions for children. Can you say a little bit about your reaction to that and kind of the role the nurses are playing right now before foster care placement occurs?

LARENE ADAMS: You know, I agree it would be a really good addition to our program for my nurses to have the ability to help out with CPS cases if we could get the funding so we could have additional staff to do it. And my nurses are always happy to talk to CPS workers and answer their questions to help them out, but they can't go out on the CPS investigations, so they're not available to do that.

CHAIRMAN SANDERS: And I did want to follow up on that and ask about the funding. Is that because of the way the funding is structured or are there other reasons for that?

LARENE ADAMS: No, it's the way the funding and contract is written. It's specifically for foster care.

CHAIRMAN SANDERS: And do you know what the funding source is?

LARENE ADAMS: Yeah. It's -- it's Medicaid administrative case management.

CHAIRMAN SANDERS: Interesting.

LARENE ADAMS: So it's skilled medical professional. My nurses are all registered nurses, and so the funding mostly is -- comes down from Medicaid, and it's about 75 percent and then DCFS pays the state match.

CHAIRMAN SANDERS: Thank you. Thank you very much.

So Chief Greg Butler and I believe he has two colleagues with him. Chief Butler, welcome.

CHIEF BUTLER: Good afternoon. Thank you for -- good afternoon. Thank you for the invitation to be here today. I am Chief Rick Butler with Woods Cross Police Department and this is -- I am Chief Rick Butler with Woods Cross Police Department. And over on the left there, the handsome young man is my lethality assessment protocol expert that I brought with me, Sergeant Adam Osoro.

SERGEANT OSORO: Hello.

MS. OXBORROW: And my name is Jennifer Oxborrow. I'm the state domestic violence administrator for the Department of Human Services which is housed in the Division of Child & Family Services for Utah. We're really excited to be here and talk with you. Although we have some important advancements that we've made with regard to domestic violence, we think we can do more. And we're very excited to have our partners in law enforcement here to talk about some of that with us.

So Utah last year was able to set aside some funding, significant funding, for a lethality assessment protocol, and we're modeling that off of the Maryland model. I don't know if anyone's familiar with the Maryland lethality assessment and danger assessment developed by Dr. Jacquelyn Campbell at Johns Hopkins University and supported by the Department of Justice.

But we see really promising outcomes from that, and so we're working with our law enforcement agencies and the victim service providers that we manage with state and federal money to try to build a partnership and do some of what the commission has talked about today, try to recognize that really high risk and that most dangerous risk of lethal violence early on and try to help keep our kids safe and our families safe and connect people with resources as quickly as we can. So we're excited to talk to you about that today.

We're managing funding, federal and state funding, right now through the Division of Child & Family Services. About 25 percent of the statewide provision of care, the funding comes through the Division of Child & Family Services, and that really provides for emergency shelter, supportive services, and behavioral health care for people who are impacted by domestic violence in Utah.

I think I'll probably turn it over to Chief Butler and Sergeant Osoro to describe to you. They've really done some groundbreaking work in Utah. They kind of went first. They went and they found a protocol that was saving lives and they found a way to implement it here. And they're now leading this pilot program in four areas around our state in this next year with some funding that our legislature appropriated to this. And they're really the experts, so I'm going

to turn it over to them to describe to you why this protocol is important and what we're hoping to see it accomplish.

COMMISSIONER DREYFUS: What's the name of the assessment?

MS. OXBORROW: It's called the Maryland Lethality Assessment Protocol. It was developed by Dr. Jacquelyn Campbell out of Johns Hopkins University. And the broader assessment that Dr. Campbell first developed is called the Campbell Danger Assessment. We have samples for you we can leave with you.

CHIEF BUTLER: I'll tell you a little bit about the lethality assessment protocol and then I'll have Sergeant Osoro tell you about the actual questionnaire that law enforcement asks on the scene of an intimate domestic violence situation.

We believe that with this program if he can just duplicate what's taken place in Maryland that we can reduce callbacks to domestic violence situations by 60 percent across the state. And more importantly we believe that we can save anywhere from 12 to 20 lives annually each year just depending upon how many we actually have.

We do know that almost -- the 10-year trend in the state of Utah that almost half of the -- the murders in Utah are domestic violence related, nearly half of them are from domestic situations, and we think we can have a dramatic effect on reducing that number.

And the protocol is a very simple thing that an officer on scene does with the victim of a domestic violence situation. It's 11 questions. It really doesn't add any more time for the officer's investigation as what they would conduct during any domestic violence situation. It can be done while the other typical things that you do are taking place, whether it's medical treatment or you're documenting photographs and such. And even if it does add extra time, the protocol is tested out that it takes about 10 to 12 extra minutes.

And that's valuable time, because if we reduce the number of times we go back to the same homes over and over again by 60 percent, we're way ahead in the long run. Plus more importantly, to echo what the Attorney General said, maybe it doesn't sound like a whole -- a lot of lives saved when you're talking about 10 to 20 in a state this large, but it's very important to that family and those relatives and those kids, and it's important in our communities.

So I'll let Sergeant Osoro tell you a little bit about the 11-question lethality protocol that we go over with the victims.

SERGEANT OSORO: So in Maryland they implemented this lethality screening protocol in 2005. Since then they've seen over a 42 percent reduction in their intimate homicides. And that number caught our attention, and so what we did is we had them come out. They trained us in 2012, and we were scheduled to begin implementation of this program in our city in 2013, which we did.

So just briefly, the questionnaire is 11 questions, and what you do is the officer asks your domestic violence victim on scene these 11 questions. One of the interesting things about this program is sometimes we do have victims that are overwhelmed and they may not want to

answer the questions on scene. Part of this protocol is even if the officer has a feeling in his or her gut that there is a problem in this home -- and most of the time there are very clear signs of prior abuse, sometimes the officer may personally know that family or have been there before. We can still initiate that protocol.

The unique -- the unique thing about this program is we put our victims in contact with a provider on scene. We don't just leave a pamphlet. You know our state law says that we will leave a pamphlet, hey, this is a number you can call to get services. What we've seen is a very small number of victims actually do that.

So what we've done is we've taken that burden away from the victim as a law enforcement officer, and we make that phone call for them. That doesn't mean we force them into services. It just shows our victims that as law enforcement officers we are here to support you and it's okay to make that phone call.

So what we do is we put our victims on the phone. Sometimes if you have a victim that's hesitant to speak with an advocate, we will set up a safety plan, and usually by the end of the phone call our victim is willing to speak with an advocate. Now, whether that is -- you know, a lot of times you have a victim that doesn't necessarily need housing. They have supportive family members, but we will set that up for them.

What we have done in Davis County as part of implementing this program is that you have to have a shelter or advocates that support you. It doesn't do us any good to go in there and make a bunch of false promises and say everything is going to be okay if we don't actually have those services in place. So what we've done in Davis County is we've partnered with Safe Harbor. They are our domestic violence shelter for the county. They're also in charge of all of our protective orders which makes it convenient for us, because if we get Safe Harbor on board, then they can say this what we're going to be doing in our county. So we've been lucky that way.

So what we do is we put our victims right in contact with an advocate, and then not only do the advocates follow-up with the victims, but our agency as well will make one or two follow-up phone calls. And we do that from the officer's cell phone. You know, it's nothing the victim has to sign. They don't put their name on it.

You know, and we found that it's been very beneficial not only in getting our victims out of these dangerous situations but also for the prosecution of these indications, because now you have a prosecutor and now you have a judge that has this form that says this victim is high risk, you know, yes, the offender has threatened her with a weapon; yes, the offender has choked her; you know, yes, they have threatened the children in the past. And I think that carries a lot of weight when you look at these forms that -- you know, these are people that need our help and, you know, let's all move forward together and make sure it happens.

MS. OXBORROW: We love the coordinated effort. It really gets us all speaking the same language, and we're deeply grateful to our law enforcement agencies who did go first and found this protocol and brought it to us as a solution. We didn't have any additional funding to meet the additional need, so we were looking at ways that we could do more with what we had, and this has really been a great way to get us all speaking the same language,

understanding what standardized approaches are, and how best to make sure that the people with the greatest need are receiving those emergency services, so we're very, very excited about this.

We're piloting it in two urban and two rural areas, and we hope to bring it to scale in the following fiscal year. So it's entirely funded by state general funds, and we have an evaluator that's housed within the state domestic violence coalition who will be gathering the data and looking at the outcomes to make sure that we have a real and sustainable plan for our state.

It's pretty exciting, too, when you think about it from a child protection angle because we have a lot of children here in Utah. So I think the CDC says that Utah has one of the highest birth rates, if not the highest birth rate, in the country. And we know that we have a number of children witnessing attempted homicides at domestic violence -- in domestic violence situations. And -- and so we know we need to get to those kids and offer them supportive services and wrap those families up in good care as soon as we can to try to break that cycle.

CHIEF BUTLER: And that's -- that's critical. It's the reason we're here speaking with the commission today is that it's -- often the children are overlooked in the situation. We know that 80 children witnessed a parent murdered last year in the state of Utah, and that's horrible. So we believe that when we reduce these intimate violence homicides and we reduce the callbacks to the same homes over and over again, we are hugely impacting the future growth of our kids here in this state, and that's a critical component.

MS. OXBORROW: We can -- we can take your questions now or we could probably go on and on about this because we're so excited, but if you have --

CHAIRMAN SANDERS: I know we have a number of questions.

MS. OXBORROW: Sure.

CHAIRMAN SANDERS: Commissioner Petit.

COMMISSIONER PETIT: A couple of questions.

One is: If an offender who was successfully prosecuted before goes to prison and gets out of prison having served time and is heading back into the community from whence he came, including perhaps the relationship that he had going, are you guys notified by -- does the prison call you guys and say somebody is being released, they're on their way down? Are you informed of that?

SERGEANT OSORO: We are. We -- not only are we informed about our domestic violence cases, but any felony cases we are advised when an inmate's released.

COMMISSIONER PETIT: And then I agree that this has a lot of potential for child protection, but how is that playing out right now? You're going on domestic violence cases. Do you go out on CPS cases, per se, when a report comes in that some terrible thing has happened?

SERGEANT OSORO: Yeah, our cases are generated one of -- mostly one of two ways. Either we get a call whether that be a -- you know, a husband and a wife fighting or noise disturbance and we have officers on scene and we in turn called Child Protective Services or

someone may call Child Protective Services and make -- most of the time it's an anonymous phone call. And they in turn will send us a -- we call it a CANR report, but that's a child abuse and neglect report. And then we will open a case as the law enforcement agency.

COMMISSIONER PETIT: And so when -- the next step when you -- somebody decides to press charges, right, the DA -- this goes into the DA's Office? I mean, do you guys have a protocol with them or a standard process that you follow through the District -- with the District Attorney? And related to that is this issue of domestic violence restraining order and -- which, you know, the court or whoever it is issues that. What's been your experience in whether that's honored or not by the individuals that they're directed to?

SERGEANT OSORO: I can tell you that in our county, in Davis County, again, like I said before, we work with Safe Harbor. They're in charge of doing all of our ex parte protective orders. I can tell you since we've implemented our lethality -- the lethality assessment protocol, that form is included within any application for an ex parte so the judge will see that, and we've seen great success. Again, our community is fairly small. That's why we're excited to see this pilot project roll out to give us some more substantial numbers.

I would just like to mention just briefly, before we started our implementation date we had a case that started becoming a little more prevalent in our city with one of our local families. So I was speaking with Chief Butler. He decided, hey, do you know what? We haven't started this lethality project yet, but I think we should do an assessment on this young lady. So we did. We sat her down asked her the 11 questions, and immediately she flagged as very high risk.

So we discussed with her her options for services and ultimately she was able to get herself and her three children out of the home. As this case began to escalate, ultimately after a brief police standoff the husband ended up taking his own life. After speaking with the ex-wife, by this time, this female who had screened in high risk, she told us that during this police standoff that he -- her ex-husband admitted to her that he had gone back to her house and in fact tried to locate her and her three children. So she -- you know, our very first lethality screening, this -- this woman is crediting the -- the protocol for saving her life and the life of her three children. So that I can attest to in our small community is our very first one, you know, potentially saved four lives.

MS. OXBORROW: Your question's a really valid one, and I think the response and the coordination varies quite a bit in different parts of the state. But the beautiful thing about this pilot project being housed in the Division of Child & Family Services is that we really get to learn how to make this work and improve safety in families.

And we -- we do that in partnership with the Domestic Violence Planning and Advisory Council in our state which is a multidisciplinary committee that's housed in the Commission on Criminal and Juvenile Justice. And that includes members from the Administrative Office of the Courts, prosecutors, defenders, people from the clinical community, law enforcement, adult probation and parole. So we all get to learn about this and understand what the -- the validity of this standardized approach, this protocol, how it can really help.

COMMISSIONER PETIT: Does a restraining order work and is there an overriding provision if somebody thinks it's not going to work?

CHIEF BUTLER: A protective order works if you have a law-abiding sentence that's going to honor that order from the court. But our experience is that it's a piece of paper and it's not going to protect somebody. It's going to give us power to arrest somebody. The other unfortunate thing is in the case Sergeant Osoro told you about, this person was arrested and out the next day, arrested and out the next day, protective order or not. They're in and out. So the protective order didn't stop him from trying to get to his wife?

COMMISSIONER PETIT: What's plan B when the restraining order doesn't work?

CHIEF BUTLER: Plan B was the safety plan. We got her out of the house. He had gone to have one last meeting with the family and the wife. He -- you know, the sergeant didn't mention that he went to this one last meeting heavily armed and everybody was -- is pretty confident that he went there to probably kill the entire family and himself and that was going to be his last meeting.

So our experience with when the protective order doesn't work is make sure that the victim has a safety plan or we get them into a shelter or they know what they need to do to protect themselves. In this case she initially did not think she was in any danger. It came to - - it came to us through a CANR report, through a child abuse report, and that's how we became aware of it. And the victim really didn't think she was in any trouble, and it was after sitting down and doing the assessment, that she realized she was in danger and her kids were in danger. And then we enacted a safety plan, and fortunately she was with family when he went back to the house looking for her that -- that fateful night.

MS. OXBORROW: We know from the National Network to end Domestic Violence that lethality risk goes up significantly in the first 72 hours after a protective order in the case of intimate partner violence. So your question is really spot on. It's essential for us to have a coordinated response to victim services in that 72-hour window and thereafter.

And what Dr. Campbell's research through Johns Hopkins has shown is just what the chief just described. About less than half of the women who are at most risk for lethality at the hands of an intimate partner, less than half of them realize that. So this assessment is a great way to raise their awareness, too, and help empower them to reach out for some support.

CHAIRMAN SANDERS: Commissioner Dreyfus?

COMMISSIONER DREYFUS: First of all, I just want to thank law enforcement for demonstrating the best of law enforcement. I've been in human services, my career, and to see law enforcement realize their role and partnership in the community is wonderful. So thank you very much for that. You're definitely demonstrating the best.

So my question is one that you can appreciate. As a commission we're trying to eliminate fatalities of children by abuse and neglect. A very small N -- one is way too many, but it's still a very small N nationally. Right?

MS. OXBORROW: Right.

COMMISSIONER DREYFUS: And is there any way when you're doing your evaluation of this pilot, is there any way that your evaluators -- maybe it's university partnership -- something that can start to help make the connection between a reduction of fatalities from abuse and neglect in your state and this intervention? Can you see any way to start connecting the dots? Because we're hearing all these great things, and as a child welfare -- former child welfare director, I'm listening to this and going, yeah this just makes all the sense in the world. We know DV has a high correlation in the homes of the children who ultimately end up being killed by abuse and neglect.

MS. OXBORROW: Right.

COMMISSIONER DREYFUS: But trying to connect the dots. Right? Is your evaluating in any way -- could it help with that?

MS. OXBORROW: So it's an interesting -- personally for me it's interesting timing. I've had this role as a state administrator for two years. I'm leaving this role next week and stepping into the role of Executive Director for the state domestic violence coalition, and so I'm very, very motivated to do exactly what you just said.

We already have a contractual agreement with our Utah Criminal Justice Center which is housed within the University of Utah to evaluate these things. And what -- I'm going to make a promise to you, that we're going to look at outcomes, true outcomes, not simply service delivery, how many assessments do we do, but what is that providing and how is that connecting the dots to overall safety.

So I'm not sure exactly how to do that. I'm not a researcher, but I know where to find good researchers, and we're going to -- we're going to look at that closely.

COMMISSIONER DREYFUS: Thank you.

MS. OXBORROW: You're welcome.

CHAIRMAN SANDERS: If I could ask a follow-up to that, and actually I want to confirm some of the things that you said.

I think, Sergeant Osoro, I think it was the -- you mentioned that one of the goals was to decrease domestic violence -- domestic violence by 60 percent, intimate domestic violence, and save 12 to 20 lives. So you have some really specific goals using the tool. It sounds like in Maryland there was a -- if I got it right, a 42 percent reduction in intimate homicides and 50 percent reduction in domestic violence.

And so it seems like there's both a track record and you have some specific ideas. Can you say what you see needing to happen to achieve those goals? Is it just implementation of the tool? Are there other things that need to happen as part of that?

SERGEANT OSORO: Sorry. I'm getting used to this mic thing, starting my mic career.

I think our first step is statewide implementation here. Like I said, our first goal is to get it countywide in our county. Like the Chief touched on, just getting these people out of the dangerous situations, taking action, whether that be removing children and spouses from the

dangerous situation or ultimately just taking better action on these cases so we don't have to keep going back over and over and over to these same houses.

Because I'll tell you, since I started as a rookie policeman, we call them frequent fliers. We have families in every jurisdiction all over the country that they're -- they're our problem children. And we need to step up and take action before these -- I hate to call them minor problems, but non-homicide cases turn into homicide cases.

MS. OXBORROW: I can -- I can add to that as well, Chairman. Our statewide victim service providers work with very limited funding and tend to be at capacity. So I'm very concerned that people with high lethality risk are not able to obtain services often or the continuum of services that they need in order to be safe.

So I really think what we need to do is look at prioritization process and then make sure that we're working within our statewide system so that no one's turned away. And I fear that's been happening somewhat and we need to address that. We need to make sure that -- that we are able to serve people at the greatest risk, and I think the standardized approach is really going to help us do that.

But -- but we need to -- we need to motivate more partnership. We need to really build those relationships between law enforcement and our victim service providers and make sure that we're studying what works, to your earlier point, so that we know how to bring that to scale.

CHAIRMAN SANDERS: Commissioner Petit has a question.

Let me follow up on that. The -- you mentioned connecting to services as being an important part of the work that's been done to this point. Can you say what services have been helpful to this point? And it sounds like they may not have been thorough evaluations, but what have you found to be helpful? And the second part of that is you earlier mentioned moving the victim and children from the home. Have -- is that a strategy that you've used at all in child abuse and neglect?

MS. OXBORROW: So to your first question, our director of Child and Family Services, Brent Platt, commissioned a two-year statewide needs assessment to try to determine exactly what we need, what's working, what's not, what is our capacity, and what are our gaps in services. And so that statewide needs assessment, which is fully funded with our federal award from the Family Violence Prevention and Services Act funding that we receive, will start on July 1st, and we're really excited to see some -- some data -- some data-driven approaches to how to address this and better serve those in our communities.

To your second question, I'm not sure I understand exactly but I'd --

CHAIRMAN SANDERS: So typically in child protection matters children are removed but not necessarily the adult victim, and I was wondering is that a strategy that you've used at all in child protection, removing the -- the victim, the adult, the caregiver along with the children versus just moving the children.

MS. OXBORROW: Utah does have state statute that allows us to trigger a shelter hearing if -- if a family continues to be in a dangerous situation. We obviously try to use that as a last

resort. We really try to strengthen the protective capacities within the family and bring them some strong supports to keep that family unified and keep them intact and keep them safe. But we do have the ability to trigger a shelter hearing and require families to go into shelter if harm continues.

What we try to do most of all is -- is have a community-based approach. So I think, you know, in the early '90s we saw this model for domestic violence survivors where we tended to push people more towards emergency shelter, get everyone into emergency shelter and then we'll sort out what supportive services they need.

What we're trying to do now because we have a couple of decades of research behind us, what we're trying to do now is match the right level of service with the right level of need. And so this -- this assessment process is just key in determining what people need, what people want, and how to engage them in their own safety planning. Did that answer your question?

CHAIRMAN SANDERS: Yes, it does. Thank you.

Commissioner Petit?

COMMISSIONER PETIT: Yeah, my question is related to that -- that question. CPS and domestic violence are -- a lot of it can be dealt with through the civil courts, family courts, civil proceedings. But the individual who's the threatened -- threatening perpetrator can be dealt with by the criminal courts.

So when I hear you say we can move a mother, and it's typically going to be a mother -- a mother and kids into a shelter, which is fine, getting them out of the scene, but what about getting the guy out of the scene? So what does it take from a law enforcement point of view to be able to put this individual where they belong which, sad to say, you know, we still need to incarcerate in our culture? I mean, what stands in the way of that when there's a threatening individual? Do you need a specific crime to have been committed or the threat of a crime or what?

CHIEF BUTLER: I agree it is unfortunate we still have to incarcerate people, but some people that won't follow the law and are a danger to others, some -- some have to be incarcerated for the safety of the public.

What we do is we -- we bring the cases - - in the situation, the case study we had where we believed we saved the mother and her three kids, as I said, he was arrested and he was out and he was arrested and he was out. You know, I understand the criminal --

COMMISSIONER PETIT: Arrested and out, what do you mean by out? He was arrested and out what?

CHIEF BUTLER: Bailed out of jail. So he was arrested and bailed out of jail time and time again. You know, I don't know if the criminal justice system is overwhelmed. There's no -- no problem arresting people. There really isn't. It's getting them housing and room in the jails. And incarcerating everybody's not the answer, certainly not the answer, but it has to -- it has to have its place.

But the criminal justice system moves along so slowly that this guy was going through the system and hadn't even -- over a period of months and months and months had not been before a judge yet because everybody is overburdened, law enforcement, the prosecutors. The whole system is overburdened, and it moves slowly. And it's important to move slowly to make sure we treat people correctly and their rights are followed and honored. But this -- this guy never got before a judge before this all started and ended, and it went over months and months and months.

COMMISSIONER PETIT: An issue in a lot of the cases is the kids are being moved out of their ZIP code, they're leaving their schools, they're not near family relatives, they've had to be located someplace else. So I appreciate what you just stated, but there's obviously a cost to the children when they're having to be moved around in an unsettled situation.

SERGEANT OSORO: I would just like to touch on when we talk about removing the victim and the children, it's during that critical 72 hours that makes a difference as far as the intimate homicides go.

MS. OXBORROW: And I -- one more bit of good news, I feel like I get --

CHAIRMAN SANDERS: We're going to have to wrap up because we're --

MS. OXBORROW: Okay. Okay.

CHAIRMAN SANDERS: We have one more presenter, and then for the commissioners we're going to take a lunch right after the -- right after Mr. Parrish is completed. So I want to thank the three of you. This has been very helpful again.

MS. OXBORROW: Can we leave this with you?

COMMISSIONER DREYFUS: Sure.

CHAIRMAN SANDERS: Sure. Thank you.

CHIEF BUTLER: Thank you very much for your time.

CHAIRMAN SANDERS: Thank you.

SERGEANT OSORO: Thank you.

CHAIRMAN SANDERS: So the final presenter is Robert Parrish. He's a district -- Deputy District Attorney, the special victim team in this county.

Thank you, Mr. Parrish.

ROBERT PARRISH: I did it.

COMMISSIONER COVINGTON: You're smart.

ROBERT PARRISH: I had enough examples all morning that I did it right.

Let me just say a couple things about my experience so that you have a good idea about me, and then I'll move right into what I want to present. I'm very aware of the time crunch at this point.

I've been involved in the field of child maltreatment since 1982 when I was in the Attorney General's Office.

CHAIRMAN SANDERS: If you could move a little closer to your mic.

ROBERT PARRISH: Sorry.

CHAIRMAN SANDERS: Thanks.

ROBERT PARRISH: So I started in 1982, and my first experience with child abuse was revising the child sex abuse laws in Utah. In 1985 I handled my first criminal prosecution which was a child homicide in southern Utah, and by five years later that had become my specialty. I really didn't choose it. It chose me.

And in 1990 in the Attorney General's Office we applied for a special grant that funded a child abuse assistance unit, so I got a pretty unique opportunity to travel all around the state of Utah and handle prosecutions, either as co- counsel or as lead prosecutor that involve physical abuse and homicides of children.

And that was during the same period of time that things like the shaken baby syndrome were really becoming a major issue. And so I've handled probably close to 50 to 60 child homicides in the prosecution area, plus I've been a child protection attorney in the Attorney General's Office. I was in Dave Carlson's position for a couple of years in the '90s, and then I was a guardian ad litem for six years and the Deputy Director of the National Center on Shaken Baby Syndrome, the director of which is here today. So I've had a wide variety in addition to being on the APSAC board of directors for six years. So I've gotten to rub shoulders with experts for a long time.

And one of the things I want to start by talking about today is just how complicated this area is. You already know that because you've had a lot of information from a lot of different people. But if it were as simple as just looking at cases where there's a DCFS history with the family and an escalating pattern of abuse and then fatality occurs, this would be a pretty simple thing for all of us to handle. It's not, and you now know that because you've heard from so many different people.

My cases have ranged the gamut from situations where people kill children, it's the first time they've ever lost control and done anything that would qualify as child abuse to situations of neglect homicide. A couple of years ago I handled a case involving a mother who left her seven-month-old baby in one of those rope handled tubs that you use for washing, you know, clothes and storing things and all of that and walked away and took a cell phone call for 15 minutes and came back in the room and the baby had drowned in this tub because there's no way to get out, you know, when the baby is inside. And she'd also put baby oil in the tub so there was no, you know, friction for the baby to be able to get out.

So those cases are very difficult, and all of these cases are tough to handle because they range the gamut from people who really did set out to cause a fatality of the child. Sometimes those are live-in boyfriend/girlfriends who just want mom but they don't want the children, but those are rare. Those cases are probably less than 10 percent in my experience of the child fatalities, and most of the others involve regular people.

One of the barriers we have when we take these cases to court is people hear about things like the shaken baby syndrome or very egregious injuries that have been suffered by children, whether it be fractures, head injuries, or whatever and they expect a monster in the defendant's chair and they don't have that. They have their next-door neighbor. They have their cousin. They have somebody that looks just like them and acts just like them and had that same experience in life.

And so it's extremely important to understand that fatal abuse of children can happen in a number of different circumstances, and most of it, at least in my experience, was not intended. The people didn't get up in the morning and say I'm going to shake my baby to death at 2:30 this afternoon. It doesn't happen that way, so it makes prevention very difficult.

I was very glad to see that you're focused on near fatalities. As of right this moment I have four pending child fatalities, but I also have five pending near fatality cases in court, one of which was a woman who hid her pregnancy from everybody and when the baby was born she let the baby sit on a floor for 24 hours and then decided she had to do something so she placed the baby in the neighbor's garbage can. And fortunately the neighbors heard something that sounded like a cat mewing, got some help, got the baby out of the garbage can. The baby's going to be fine but likely will have long-term disabilities. And, of course, lots of kids who have inflicted head trauma will have long-term disabilities, and those -- those cases are heart breaking.

I want to start with just a very brief comment, and I've provided a handout because I knew I wouldn't have a whole lot of time to cover everything, so you'll get that handout with all of my recommendations and suggestions and all my contact information. But the first thing I want to talk about is how difficult it is to prevent child fatalities and severe physical abuse when we have media stories over and over and over again that misrepresent the science of inflicted head trauma, that say that the shaken baby syndrome has been replaced or jettisoned or whatever. Those are all bogus media stories, the most recent being the 54-page "Washington Post" series, but they're all over the country. And unfortunately NPR and PBS and everybody else has picked up on this bandwagon of saying that people are being falsely convicted of the shaken baby syndrome which is not true. The shaken baby syndrome is not a crime in any state.

There are innocence project lawyers, there are law professors, there are others who have an agenda, and the main agenda is being driven by physicians who are not experts in child abuse who testify regularly in courts as either parents' experts in child welfare cases or as defense experts in criminal cases whose agenda is to make money on this, and that's where these media stories come from.

So the unfortunate aspect of that is now there are some people in the public, including parents and caregivers, who have been given an absolutely wrong message which is shaking is not dangerous to babies. I can tell you it absolutely is. I've handled dozens and dozens of cases and continue to handle those cases and will continue to do so because there's nothing wrong with the science. And I'm sure Dr. Campbell could have addressed that as well. So it's

very difficult to prevent when we've been trying for years to get parents to understand how dangerous something is and now there's a mixed message being given by the general media.

So I'd like to talk about just a few very quick points, and the first one I want to talk about is something that's been touched on earlier, and I don't want to rehash anything that anyone else has said, but there is room for improvement with Child Protective Services and how we handle these cases. And Dave Carlson talked about the project that we've engaged in now in my county which is the first of its kind in Utah to specialize the assignment of CPS workers and law enforcement for that matter on physical abuse cases, recognizing that child sex abuse and child physical abuse can be as different as, you know, burglary from, you know, some other types of crime.

It's a very different dynamic. It's a different type of perpetrator and a different kind of motivation that we have to deal with in these cases. So we're now asking that CPS workers be teaming up with law enforcement, that we specially train them and assign them to just handle these cases when they come in so that they know what to look at, so that they know how to identify the perpetrators which is a major issue in our state right now that has resulted in some cases being handled in less than adequate ways, and so that they understand the medical basics of what causes injuries, the mechanisms of what causes injuries to children, and the behavioral commonalities. There's no profile of a child physical abuser or a child homicide perpetrator, but there are some common behaviors.

In fact, if I were to tell you about all of my cases, I would say about 90 percent of them involved the perpetrator calling someone other than 911 after they've just caused serious injury or fatal injury to a child. They call their mom and they say what the hell do I do now or they call the partner, the mother of the baby, or they call someone else before they call for assistance. That delay in seeking care is -- is really important for us as we prove these cases in court.

I think it's time to consider a paradigm shift with CPS workers. This was an idea that was floated years ago in Utah and never really went anywhere. But instead of having CPS workers be people who are just getting out of social work school and having these extremely difficult decisions to make, I think it's time for us to say CPS is something you aspire to. You work with DHS positions. You work with DCFS in various other ways. You learn the field of child abuse before you're on the front lines making that first contact with the families and deciding what needs to be done. I think it's time to do that.

I also think it's time to mandate joint investigations between law enforcement and CPS, and that's got to be mandated because it doesn't work otherwise. That's been the model for three decades, but it's still not working in many areas of our state.

I want to talk next about improving parenting because this may sound a little bit strange coming from a prosecutor, but I'm concerned about a general decline in the quality of parenting in our country and certainly in my state as well. Now, obviously I see the worst of the worst every day. And if I thought that was what everybody was like, I would be, you know, interminably depressed and I would probably not be able to do my job.

But knowing what does happen and what does cause people to create these problems for kids leads me to think that we need to have various -- very important prevention messages provided to parents and caregivers of children, something that will come into their head right before they do something to harm the child. And one of the best was suggested by one of Dr. Campbell's colleagues. Dr. Bruce Herman, who's an emergency room physician but also a child abuse pediatrician, once said to me, you know, no child has ever died from being placed in a crib and crying themselves to sleep, which is a pretty profound way to think about it. Because the kids who are dying are the kids who the parents believe they have to stop their crying. The parents believe that they have a social responsibility to do something that maybe they shouldn't even think about. For instance, the research makes it very clear kids cry even when all their needs are met. It's something you don't always have to do.

The other thing that I think is really important in the messages that we need to make or get to parents is that there's always somebody you can call for help. We have family support centers in Utah. DCFS now has programs for crisis support. But I think it needs to go much, much further than that. I think that when parents get to the end of their rope, they need to have somebody they can call no matter how socially isolated they are otherwise.

And if it doesn't exist now, then we need to make sure that happens. It could be a community resource. It could be a religious organization. It could be anybody who's willing to be on call. But we have suicide prevention hotlines. I think we need child abuse hotlines as well just so something will pop into this person's mind and say I need to set the baby down and go make a call.

The other things that I think are very important are parents need to understand that they have a duty not just to provide the basics of care for their children, but they also need to nurture those children. Because the cases that I see involving global neglect are some of the most sad and tragic of all because many of those kids have permanent brain disabilities, permanent neurological issues, and parents don't even know what they're doing to their children. There's all these messages that just aren't getting out to the children -- or to the parents.

And the last thing I'm going to talk about and then take questions is what we're working on now is a statewide effort to coordinate the processes of criminal justice and child welfare in the same families so that a prosecutor contacts DCFS gets all of the records including all the history of the family including unsupported allegations which tell me a lot in most cases. The child protection attorney contacts me and says are you going to file charges, what are those charges, what are you going to do in terms of the interim orders involving the family.

By working together we can actually work out a disposition of both cases that keep the family from doing the same services twice. But one of the interesting things I've seen is the child welfare system of course is very time limited now. And I can keep people on probation or in a plea in abeyance for up to three to four years. So even if they're not done with their service plan to make the problem go away and to make them safer at least to be with children, I can work out a probation condition or series of conditions that ends up achieving the same goal.

I don't have time to talk to you about individual cases, but I can tell you that this has been working in the last two or three years and that we've had people come forward and admit

what they did to cause near fatal injury or fatal injury to their children, and we've actually been able to reunify some of those families. So there's all kinds of things that we, you know, are trying and trying successfully.

So thanks for allowing me to be here today, inviting me to be here today. As my granddaughters would say when I found out there was a commission, this is awesome.

CHAIRMAN SANDERS: Thank you, Mr. Parrish.

Any questions?

Commissioner Petit?

COMMISSIONER PETIT: The last -- thank you very much. That was very illuminating, and I'm looking forwarded to seeing your comments and recommendations beyond what you've delivered today. And you talked essentially about there isn't one approach that works best because there's a variety of profiles that people look like in situations that they're in.

But two questions. One is in those cases where there is a history -- and you said there were many cases where there is no history, so it's kind of tough to prevent something when there's no indication that there's a problem. So sticking with those cases where you've got people through -- they're repeating their childhood, they're repeating their cycles over several generations in which the way they get what they want is they push people around, they use violence in those cases.

What do you have -- and this is -- rolls into the second questions. The vehicle -- when you said there are some of these people that have committed near fatalities or fatalities and you can still invoke what sounds like you've still got a string tied to them through probation or something which you can yank them back into the process. But how would that happen? Does that happen just within the DA's office or does CPS call you and say we've got a situation or is there a multidisciplinary team in which your guys are going around and saying, you know, we didn't know this guy was out, we didn't know he was back in this household, we thought she divorced him, we didn't want him around, and all of a sudden she's telling us that he's harming her or harming kids? I mean, what's the vehicle you use that actually ties this together?

ROBERT PARRISH: You know, good question. The vehicle we're trying to make work, and it's starting to work quite well, is the Children's Justice Center. We're the first county in Utah to have the Children's Justice Centers take a real active role right from the beginning of the investigation where they screen all the child physical abuse cases and all the child homicide cases and everybody comes together.

Somebody earlier asked a question about why not have the team -- the multidisciplinary team activated not to review after the fact but right at the beginning, and that's exactly what we're trying to do now is to get all the different people involved so that information sharing begins right at the beginning of a case.

I've seen other states they do things like rapid response teams where everybody is mobilized right away: Law enforcement, CPS workers, prosecutors and the child protection attorneys. That's the goal. That's I think what we're working toward.

Now, in terms of, you know, does that work perfectly, of course not. There are many cases where we don't learn about a problem until it's too late. There's -- I can give you an example of a case a few years back where the mother had her five-year-old daughter removed, and at the time of removal she said I'm really glad you came and took her because if you hadn't come I would have killed her. That's a pretty big red flag. And she was placed -- through a service plan she was actually allowed to plead guilty by our office. And, you know, the conditions of probation were finish your service plan, which she did successfully. And after the trial home placement started all the same abuse kept happening with this child and it ended up being a near fatality because she hit the child at the age of seven with something hard enough to cause a permanent brain injury, and she'll be in a long- term care facility for as long as she survives.

So, I mean, we look back at those and we say why didn't we see that coming.

COMMISSIONER PETIT: Well, speaking of looking back at those, there's some upwards of 2500 kids a year killed, 3000, 4000, something. We're not sure exactly, but it's a significant number. And we heard this morning testimony, if you were here when the department was making its presentation --

ROBERT PARRISH: I was.

COMMISSIONER PETIT: -- on the number of children that were already known to the department that were killed. We know that many of the children, half or more, in the next year who are going to be killed we already know. We already know who they are. We know the pool they're going to come from. We know the 100,000 or 500,000 or two million pool that they're going to come from.

What's your thinking on the worthwhileness, the utility of looking back at some of those cases the department has open right now, some of which progressed forward to the point where the children were killed -- and you introduce this notion of a 25-year-old social worker, meaning really an inexperienced person who doesn't see what that looks like. Would there be utility for a multidisciplinary team to go back and look at a thousand cases that are already open in this county and whether or not, gee, here's something that we missed, the 25-year old person missed, I'm a cop, I'm a DA, I'm a physician or whatever it is I'm doing a desktop review. Would there be some utility in that?

ROBERT PARRISH: I think there would be. Just a little bit to tie in with Dr. Campbell's presentation about the research, it would be more helpful if we knew what we're looking for, if we knew what those risk factors were, and maybe that effort would result in identifying some of those risk factors that maybe right now we don't even really have a good handle on. So I think it's worth doing. I think it should be a statewide effort not just county by county. And the best people to do that would probably be the state Department of Health.

You asked a question earlier about, you know, the total number of fatalities in Utah, and that's actually handled by the Utah Department of Health who take into account all those deaths that were known, families that were known to the system but also all the others as well. And I've been on that child fatality review committee, the statewide child fatality review committee, most of my career. Started in 1992 and I was one of the charter members

of that. So there's a good source of information there, and that would be a great group to ask to do that kind of retrospective, you know, examination.

COMMISSIONER PETIT: Hillsborough County in Florida has done that and they do have an actual set of criteria that they say --

ROBERT PARRISH: Great.

COMMISSIONER PETIT: -- these are the facts that we're looking at which I think deserves another look by us as well.

CHAIRMAN SANDERS: So we should probably -- we have two more questions and hopefully they'll be brief.

Commissioner Covington?

COMMISSIONER COVINGTON: Yeah. Thank you, Mr. Parrish. I really respect the work you've done for most of your career. We've been sort of following -- I've been following you. I remember way back when -- the first shaken baby conference in Utah that I attended.

So I've been thinking, it hasn't really come to our -- we haven't had a lot of discussion on this whole sort of shifting of the pendulum back around the prosecution of abusive head trauma and how hard it is now. It's getting harder and harder to prosecute these, and convictions are getting overturned. Do you have some ideas on some significant recommendations that we could be considering at a national level in terms of addressing this?

ROBERT PARRISH: You know, that would probably take a lot longer than we probably ought to take today, but I would be more than glad to share with you -- just send me an email. I will share with you all the things that I've been doing with APSAC to respond to some of the misinformation that's out there, with a number of different kinds of agencies to respond to that misinformation. Because what's happening is the misinformation is affecting jurists, but now it's also --

COMMISSIONER COVINGTON: Right.

ROBERT PARRISH: -- getting back to judges, and the judges are reversing cases based on what's allegedly new research, and it's not new research at all. It's the same stuff we've been dealing with since the 1980s, and they just don't know that.

COMMISSIONER COVINGTON: I'm just thinking instead of, you know, dealing with this on a case-by-case basis which is sort of what's happening now, if there's some thoughts about what could be done at a more national level to sort of try to address this.

ROBERT PARRISH: The National District Attorneys Association is kind of the key, and they're coming up with what's called an abusive head trauma kit which will have information on each one of the well-known defense experts, how to cross-examine them, how to, you know, review all of the --

COMMISSIONER COVINGTON: More tools.

ROBERT PARRISH: -- science behind everything. But the bigger problem is training prosecutors to know what they need to know, because I've learned it over 32 years. Most people don't have that kind of luxury to learn and they get a case two or three years into they're career. So what we're trying to do is substitute for that so that they have a place to go where they can do their homework and get it up -- up to speed quickly.

CHAIRMAN SANDERS: Thank you.

Commissioner Rodriguez, this will be the last question.

COMMISSIONER RODRIGUEZ: Well, I was just thinking about the statement that you may made about how important it is for every parent who's under sort of stressful conditions to be able have somebody to call. And I was also thinking about how difficult that is to sort of artificially create that. And, you know, when you can, you can typically artificially create it in the moment. But in terms of that being a long- term person that you feel like you can always call if you're -- and so I'm just curious.

With the families that you are seeing, have you seen any efforts made to sort of build up their natural support system like identify -- if they're very isolated to identify family members or other folks in the community who are not, quote, unquote, you know, paid professionals or programs who can be there are to support that parent and their parenting?

ROBERT PARRISH: Definitely. And, again, it's just on the sort of nascent beginnings, but I've seen all kinds of different approaches that are -- that are working. Let me just give you a quick example, and that's with refugee families who come here as refugees from various countries from, you know, all kinds of different cultural beliefs and backgrounds.

Now they have to obey a series of child abuse laws. Child abuse wasn't even on the agenda for them because that's -- you know, they're just trying to survive on a daily basis. So there are outreach services now being offered to that group to not only educate them about child abuse laws in Utah but offer them support and assistance from other similar people who come from the same state so that if they're in that crisis they -- you know, they can call somebody and talk to somebody who understands their culture. That's just one of many examples of things we need to do.

And, you know, I think the main message that needs to get to all parents is there's no loss of face in asking for help.

COMMISSIONER RODRIGUEZ: Right.

ROBERT PARRISH: I mean, most people believe that it would be worse to call for help than the ultimate result which is hurting the baby. And, you know, I think that's really unfortunate that we can't get beyond that.

COMMISSIONER RODRIGUEZ: Thank you.

CHAIRMAN SANDERS: Thank you very much, Mr. Parrish.

COMMISSIONER DREYFUS: Thank you so much.

COMMISSIONER COVINGTON: Thank you so much.

COMMISSIONER DREYFUS: We need to clone you all around the country.

CHAIRMAN SANDERS: We're going to take a lunch break. We'll return at 1:40 and we'll have our next presentation on Wichita.

(A break was taken from 12:55 to 1:53.)

CHAIRMAN SANDERS: We'll go ahead and get started. We have two people from Wichita: Vicky Roper and Vera Bothner. And we had -- by chance, and it was Commissioner Dreyfus, heard about the outstanding work that's occurred in Wichita to reduce child abuse and neglect fatalities over the last eight or nine years. And we had a chance to talk to Ms. Roper to get an overview of that and thought it would be ideal for the full commission to hear the work that's gone on. It's very impressive.

I'll turn it over to the two of you. Turn your mic on.

VICKY ROPER: Okay. Thank you, Chairman Sanders and members of the commission.

I am going to do kind of a PowerPoint and then turn it over to Vera who will do her little piece. Is there a way to advance these?

STAFF MEMBER: You press the green button.

VICKY ROPER: On here? Ah-ha. Okay. All right.

The Wichita Coalition for Child Abuse Prevention formed in the fall of 2008. We had eight child abuse deaths that occurred that year, and "The Wichita Eagle," our local paper, called that out, and put out a challenge to social service agencies to come together on this.

And we had a summit meeting that was interesting and have had probably 116 people at that original summit meeting. A sense of urgency had really been created. And this work began as the Wichita Child Abuse Fatalities Community Response Team, and over the last six and a half years has turned into the Wichita Coalition for Child Abuse Prevention.

It currently involves over 130 people representing over 60 agencies in Wichita. This is sort of a noncomprehensive list of partners. I think there's 48 on there. We actually have 6O and I couldn't figure out how to get them all on one slide. So you can kind of see that this is a multidiscipline group that's coming out of social service agencies, early childhood, government groups, you know, the DA's office, law enforcement, faith-based groups, parent leaders, business. We have nine sectors represented and we track those. The hospitals have been key partners.

The structure of the team, it's really a community change initiative. We did a lot of research in the very beginning, and HHS had created a community change initiative. Information, we spent some time talking to The National Center for the Study of Social Policy and the Council on Accreditation, which accredits my agency. The Kansas Children Service League had created a community change initiative standard that we met. So we started that way.

We've since probably moved into more of a collective impact team. As that work was coming to the fore, that Stanford Innovation didn't really have their article come out until 2010, so it was sort of -- we were in a couple years before all of that.

This work has been funded by the Kansas Children's Cabinet & Trust Fund, which is our CBCAP lead agency. And they have funded with CBCAP funding stream. That funding stream in our state funds before abuse ever happens in the first place, so what I think of as primary and secondary work. And we started with $33,000 which funded Wichita State and some of my position, and now we're at $150,000 in the last two years in the work that's being done by this coalition.

The large group meets three times a year, and I chair that. And work groups meet monthly in the off months. And we probably have 40 to 45 that are really active enough in the work groups that we are doing social network analysis involving them.

Our leadership team meets six times a year and the following agencies, I guess, have taken leadership roles. We're really -- the Kansas Children's Service League and Wichita State University Center for Community Support & Research are what we call the backbone agencies for this initiative now. Kansas Children's Service League is really a child abuse prevention agency. We're 14 million.

We -- Kansas was one of the first states to privatize child welfare, and we were a contractor. But at some point we had the Department for Children and Families' secretary that came in and cast the deciding vote were we weren't going to stay in child welfare, and we moved into child abuse prevention. So we have reinvented ourselves really as child abuse prevention, although we do have a sliver of child welfare. We have resource homes that are, you know, doing some therapy work and we have some adoption.

So these are the agencies with additional leadership team roles: The Wichita Children's Home which really helped me with that initial summit meeting and taking a huge leadership role. Subsequently, the two hospitals in Wichita which serve 10,000 as far as birthing hospitals, live births, which is the largest in the 13-state area out of Wesley. Kansas Department for Children & Families has taken a major role, and we'll talk about that.

Rainbows United is our children with disabilities agency; the Child Advocacy Center of Sedgwick County; the Junior League Wichita which adopted child abuse as their cause for multi years; Child Start, which is our Head Start agency and our resource and referral agency for child care, thus they've combined the names to Child Start; and the Wichita Police Department.

Very early on we've had a lot of champions that helped us with this work. So in addition to "The Wichita Eagle" that created a sense of urgency, our champions really got in there earlier and a former lieutenant governor for the state of Kansas, Utilize Wichita Police Department data. Your Child Death Review Board data is going to take two years to get to you, you're going to have all these obstacles, and, you know, he made that happen immediately. So that was wonderful.

Our first meeting was at our governor's Conference for the Prevention of Child Abuse and Neglect, and Dr. Vince Felitti just happened to be presenting, and Elizabeth Shore just happened to be presenting, you know, the author of "Common Measures," and they met us and did an attaboy, you guys can do this. So that was really helpful in the very beginning, too, so I've got to credit a lot of champions for helping get all of this started. I think the beginnings are pretty crucial to any initiative like this, and they were very involved in our beginnings.

Okay. So Wichita, Wichita is the -- we say we're the aircraft capital of the world, and our market niche is corporate and leisure aircraft, and you can imagine how that has been decimated in the economic downturn. Boeing has left Wichita over the course of this time and we have had layoff after layoff after layoff after layoff to the point that the Annie E. Casey Foundation came out with information in 2012 that Wichita was one of the five worst metropolitan areas for having children move into poverty during the economic downturn from 2007 to 2011.

So recognizing that we were in an economic downturn and we were starting early in 2008, and this was mostly at the very end of 2008, to see this kind of spike in fatalities, we moved -- mobilized, to implement systems to prevent child abuse from happening in the first place. Those first eight fatalities nobody was in the child welfare system. This was not a child welfare issue. We needed to come together and figure out how to prevent abuse from happening.

Our mission was to empower organizations in Wichita to create an effective system to prevent child abuse and neglect, and I take that a little further. You know, really it was to make this about kids and families and make sure that we were the leaders that were coming together as this was happening in our community, and we needed to figure out how to step up and lead and to collaborate. And I can remember one meeting where I said this is -- this has got to be about kids and families and if you can't do that, step away - - I mean, push your chair back and step away and ask somebody else from your agency to step forward.

On the eight child abuse fatalities in 2008, the Wichita Police Department categorized seven as child abuse-related homicides and one as a child abuse neglect death. And the triggering event determined in three of the five fatalities where the information was known was child crying. We kind of know over the course of, I don't know, 2007 to 2014 we're at about 44 percent of our fatalities are abusive head trauma.

Six out of the eight fatalities happened while the child was in the care of someone other than a biological parent. That was unusual, as the national data didn't paint that picture for us, at least in the beginning when we first started. You know, we could see that in child maltreatment 2007 it showed that 70 percent of the perpetrators nationally were a biological parent. We've subsequently learned that we have a boyfriend issue. This was the first year in those original eight. Three were boyfriends to the mom, one was a stepmom, one mother, one father, and two daycare. In subsequent fatalities we've seen a lot more boyfriend situations, and I'll hit that.

All eight fatalities were children birth to four. That's a little much, but expected. Male perpetrators, 10 of the 14 perpetrators from the whole period were male; seven were

boyfriends or ex-boyfriends of the child's mother. The Kansas Attorney General's Office Child Death Review Board report lists male living in the home who is unrelated to the child is a risk factor for these child abuse homicides.

This is a police department slide. You can kind of see what was going on in previous years and the spike that happened and what that looked like. And our department for children and families mapped substantiated cases, they mapped fatalities, they overlaid those, they looked at TANF. You can, not surprising, see that our highest areas are -- we call it right down the canal route which is the heart of the community.

We use the Heart of Change, John Kotter and Dan Cohen, kind of as guiding us in the initial years in the very beginning. You know, build an increased sense of urgency, build the guiding team, get the vision right, communicate for buy-in, empower action, create short term wins, don't let up, and make change stick.

And then we moved into collective impact. Our Kansas Health Foundation established a Kansas Leadership Center that had done a lot of training. Six -- actually eight members now of our leadership team have been through that collective impact training, and both of our backbone agencies are the backbone agencies for our CDC Essentials for Childhood Project for Team Kansas, and we've all been through the FSG training in addition.

So you guys have probably seen all of this, but collective impact is about moving from isolated impact, which is where we were before we began all of this, where everybody was sort of siloed and in turfs. And in the very beginning, you know, boards wanted certain things out of this and, you know, we were going in, meeting with boards and meeting with individuals from agencies and trying to ascertain all of that and then move to collective impact, and how can we work together, and I am a big believer in this. We are better together. If, you know, two heads are better than one, 130 heads are better than two. So we are better together.

This is a little bit from -- I think these are FSG slides around collective impact. This is what needs to be in place in order to call yourself a collective impact project. You have to come together with a common, agenda which we had, shared measurement. We had in that first year, year and a half 61 strategies. I mean we were doing it. You know, I mean 44 over here. So, you know, we were -- had a common agenda, shared measurement, mutually reinforcing activities, continuous communication, and backbone support. And I can't tell you how important I think backbone support is, to have that in there. And that's what I think is missing in most collaborative projects.

And then to support progress against the common agenda, this -- these are the activities of those backbone organizations. I know a lot of things will say maybe you just need one backbone organization, but we've divided it into several. How the CDC set their essentials project up is they had required partners from the beginning which I think has worked really well. They are prevention.

So, you know, it was the Prevent Child Abuse America chapter of which I'm the director in Kansas. It was, you know, the CBCAP lead agency of which the trust fund was. It's the, you know, Circle of Parents or Parents Anonymous group, you know, as an empowerment piece. It's the health department. So, you know, it's -- it's a lot of different groups that are required

and coming together initially, and we've deviated from that a little bit now that we kind of are in to this, but I think that's been really helpful. Supporting aligned activities, establish shared measurement practices, building public will, advancing policy, and mobilizing funding -- you have some handouts from me that show a lot around this.

We adopted, initially early on, the strengthening families approach. We looked at a social ecological model and we started in probably a little more at the individual and relationship level, but we have since really moved to cover the entire social ecological model and have brought in ACES and safe stable nurturing relationships in environments and getting us to the community and the societal levels. But these have been great in really giving shared language. And, you know, we had a town hall meeting about child abuse prevention one time in Wichita, and, you know, with 116 people at that time on the coalition, everybody knew what this was and everybody knew -- had input into how do you prevent child abuse and neglect, and I didn't have to say a thing.

The strengthening families work is around protective factors. And we're lucky in Kansas, the University of Kansas designed the initial protective factors survey, so we go back many years and we're able to utilize that. I think it got its evidence base in 2010 and has really helped us. Our -- this is a CBCAP project, and our Kansas Children's Cabinet and County Trust Fund lead agency is requiring us to use common measures. They selected about seven in the CBCAP project. We're utilizing the protective factors survey and KIPS for our work so that we can tell a prevention story to legislators and to other cabinet members and a lot of different groups. And common measures have been huge in Kansas.

This is a little bit about the safe, stable, and nurturing relationships framework, and this has also been adopted by the Kansas Children's Cabinet and Trust Fund. They kind of have three buckets, and one of the buckets is healthy child development, and one is strong families. And so this framework has guided all the CBCAP work in the state of Kansas.

We have trained the entire group in adverse childhood experiences and safe, stable, and nurturing relationships and environments. We've handed out the CDC's most recent posters about how you talk about this and what works. We've done a lot with messaging. We are the Prevent Child Abuse America chapter who are really kind of known for a lot of the messaging and prevention and working with frameworks. And we've added bullets around adverse childhood experiences and SS -- I shouldn't call it that, safe, stable, nurturing relationships and environments to that messaging.

And then this talks a little bit about in our work we weren't allowed to press send at the very last minute. We were able to submit for a, you know, letter of intent, but in the last minute the state said we're not going to let you press send. So we are a self-sustaining state with a level one commitment, and we have received $150,000 in private support to make the same commitment that the funded states are making in this project. And it's the same Wichita State and KCSL backbone, so we're able to bring a lot of that into this -- into the Wichita work.

Initially -- I kind of divide what's happened into maybe a couple of parts. The first 18 months we had different work groups than what's been going on subsequently since then. And we're

starting to see that we think that will probably happen in our essentials work, too, so I -- you know, I think that's the thing.

Parent support is chaired by, you know, one of the social workers from the hospital, and then community awareness was chaired by the children's home early, and part of what they did was try to increase services. But what happened in the -- you know, we've just kind of experienced cut, cut, cut, cut, cut. So it's, you know, working on advocacy and it's working on, you know, all of those pieces. But you can see kind of where we were going.

We created a strengthening families resource map for the medical community. The medical community felt like an unusual partner, like they'd been disconnected from early childhood and child abuse prevention, and the hospitals really desperately wanted strengthening families resource maps. So we put that together and showed them where all these services were to make referrals and, you know, kept that up.

The big thing that the community awareness work group then did was to implement the Period of Purple Crying. This was 2009. It had been an evidence-based model with two new randomized trials and created by the National Center on Shaken Baby

Syndrome. We love it because there was a lot around healthy child development in there: Infant crying is a normal part of healthy child development, be careful who you leave your child with, don't leave your child with somebody who has anger management issues. You know, there were just a lot of messaging in there that we liked.

We had 35 people come together to preview all the materials and do a side-by-side, you know, model 25-member agency work group, and it was selected there. We had originally brought in Marilyn Barr, the co-founder, and she presented at the 2007 governor's conference, and then we piloted in southeast Kansas. And so the Department for Children & Family staff who'd piloted it got on with Wichita and shared their experience and made recommendations and helped us with lessons learned about moving forward.

This was done differently in Kansas probably because it -- it came out of urgency and it went statewide quickly. People didn't want just Wichita doing this. So 68 of the 70 birthing hospitals in Kansas are -- have now adopted this. But it's gone champion to champion because of the collective impact team that was involved in Wichita. You know, the child abuse pediatricians talk to the other child abuse pediatricians. The nurses talk to the other nurses. The hospital staff talks to the other hospital staff.

It went -- we didn't go by, you know, position, like this position should always be implementing the Period of Purple Crying in a hospital. We went with who the champions were that had the passion for this and would continue it in the future when they left their position and attribute a lot of that to success.

2010 to 2015 we changed the work groups. The Period of Purple Crying moved to a program of case DSL and crisis nursery. We visited St. Louis and their crisis nursery, and that was adopted by a work group; fatherhood, because our fatherhood numbers were so high; further research and education; and then community outreach. And you can kind of see here what the different missions are.

We were just trying to provide drop-in childcare and case management services for children in crisis nursery whose families were experiencing extreme stress in order to prevent out-of-home placement, preserve the family unit, provide resources for empowerment. And we're now trying to move into a 24/7 facility and have the green light from several agencies, so we'll see how that progresses.

Fatherhood, we're assisting agencies to become more father friendly. We're using national fatherhood initiative checklists to, you know, do that and then implementing Daddy and Me activities, summit meetings, those kind of things to do our work. And it's very -- we pulled business in and we pulled all the agencies in and Bikers Against Child Abuse and Junior League Wichita and Kids for Kids at some of the local high schools, you know, to help us with all of this, so it's very grass roots.

Education and research, we're implementing presentations for the medical community. Our child abuse pediatricians, which just kind of came in midway through the process as a, you know credential, recognized that most of the people that were fatalities had seen a medical professional earlier, but they hadn't realized that they were victims of child abuse. So lots of education has been happening by our child abuse preventions, and they've brought many of us in from the coalition to do different presentations.

And these have reached across the state, and they've put together -- we've all put together teams that have gone in when there's been a fatality in another community that may not know what we know. And, you know, our law enforcement may go in. The, you know, medical community may go in. And they have been amazing.

Real support for parents, that's working with neighborhood groups in the 67214 ZIP code which is our ZIP code with the highest number of fatalities and substantiated child abuse and neglect. And they're getting resources in to access points for parents from that ZIP code area, so diapers, wipes, formula, but also resource information, parent help line information, you know, all -- quality childcare, you know, resource line information, all those kinds of things that you would expect.

And they're working with the faith-based community. We have worked with the Catholic church and the Methodist church in two of their food banks, but we just went in last week with Partners for Wichita, which is a coalition of dozens of churches around the community to help us -- we're having funding cuts, so help us get all of this donated and, you know, get the churches better engaged.

And this is what -- I'm not really sure on the 2015 number, but this is what we think we are in the last year, in 2014. The Wichita Police Department presented on this this morning, on our numbers this morning, so this is where I think we are. In 2014 one of those fatalities was a hot car death you may have heard about in Wichita. And in 2015 -- and I -- I don't know. It doesn't look like they're counting this, but it was a mom and a child, very young child, who moved to Wichita and moved in with a boyfriend from another community long ways away, and then the boyfriend was the perpetrator of the child by Wednesday. So they came in over the weekend, and the fatality happened on Wednesday.

The leadership team identified achievements. So the big one was networking amongst social service providers -- or service providers to improve the prevention service delivery system and remove barriers to services in the Wichita area, creation of the strengthening of families map, implementation of the Period of Purple Crying, establishment of the crisis nursery, beginning the real, you know, support group, creation of the Greater Wichita Fatherhood Coalition, and establishing the research and education team.

I was asked about the role of the Wichita Police Department, and I wanted him to be here, but he had other meetings that took priority. But the mayor appointed the deputy chief to the coalition, and he was absolutely a difference maker. He was fabulous. The Wichita Police Department data was used, so he made sure that was always available in realtime, and he communicated at every single large group meeting. We worked together on the advocacy efforts amazingly well. And he went and talked to the media to give us opportunities to get prevention messages out. And even when our Department for Children and Families was under fire on a case, he would back the media down.

And our deputy chief and DCF regional director and I met with school district staff to get Elijah's Story and the Period of Purple Crying taught to every high school sophomore by school resource officers who were males, so we needed those male role models doing this, and he made that happen within days. I thought it would take a year. It was days. And then he worked with other police departments across the state as child abuse homicides occurred, and he would talk to us about the latest cases in realtime.

So examples were a new mom arrested for traffic tickets and taken to jail, and the child was killed by the boyfriend. And the deputy chief -- corrections was in the room and said, hey, corrections, what's up with this, and they said we'll get on this. Everybody said we'll get right on this. And then a baby was overswaddled and died and the deputy chief talked to the hospital staff about their education, and I thought they were going to push back, and they said we've got brand new parent educators, we'll get right on this.

And then the regional director for the Department for Children and Families was amazing. She introduced us to Vera Bothner. I think -- and she'll talk next, but I think she realized we were in over our head and needed that assistance. She was a -- you know, a great champion. She secured Department for Children and Families funding in each region for Period of Purple Crying. We had been using self-made materials around abusive head trauma and shaken baby syndrome, and those had just run out coincidentally, and they said, you know, we've got 35,000 here. And I said I think there's more evidence-based models, I think we can do better. And she helped drive that through DCF. And then that was only enough funding for Kansas City, Wichita, and Topeka, and so she was able to get funding from her peers regionally to cover the rest of the state. And she met with us with the Wichita Police Department to get Purple and Elijah's Story into the high schools.

She met with the hospitals and me when Medicaid paperwork wasn't being processed quickly enough and new moms were delivering without prenatal visits and helped the hospitals navigate the system to get that changed. She coordinated maps at DCF to overlay, which I've talked a little bit about. So she was a real champion.

And the current staff from DCF have been great too. One went with us -- kind of the No. 2 person in our region went with us to the St. Louis crisis nursery and has had great input into that, you know, project. And their regional director and community liaison have been very involved in all area -- in the different work groups and getting staff into the different work groups and getting us the data that we need timely, which has been amazing.

The health department people have asked me about their role in this. They gave us survey results that showed that Sedgwick County, which is our county, saw child abuse prevention as a top priority, I think it was No. 2, and presented on those results at a large group meeting. They met with me about coalition building. They kept staff on the work groups and the large group, and they connected this project with other projects that they're doing.

So I'll turn this over to Vera.

VERA BOTHNER: All right. Thank you, Vicky.

So my business partner and I have a business model where we are very particular about what we do, and it tends to be complicated issues. And in this particular case when the head of DCF called, I'd already been paying attention to the news. And my particular passion is early childhood, and so I immediately agreed to come and donated the time to help get the coalition started on the right path with the news media.

VICKY ROPER: It was all free.

VERA BOTHNER: It was all free.

We -- we specialize in audience research and strategic communications and strategic planning. We have worked with numerous coalitions throughout Wichita and throughout the state of Kansas, and I can tell you just from an outsider as someone who watched this coalition put together and then has seen its success, they have done it all right, and we know how rare that is.

My business partner and I have worked with a lot of coalitions, many who get it right, but it is hard, hard work. On top of that it's hard for prevention for strategic communications because prevention is complicated. It's very complicated. If it works, you've prevented something, which is not an easy story to tell. The news media in particular need easy stories, and they need easy stories because we have very short attention spans as human beings.

In 2008 our attention span was 12 seconds. In 2012, four years later, it was eight seconds. Soon I'm afraid it's going to be like two seconds. So being able to package and tell stories, particularly in prevention, is very, very difficult. Strategic communications, we really focus on three areas, and we worked with the coalition on this very carefully.

It's got to be targeted. Who's the audience? Who are we talking to? What's the outcome we want? It has to have an outcome or else you're just saying words. What do we want people to do? It also has to be incredibly consistent, very simple messages. This is very hard for coalitions to do because we all talk in jargon. Right? And we all tend to talk in different jargon. And the public shuts off jargon and shuts off complicated messages. And if it's not consistent, it never ever breaks through.

One of the things I was most impressed with the coalition, and it really caused me to continue to be involved, was their evidence-based efforts. And I believe the same thing in communication. In fact I think what we do in our issues like child abuse prevention is so important that if we're not using evidence-based strategic communications, then we are failing, the ultimate fail, because you have to know that those messages will get through.

Large corporations spend millions of dollars doing audience research to know that their messages will get through and will be understood by the audience. And too often we sit around and just in a room come up with the messages that we think that should be there. That's one of the reasons I'm very impressed. I know you've talked with Frameworks Institute. They do a great job of really studying how people actually talk to each other about social issues so that you know that you're getting through. Our attention is really just too valuable to these -- for these issues to do anything less.

With the news media you usually have two options. One is reactive. They've caught the story and they're coming to you, which is what happened really essentially with the coalition. Right? The other one is proactive. We have a story and we need to get their attention. They have different push and pulls of those situations, but either response has to be essentially the same. It has to be the same clear, consistent messages. You have to know absolutely who you're talking to and what you want them to do.

The other thing is the coalition has to be open to all being on the same page, and that's where I cannot talk enough about how well Vicky really managed this coalition to make sure everybody was on the same page. Her talking about if you can't be there, push away, it's okay, that is critical because if you have coalition members disagreeing with each other or not saying the same message, then the media gets a mixed message and then your public does not know what to do, your audiences do not know what to do.

Some people talk about mass media being, you know, the traditional media, if you will, just no longer mattering. In communities like Wichita, in most communities that are mid major communities, and I would even venture to say in larger communities as well, it is still the local media that provide what is the agenda, what does the community care about right now. And when "The Eagle" said you-all need to do something about this, they created a sense of urgency that then Vicky and the coalition was able to pick up and run with. It's sometimes harder the other way.

But that agenda setting -- there's a great quote that if you don't exist in the mass media, for all relative purposes you don't exist. There's another great quote by Abraham Lincoln that if you can build the public will behind something, then you can get it done. If you don't have public will, it's very hard to get anything done. So much of what we were about was trying to build the public will.

In addition it was knowing how short media stories need to be. It was how did we help the coalition move from the tragedy message to the prevention message. Research shows that the average length of a sound bite is 27 seconds -- I'm sorry, 27 words in a newspaper. Average sound bite is nine seconds, and the average time it takes to say 27 words is nine seconds. So whether you're on television or whether you're in the newspaper, you have 27 words in nine

seconds to deliver that message. That is not much time. If you focus on one part, you're going to miss the other part.

So part of what we had to do was build those opportunities for being able to deliver the prevention message. One of the things we worked with the coalition on was how to move it from sending out blanket news releases to finding those reporters who were either on the beat or who had a particular interest in this, whether at the newspaper, at television, and really working with them very closely. And then you have to have, again, all partners telling the same message. When Deputy Chief Tom Stolz talked to them, it's different than when Vicky talks to them. Again, if you're all on the same message, those clear, consistent messages tend to come through.

We really talked a lot about who the audiences were, and in this case we knew, and I'm a big believer, that the mass media is a reminder, it is not an intervention in itself. It is not a program. If you had not had the coalition working on the visits with every mother and father or parent leaving the hospital, then what we were doing in the mass media would not matter as much. We're not reaching young mothers and young fathers through the mass media. We're reaching grandparents, sometimes parents. We're reach opinion leaders. We're reaching the community.

And part of that is reframing it from a tragedy in a singular situation to the full complexity of socioeconomic situation, they system, if you will. That is a hard story for the news media to tell, so you have to make it easier for them because just like us they're busy with many different things and they're not going to be able to sort through it all.

When we implemented the Period of Purple Crying, it was a wonderful opportunity to take it from reactive to proactive. Here's what we're doing. Here's what is important to know. I remember thinking as a young mother it would have been wonderful -- and I wasn't that young when I had my children, but it would have been wonderful to have known here's what that process is and there's times there's nothing you can do. So normalizing -- in many ways it's about creating a series of cultural norms and normalizing the behavior that's occurring as opposed to here's a tragic one incident. And that's part of what that telling the story has to be.

News outlets love the one-person story. It's compelling. It's why they tell it that way. And stories are so important to how we as humans process information. In fact there is research that shows if you have statistics and a story, the story will win out every time. The anecdote will always convince the people that this is the case even if you have stacks of evidence to the contrary. So some of this is helping us reframe the way we talk about system situations to the stories and to being able to provide a story about how we help people through a systemwide approach. It's not easy, but it's worth it.

VICKY ROPER: Isn't she good?

Okay. The Wichita State University did a process evaluation for us every year, so 2010, '11, '12, '13, '14. You have 2012 in front of you. And it has a social network analysis which I love, and we're doing another one this year. And I was really skeptical about doing that. I thought it

would show that early childhood was all talking and connecting and nobody else, but it did not. It showed that everybody was pretty well connecting.

There were a few outliers and we would talk about that at our leadership team meeting. But the work that they did in process evaluation really helped guide the leadership team with our work. They did more than this, but they conducted focus groups, SurveyMonkeys, World Cafes, social network analysis, all sorts of different pieces to produce an annual report for the Kansas Children's Cabinet and Trust Fund and to guide our work.

And then this is kind of fun. In 2011 Prevent Child Abuse America awarded Wichita, Kansas, the 2011 Pinwheel City USA Award, and so that kind of energized, too, having, you know, that come, I guess, three years after we got started, everyone realizing that they had this huge list of standards we had to all meet, that we were doing a lot of the right things, and it, you know, helped with propelling us forward. And then this year in 2014 we received the Exemplary Service to Children and Families Organization Award Winner at the Governor's Conference for the Prevention of Child Abuse and Neglect.

So they'd asked me to make replication recommendations. I believe in the collective impact model and training. I believe in backbone agencies and that training. I -- I think I believe in required partners similar to the essentials for childhood project. I don't know who they would be or what that necessarily would be. You-all know that better. I believe in process evaluation. I think with our essentials for childhood we're moving on to the KU Community Toolkit which is ODSS. And it's something that the World Health Organization and the CDC have used a lot. I met with them at one point. They said, you know, we really need to be doing more in Kansas. I was like, yes. So they're going to help us with our process evaluation at the essential project and hopefully may help us in Wichita. Then we're using a Robert Woods Johnson tool that's reliable and valid now in social network analysis.

Publishing a media guide similar to the CDC Shaken Baby Syndrome Media Guide, and Vera would be great to help assist with this. I know there's good people. Frameworks is out there, and Lynn Davy trained us last week from the CDC, so I know there's people out there. But I just think it was critical for me when this came out kind of partway through the project to be able to send this to our champions and the media outlets to be able to draw talking points from.

And then I believe in CBCAP funding. I think the majority of these cases are happening before child abuse ever happens in the first place, and they need to be driven by people that have that link and have those strategies and have the ability to do this collective impact work.

I believe in publishing a monograph with lessons learned and contact information for communities who have done this work. I sent out something across listservs with the trust funds, with the PCAA chapters, with other, you know, listservs. Nobody had done this. So when we started, you know, we just started. And, you know, we did consult Community Change Initiative stuff and National Center for the Study of Social Policy and some other pieces that helped us with community collaboration work.

But we had to develop policies and procedures because we were Council on Accreditation approved and, you know, we had to do a lot of that. And I think it would be great to have a monograph with all -- I would have loved to have had that so...

CHAIRMAN SANDERS: Commissioner Dreyfus.

Thank you very much.

Commissioner Dreyfus.

COMMISSIONER DREYFUS: Wow, wow, wow. That was fabulous. Thank you so very much. I want to make a comment and then I have a question. And I guess to anybody here that's thinking, well, this is just Wichita, Kansas, and what about every place else, I just remind everybody in Washington state we were -- when I was secretary there, I inherited an amazing commitment by Washington State to the reductions of adverse childhood experiences. We were one of the first states with funding from the Gates Foundation to collect ACE scores by county through the Behavioral Risk Factor Survey. Today Washington state is sitting with close to 20 years of this data. Right?

This community capacity that they laid out is not an art. It is a science. It can be created and replicated. And what we found is that in the counties that had this community capacity that they just talked about, and we did an evaluation where we could clearly articulate what that capacity looked like, it was with everything you guys were talking about, right, we saw lower ACE scores. We actually saw ACE scores go down and, and because my state agency had all of social health services, we were able to look at what we were actually seeing by county in terms of reduction and incidences: Abuse and neglect, teen pregnancy, higher high school graduations, higher age of the onset of early age drinking. I mean it went -- better health outcomes. For every dollar we were spending, we were saving $7.

So I just want to as a comment say that this isn't voodoo. This is -- I think this is how our nation moves from program thinking to systems change thinking. And I think when we all are hearing about place-based work, whether it's the Harlem Children's Zone or it's Promised Zones or whatever people want to call it, right, this is really what's at the heart of it, and it is replicable and it is scalable. And I just believe it does make a difference.

I wish Dr. Rubin were here, so my comment is more on his behalf.

MS. TEMPLETON: He's on the phone.

COMMISSIONER DREYFUS: He's on the phone. I'm sure he's loving this, so great, David.

Question: Did you find with those results in the incidence of abuse and neglect obviously going way down? I'm sure there are people who would say, well, but that's really what your pattern was before. You had this strange spike and you're back down to your previous pattern. And I suppose there are those -- but have you seen a reduction in substantiated abuse and neglect? Have you seen that the children who are coming into the system are -- it's earlier where we're able to keep children safely at home and get services in there? Is it changing that Child Protective Services? Are you finding that this is having an influence on those numbers and the severity?

VICKY ROPER: Reports are up and investigations are up, but substantiated child abuse is down in Wichita. And several of you have kind of talked to me a little bit about this before. We haven't had the resources to map some of the particular areas that we've really targeted, so some of this we don't know.

VERA BOTHNER: I will say I think there has been an incredible awareness among the news media in the last few years to report, report, report. So in some ways I'm not surprised that reporting is up because --

COMMISSIONER DREYFUS: That's not a bad thing for reports to go up.

VERA BOTHNER: Exactly. So -- so to me that has really helped -- helped people realize. Now we need to take that message kind of to the next step. But it really has -- that has made a difference in the last few years, much more --

CHAIRMAN SANDERS: Commissioner Petit?

COMMISSIONER PETIT: Yeah. I agree certainly with Susan that these are great models and models of community organization and models of systems change. And then the whole use of media positioning all of this I think, you know -- manufacturing consent, manufacturing awareness is critical to all this. However, at the risk of being contrary to Commissioner Dreyfus --

COMMISSIONER DREYFUS: That's okay.

COMMISSIONER PETIT: -- that chart that you showed us at the beginning that had the number of deaths, was that the Wichita chart? You showed two charts.

VICKY ROPER: It was the police department.

COMMISSIONER PETIT: What's that?

VICKY ROPER: The Wichita Police Department data that's what we've used because they're realtime.

COMMISSIONER PETIT: But I think there is an issue, Susan, if it's what I think I saw, is that in the year prior to those eight deaths there was just one, zero, one, zero, one, zero. Right?

VICKY ROPER: Right.

COMMISSIONER PETIT: So then there was a spike of eight and then it was one, zero, one, two, one, zero. I mean, how do you know that anything that you're doing is contributing specifically to the child death reduction when it's about the same as it was before?

And the other question parallel to that, what was happening is these numbers are Wichita. What happened in the rest of Kansas during that time? So from the period it spiked to eight and then followed, what happened in all the other parts of Kansas?

VICKY ROPER: Well, we've had 292 fatalities since we've been tracking which I think is 2007 to 2014. We're up in -- we are up in reports, we are up in investigations, and we are fairly flat, really flat, in substantiations. I will say in all honesty that we have the highest definition

of substantiations in the country at clear and convincing, and, you know, I'm sure that that has impacted as well.

I think it's difficult because what's happening -- the economic downturn, we are not out of the economic downturn in Wichita. We are really not out of it. And cuts have been pretty severe to the point that, you know, our Healthy Families Program has gone from 18 sites to nine. Our agency budget which -- for child abuse prevention has been cut by 20 percent, and we are going as fast and as hard as we can to private funding.

COMMISSIONER PETIT: Just in terms of some of your alliances, though, Kansas has been boldly experimenting with certain economics that your governor has been -- and it's shrunk state revenues and all that, whether it's cause and effect or not. I'm just wondering if your allies stepped forward in protecting and preserving, you know, people in the business community and otherwise who would normally align with the governor, did they say wait a minute don't touch these services to children? Did you get any of that kind of support?

VICKY ROPER: Yeah. In Kansas City the Kansas City Chamber of Commerce has adopted early childhood as one of their big five priorities, and they have a business alliance for childhood -- for early childhood education that's advocating hard, and they're on our statewide initiative, and business is stepping up. The CDC has asked me to write a case study on business engagement out of Kansas as the example for the essentials for childhood. I just presented on all this last week, but it's probably a bigger topic.

But, yes, we have huge numbers of -- of people that are out there advocating for us on the -- on behalf of -- in the business community and huge impact that's happening in this area out of the business community.

CHAIRMAN SANDERS: Do you have anything else?

COMMISSIONER PETIT: No, I just think it's not surprising that they're getting the response they are. This is a question in part of transparency helping their state come up with what the facts are, and it's their kids as well and they're not going to just start out with no never. I mean they want to do the right thing. So I think putting this out there with the press and all that, building these coalitions, I think it's a very strong model that has been employed in a lot of different ways and people want these things to work even if it's not perfect.

CHAIRMAN SANDERS: Great.

Dr. Rubin, if you can hear, do you have any questions?

DR. RUBIN: Here I am.

CHAIRMAN SANDERS: Great. Anything from you?

DR. RUBIN: Yeah. I'm getting this echo so it's sort of a little bit weird. (Inaudible).

Yes, that was a terrific presentation. I have question a little bit sort of where Commissioner Petit was going. My -- I was thinking about the cutbacks that Kansas was seeing on direct services and wondering, for example, how this looks to families. You know, if you identify families with high risk substance abuse or mental health issues, are you able to get them

services? Have you done a gap analysis at all to see whether your clients in essence are getting their access to quality services?

VICKY ROPER: We're obviously fighting that battle. I would say our United Ways are stepping up and our private business and private support is stepping up. I mean, business paid for our birth and stage model. We're going to map county by county in Kansas.

I think that -- that we had a situation where we wanted to put hospital navigators in place in our two birthing hospitals in Wichita, and United Way was going to coordinate so that nobody was referring to themselves. And we recognized that through cuts and sequestration and other things there were no services to refer to, that we were struggling in that. I think we've worked hard to try to build some of that back up now, but I do think that that has been an issue. Home visiting programs have been drastically cut in Wichita and other services and programs as well.

VERA BOTHNER: And I might add to that. Just like everything else, the politics in Kansas is complicated, very complicated. And so you can have great advocates and lots of advocacy and because of those complications it simply may not matter. And so we as a state are sorting our way through that, but it's not easy. And everything really is on the table from -- literally everything.

CHAIRMAN SANDERS: So thank you very much. This has been very informative, and I think it's a nice segue into the discussion from the public health subcommittee. So thank you for taking the time to come and talk with us.

COMMISSIONER DREYFUS: Thank you.

VICKY ROPER: Thank you for inviting us.

CHAIRMAN SANDERS: Thank you, Commissioner Dreyfus, for discovering this.

COMMISSIONER COVINGTON: Thank you very much.

CHAIRMAN SANDERS: So I know we have Dr. Rubin, we have Commissioner Covington, we have Commissioner Dreyfus. And we're going to start with the public health subcommittee.

DR. RUBIN: You guys mind if I just say a couple comments just to get started? And then I'll sort of turn it over to Susan and Teri. I think a good sort of juxtaposition after that terrific presentation by the folks from Wichita.

I just wanted to share -- if we get into what we've been doing in this public health subcommittee, share an actual case I had last week in my practice. I was seeing a bunch of new babies in practice last week and had a one-week- old infant show up in my office, you know, born to a Medicaid-enrolled mother who disclosed to me she's 20 years old, she had grown up in the child welfare and behavioral health system of New Jersey and in Pennsylvania and had serious emotional disturbance and was on a number of different medications.

During her pregnancy she had been taken off the medications and eventually delivered, moved across state lines. Did most of her prenatal care in New Jersey and then moved across state lines and delivered the baby at a hospital in Pennsylvania. The hospital in Pennsylvania

had an inpatient psychiatrist who saw mom before the discharge, but they had no outpatient facilities there and they also had no resource maps, the kind of stuff that the Wichita folks talked about. And they told mom to, quote, make an appointment to go reinitiate treatment for yourself. And by the way, come back and see us in four weeks.

The mom, very motivated to take care of this infant, lacking social support -- she didn't even have a cell phone -- came to my office, was very honest with me about her issues, her concerns, her worries about parenting this baby. And I saw her twice in the first week because I was worried about her. I got her social worker involved. We were getting consents to, quote, share information with a child welfare provider that I found out was involved because she had tested positive for cocaine in the first trimester.

She had -- it took 10 days for the community agency to make contact with mom after birth. This baby was -- basically outside of an original investigation while in the hospital had no visits in the first 10 days of life to a mom who -- with serious emotional disturbance who was off her medication.

On the second visit to me she acknowledged to me that she was having panic attacks and said she thought about leaving the baby on the side of the road. She didn't think she was going to hurt the baby and she didn't think she was going to hurt herself, but she had the wherewithal to acknowledge that she should call a friend to watch the baby for a couple hours. Right?

So because she had no cell phone I couldn't let her leave the office with that. This is someone who's in the child welfare system, and I initiated a round of calls. And I think this illustrates to me -- the following illustrates to me what I mean by a public health crisis in this country.

The first thing we did is we called the obstetrician on call and said, What are you doing to address the fact you have a mom who has serious postpartum depression, serious emotional disturbance and you did not reinitiate treatment?

Well, we didn't really know how to do that.

Okay. Let me call the caseworker at the community agency through our Department of Human Services.

Have you figured out how you're going to reinitiate treatment for this mom? Have you figured out how to get this mom into a home visiting program, either through our McVey programs or through our city programs. The caseworker had no idea what home visiting was and thought that her weekly visits were akin to home visiting.

And so then I went through a series of calls. This was a provider that actually had behavioral health services. The first appointment they could get for the mom to reinitiate treatment for postpartum depression was in August, and so that wasn't going to work. I got so frustrated with this case I then started calling home visiting programs in the city of Philadelphia, only because I had the wherewithal to know what these programs were. Reached answering machines whose mailboxes were full, and there was no point of intake at the city level to really help guide me to really get this mom immediately into a home visitation program where she probably would have done well given her motivation.

So in the end I had to eventually call the Deputy Commissioner for the City of Philadelphia and say no one is -- no one has urgency for this case. I have a mom with serious postpartum depression and a baby who's at imminent risk for fatality. If someone doesn't do something to help this family, we're going to have a problem on our hands.

And so because of a doc calling and calling the deputy commissioner, they couldn't figure out how to get her services and so they removed the baby and they're going to try for a reunification at some point down the road.

Now, I use that case to illustrate, now, I happen to know a lot of people in my city. Most people wouldn't have made the extra calls I did, and I believe there are many young infants walking around the City of Philadelphia and other places around this country who are experiencing the same lack of urgency and the same lack of coordination at a community level. And it just so happens that most of them don't die and most of them aren't seriously injured, but they're extremely high risk for being injured.

So that's the story I wanted to tell, and now I'll give you an update on the public health commission. We did meet with the Home Visiting Research Network a couple weeks ago in Washington. That's the group that does a lot of the work around the national evaluations of all the models dealing with home visiting. I thought that was a very -- interestingly they kind of focused on a couple of key issues for us that we'll help the public policy team -- or the public health team illustrate.

They cautioned us against sort of choosing models which is something that's big in that field, that they really believe the future of home visiting is around the components and so with respect to our issues, it's around some of the domestic violence components and some of the connections to resources for parents and children and that there isn't a unique model that has -- that is either better or worse for potential to prevent fatalities.

They saw unique opportunities to integrate home visiting better in communities as part of a larger public health strategy, particularly around health homes, in the Medicaid program where Medicaid is going to be paying higher capitation, around primary care to integrate a lot of community-based services, a lot of nonprofits, et cetera, whether community health workers or home visiting programs. There are some examples of that around the country. Cincinnati Children's runs a large Every Child Succeeds program and does a lot of terrific work in programs like that.

And then they had this home visiting applied research collaborative and they had some very specific recommendations for testing the relationship between home visiting and child maltreatment fatality prevention, and so we can get some of that -- those specific recommendations and try and turn the further research back to the community.

And then they wanted to make sure we didn't forget our obligation to tackling at the federal level the issue of facilitating data sharing across systems. The more data that can be shared, the better the ability of communities to be able to identify and -- the highest risk families and maybe intervene earlier before an event occurs.

So that was the focus of the HDRN meeting. We are following up on the recommendations from the last meeting we had in Tennessee about gathering the evidence around mental health treatment and substance abuse treatment and its relationship to child fatalities. We've had one contact with the Center for the Developing Child in terms of thinking about a potential panel to examine this work -- to examine this issue for us, and I think we can play with the -- sort of who would be good in terms of testifying around those issues. Center for the Developing Child is where toxic stress -- where toxic stress was coined, you know, the movement really began there. But there are other folks doing ACE work and we need to put together a panel to try to review that evidence for us.

I know that Commissioner Horn asked for -- I don't know where we are. We'd asked for some level of an analysis around some of the dual generation reimbursement issues and particularly for states that are expanding Medicaid to both adults and children. There's gathering interest in this as a way to reduce administrative barriers to provide parents treatment through pediatric health homes. So that goes anywhere from screening for maternal depression or ACEs to treatment of depression or even treatment of tobacco cessation and other models and sort of reduce the administrative barrier. So I'd ask the staff to follow up on that request to think about forwarding those types of initiatives.

And then -- and then I think I want to also follow up on Commissioner Horn's request last -- I was thinking about all the comments that came out of Tennessee, and I was really interested in the comment Commissioner Horn made about the history of the Children's Bureau and the fact that originally in the history there was a direct report from the President and that children's issues have really become diffuse and diluted throughout the federal government so that there's so many levels of reports away from the highest accountability in the government.

And so I wanted to encourage our group to think about if we -- if we're increasing federal accountability around sort of a more comprehensive public health approach, if you will, or a collective approach, if you will. How could we get to that question? I think there are a couple options that Jennifer Detwood spelled out in sort of opportunities to interact with the federal government, opportunities potentially with the surgeon general.

I think the idea of elevating as a priority position, whether in the domestic policy council, someone around family services or family issues, you know, who would provide leadership with a direct report to higher levels of government to organize the many different groups that are working on behalf of our issues but also to strengthen family is an interesting approach.

And then I -- there was some crosstalk in the interim of also thinking about the way government has organized the MedPAC commission for Medicaid services, to potentially organizing a similar type of advisory council or commission to -- to really provide a higher level of accountability and report back around -- around the many different areas of our government that are interacting to try to help support states as they develop plans around the prevention of child abuse and neglect and subsequent fatalities.

Lastly, and then I'll turn it over to you guys, I read through the draft recommendations. I'm going to push back. You guys can eventually tell me to go away. But I'm going to push back at least with a concern that -- I didn't keep notes, but I really do believe -- and it's not just

because I'm a physician, but I really do believe that we should take advantage of the opportunity to elevate what we are doing as a public health crisis in this country.

And I -- I noticed that a lot of that wording was removed at least from the draft recommendations. I don't know if that's intentional or just because we were listing recommendations. But I really do think we have to hash that out as a commission and respectful of other people's opinions, but I'm going to push. And I think that would be in our best interest to really think about the available funding and the amount of leverage from an accountability standpoint if we were to elevate this to a public health issue. And so I'll leave it at that and I will open the floor.

COMMISSIONER COVINGTON: David, can you repeat that last piece? I didn't quite -- none of us really quite heard you there about what you want to push back on.

DR. RUBIN: Well, I noticed the draft recommendations specifically -- I didn't see specific recommendations about elevating this or even a framing of a vision around that for too long we have sheltered this issue as a matter of Child Protective Services, that to achieve a true level of accountability we need to understand that this is a public health crisis or emergency or matter of public health importance that's going to raise the level of accountability both at the federal and state level beyond Child Protective Services.

CHAIRMAN SANDERS: Commissioner Rubin, just to -- the draft recommendations were simply the compilation of the one-pagers that I got from the Public Health Child Protection and Measurement subcommittee. So it -- that's -- it's just restating those in a single document.

DR. RUBIN: Okay. That makes sense. I just didn't know. All right. Thank you.

COMMISSIONER COVINGTON: And I can see part of what -- your suggestion as being part of our introduction and our whole -- we talked at the last meeting of, you know, kind of having some philosophical beliefs that we -- where we're sort of going as a commission, and I think that's one of them.

COMMISSIONER DREYFUS: I do think -- I think Commissioner Martin has helped us with this. You know, when we say public health, right, people go -- it's back to the conversation with Vera, right, about framing and messaging and what resonates. And some people -- it's hard to understand what we mean by that. I will tell you that when I read -- and I thought what Tom put together for us in terms of all the past, you know, type commissions and all the recommendations -- I thank you again, Tom, for that. It was a lot of work.

And as I was reviewing them, one of the things that I feel this commission has the opportunity to really show that it isn't just about this linear vertical view of the world, right, but our understanding of this from a -- from a more horizontal standpoint, that this -- this is adapted work, this is a complex issue, and this is a matter of public health. And I think what I'd like some assistance with is the messaging of that, right, for the report.

But if we just make another series of recommendations like past that are linear and vertical, right, I think, you know, we'll -- we won't make the big change that we're trying to make. And I think if there's any insight I've gained from this commission over these months, it's the complexity of this issue and it's the fact of the multiplicity of partners that are critical to this

issue. And so I think at the end of the day that's what our committee is really trying to bring out and address, and I hope that's not getting -- getting lost.

CHAIRMAN SANDERS: Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: Well, I just want to say that I actually -- I really support the public health approach to it, and I think that perhaps the reason that I do is that a couple of years ago I heard a speaker talking about public health approaches to solutions. And that -- and I think it was actually in the context of the ACEs work, that when you take sort of the traditional approach to dealing with a problem, it would be you have children showing up who have a serious flu and you keep giving them antibiotics, antibiotics, antibiotics, but the public health approach is to look to see where are they getting their water from and to fix that.

And that -- so when I'm thinking of it as a public health sort of issue, I'm actually thinking that the -- of it more as the solution has to be a public health solution that gets to upstream, and instead of continuing to just sort of tweak child protection and child welfare services, to do something that -- I mean, it's becoming pretty clear, to me at least, child welfare can never do what's needed for children or families alone.

You know, I mean the question of whether children are safer with or without is a different question, but whether child welfare can actually increase the safety and resilience and the well- being of children and families as an isolated agency, I think the answer to that is pretty definitively they can't do that.

So I don't know if that's part of the messaging is that there's a difference maybe between talking about the problem as a public health problem, which I actually -- my own personal opinion is it absolutely is, or if we're talking about the solution being a public health- based solution where we're trying to sort of fix upstream the issues as well as, so it might be something to think about.

COMMISSIONER DREYFUS: Just a quick follow up. If I could just follow up from the committee's perspective. One of the things I think is important in terms of the relevancy to the commission's work -- because we weren't the commission to prevent child abuse and neglect. We're the commission to Eliminate Child Abuse and Neglect Fatalities.

We know that so many of these children were not known to CPS. We heard the District Attorney talking about that today. That makes this more of a public health issue. And so I just want to, you know, make sure that you are all helping us to continue to stay focused on the prize. But what that really opened this up for me was the meeting we had with CMS, our committee had with CMS, where Vikki -- how do you pronounce her last name?

COMMISSIONER COVINGTON: Wachino.

COMMISSIONER DREYFUS: Wachino? I thought she was wonderful when she -- when she's the one that got it very quickly, that while the "N" of fatalities is relatively small comparatively speaking on a national basis, that when we're moving that number, right, the cascading influence of that in terms of inoculation, right, across all children, she really got that those few things that we're doing to eliminate fatalities, that focus, has a larger cascading across the safety of all kids.

COMMISSIONER PETIT: So I think that this is -- absolutely makes sense. I don't know of anyone on the commission who doesn't agree with it. If there are, we'll hear about it. But the part that you'll hear from me about it is that public health -- we don't want to cast that in the same way that some people -- the way they're casting CPS right now. I get that CPS and child welfare isn't going to take care of every kid. But I get that we need to go upstream, as we've been saying for many, many decades and find out and deal with it there.

But public health is an important adjunct. It's part of the adjudication -- it's part of the adaptation that you were talking about, but we've also heard month after month, day after day about shortcomings in the CPS system, much -- much of which are resource -- is a result of resource deficiencies, not only that, but also because of that. I don't want to see us go with we now elevate this approach, public health, which by itself without -- if you don't view a large part of this issue as a public safety issue, it is a public safety issue. It's also something else. And so sometimes they overlap, sometimes they don't.

We don't -- let's agree that we don't want anything to be linear. We don't want law enforcement to be linear. We don't want --

COMMISSIONER DREYFUS: Exactly.

COMMISSIONER PETIT: -- child protection to be linear. We don't want public health to be linear. It's more complicated than that. So I'm hoping that we're not just dismissing -- well, it's tweaking CPS. It's not tweaking CPS. There are major additions that need to be made to CPS like the adoption of standards, federal accountability. There's a whole series of things, including some of the stuff the DA talked about today in which, yeah, you should not be putting 25-year-old inexperienced workers in complex family situations and think that they're going to be able to deliver. I mean there's a lot of other stuff that needs to happen as well.

COMMISSIONER COVINGTON: I think we're all in agreement with that. I mean, I don't think we're trying to throw babies out with bathwater, so to speak. I mean, I think we're being comprehensive, but these recommendations really do tie into -- and that was our charge was to think about it upstream, whereas the other committee, the CPS policy whatever committee it was called, you're looking more at kids that are in the system. So I don't think we're trying to say one is more important than the other. I think it's going to be an entire cluster of recommendations.

COMMISSIONER PETIT: Right, I agree.

COMMISSIONER COVINGTON: You know, at the risk of sounding critical about Utah, and I really don't mean to do that because we're here. But I thought today's example was a really good example of why things have to change, which is the child welfare folks really didn't know what was going on in the public health agency around prevention and maltreatment. And my vision of a future is it's all integrated where it's not siloed and different.

You know, we've been in a couple states where we've seen some really nice integration across those systems, and my dream would be where the federal government would really support and find a way to incentivize states to be better integrated across their entire systems of

services for families, rather than thinking of child welfare as one silo of kids that are affected through abuse and neglect versus families that are getting broader public health support.

STAFF MEMBER: We have a commissioner on the phone requesting the floor.

CHAIRMAN SANDERS: Go ahead.

DR. RUBIN: Yeah, I was just going to say, yeah, I -- I mean, I agree with Commissioner Petit. I mean, in the way I frame public health, law enforcement and CPS are part of the public health response. Clearly they have a dramatic input into that public health response. They're just not alone out there. And so all the recommendations and accountability you're demanding, and we're all demanding, I think are going to be a part of this report.

And so I -- I just want to just state that, you know, I think I'm fairly collective about the way public health -- public health response would look, and I also agree that most the cases are known to child welfare. Some of the improvements -- so, you know, a substantial number of the improvements that we're going to be seeking are going to be direct and linear with respect to that system.

CHAIRMAN SANDERS: Commissioner Martin?

COMMISSIONER MARTIN: Can you repeat the last thing you just said, something about linear to which system?

DR. RUBIN: Well, Child Protective Services. I would agree we found some issues around workforce, we've found issues around sort of how you use -- like in terms of sound bites. My advocacy for the public health response does not diminish the prioritization of substantial changes and accountability that's needed within child welfare systems, so I don't see them as sort of -- you know, sort of mutually exclusive.

COMMISSIONER MARTIN: So I guess my point is just to reiterate that so long as we're talking about a public health model that includes the child welfare agency and all the other elements that we've been -- well, it hasn't always been clear, Teri, though, in fairness.

COMMISSIONER COVINGTON: I don't know.

COMMISSIONER DREYFUS: You're right.

COMMISSIONER MARTIN: It has not always been clear, and so I think it's imperative that we put that on the table and we make certain that's where we're going. Because that's one of the reasons I've had hesitancy on joining on board on this thing because it appears as if we were changing the system to do a public health system, and that's not what -- that's not what I think would be best based on the testimony and the recommendations we've heard thus far.

I think there are some elements of a public health system that would benefit us greatly by pulling together an integrated system. I have no problem with that, but I'm not -- I'm not at the point where I'm throwing the system out and developing a public health system.

COMMISSIONER PETIT: Yeah, and, you know, I think that's a good point, and I think -- my guess is David agrees with me and we all -- we all agree with it. I don't think either system

takes over the other. That's not what this is. At some point it's going to be determination as to what portal this belongs with. In some cases it's straight public health and there are not issues of death or serious harm to a child, but there -- and it's going to depend in terms of the initial diagnostic work that's done, the intake process, et cetera, I mean, so -- but my point is that you have two systems that can stand side by side working with one other, integrated where they need to be. But I don't see tomorrow passing legislation that says all the CPS agencies start reporting to public health in the states or -- or the other way around, or the other way around. They just both need to be beefed up.

COMMISSIONER RODRIGUEZ: But maybe I'm completely confused, then, because I'm not hearing this as public agency versus child welfare agency. I'm hearing it as being an approach, being --

COMMISSIONER DREYFUS: Everybody adapted to it.

COMMISSIONER RODRIGUEZ: So if I'm wrong about that, if what we're talking about is public health agency, then I revoke everything that I just said. But I thought what we were talking about is a public health response which includes the public health agency, it includes CPS, it includes law enforcement, but it's more a philosophy than --

COMMISSIONER MARTIN: So why don't we call it what it is? It's an integrated response.

COMMISSIONER RODRIGUEZ: It's an integrated response and the other --

COMMISSIONER DREYFUS: Using -- using what we do have in science, what we know to be the best practices of a public health response. What we heard today from law enforcement around domestic violence, that is a law enforcement agency using a public health response. When we heard from Wichita how they're using the Ages & Stages and they're looking at the development of children in CPS, that is a perfect example of an adaptation of a public health response there.

So you're -- I'm so glad, Judge, you keep pushing on this because it's helping me get clear in my own thinking. People hear public health and they go to agency, the bureaucracy that heads it up. We're talking about wherever you -- think of this ecosystem, right, all these players. CPS is a player, law enforcement's a player, health care's a player, education's a player, courts are a player, right?

I think what we've got to do is frame up that there are certain best practices in the science of a public health response that all have to adapt to. Does that -- and that's really what this is about. Thank you. This is helpful.

COMMISSIONER COVINGTON: No, I think, too -- I mean, I think we had this conversation last week, and I think -- we don't fix it in our commission report and how we frame it -- because I think language becomes very powerful. And I think -- I think we made the recommendation last week that we probably should spend some time trying to think of a really powerful phrase or term to use instead of public health because I think when this goes out as a report, most people are going to go to public health agency as being the place where we're seeing all of this happening. That's not, I don't think, at all what our committee has been thinking, but it

seems to always float back that way. So we probably need to spend some time thinking about language.

COMMISSIONER RODRIGUEZ: But I think it's also the dichotomy of how we even set up our subcommittees, because to me I also don't agree with public health being the upstream approach. I think you can use a public health response at the point of contact with the CPS agency, that it's an approach. So it's -- we set up these committees -- these subcommittees saying public health takes all kids who are not known to the system and sort of designs the far upstream and then our CPS subcommittee takes them when they touch. And in my mind what I think I hear from all the testimony is that we need to use the public response at any point that we touch, whether it's early or late.

CHAIRMAN SANDERS: If I could make a comment, and I think Judge Martin touched on it. I had the opportunity to visit one of the federally-funded research centers that actually now has an agreement with HHS. But prior to that they'd had an agreement with the FFA and had done a lot around airline safety. And it's absolutely fascinating, and I think we need to have an opportunity for everybody here to do a site visit, because I think they've laid out the path in many ways for what we want to look at.

The -- this issue of airline safety has moved from really purely a retrospective look at a crash to being able to use data to look at patterns -- use multiple data sources to look at patterns so that they can tell there's going to be trouble in the Pittsburgh airport or there might be trouble in the Kennedy airport, not saying any of those things for anybody flying to New York or Pittsburgh.

But they really use multiple data sources and using it -- using predictive analytics but as an integrated approach, but it's -- it's the public health approach that we've been talking about. That doesn't take away from pilots need to do certain things on an airplane that really aren't upstream, I mean, while they're absolutely flying -- actually flying.

The other thing I would just say is what was striking is we keep talking about the small numbers in child fatalities and how it makes it more difficult, but the peak for airline fatalities in the U.S. was about 600 fatalities, so it was a small number. But if you look where it is now, it's about zero. And that reduction has been due to very intentional approaches that I think we can take in child welfare.

COMMISSIONER COVINGTON: And you didn't hear people saying to the NTSB or FAA you shouldn't be doing that because the numbers are small.

CHAIRMAN SANDERS: Exactly. Exactly.

COMMISSIONER COVINGTON: You'd never hear that.

COMMISSIONER DREYFUS: So, David, would you say really it's what Tennessee said to us. They're adopting a safety culture, and that that safety culture, both in CPS, in law enforcement, in domestic violence, in health care, is that what we're talking about?

CHAIRMAN SANDERS: I think so. I actually think that seeing this would be very helpful for everybody who heard the presentation in Tennessee because I think it's actually an unfiltered

presentation of what we heard in Tennessee, just really very advanced work that we should be doing in child welfare.

STAFF MEMBER: We have Commissioner Rubin who wants to make a comment.

CHAIRMAN SANDERS: Go ahead, Commissioner Rubin.

DR. RUBIN: Yeah, I'm going to say a couple things. First of all, thank you, Judge Martin, because I think by your continuing to push back, it means that I -- that we haven't done a good enough job to articulate what we're talking about. In no way was I recommending a different system. I think it was around this response.

I will say in answer to Commissioner Covington that -- the language -- language does matter. I agree we -- we don't want to sort of spiral this in the public health agency, but there is such a -- there is such an opportunity to align our report with accountability.

And when I talk to my folks locally from CPS and what we heard in Oregon, the fact is, is when CPS tries to organize the response across the community, they're lucky if people come and really dive in. Whether it's the Medicaid program or Child Protective Services or public health centers or SCUHCs or it's the behavioral health program, et cetera, they come -- it's -- you know, if they haven't had some. It's not a priority.

So what we're trying to do is not to make it easier for a community like Wichita, what they did or what Oregon did. We're trying to demand a higher level of accountability so that it's very clear across these communities that if you create the cross-system response, which obviously CPS is going to be a major player, that you're not just responding out of the goodness of your heart that your friends over at CPS called. Your mayor or your governor is demanding accountability because there's actually true risk to the city or state if they're not organizing a more collective response.

And I think that's the way I sort of -- sort of align the levers. I think the language we choose for how we do that is -- I used public health because I think there's a vehicle there that really attaches some significant financial levers around accountability, but the response is what we've been talking about and I think we probably all agree on. It's just a choice of words.

COMMISSIONER MARTIN: So that's -- exactly from what you said is why I think not using the term "public health" is important. And let me explain what I mean by that. So when Kansas -- just because Kansas is right in my memory, we just heard from them today.

So when Kansas comes and testifies and gives us information about their integrated approach and how well that has done for their community, they're calling John over in the sheriff's department, they're calling Sally over in DCFS, they're calling Josephine over in domestic violence in their state and in their regional locales. What David is talking about, the FAA, the Federal Aviation Administration, they're calling the Secretary of Education, they're calling the secretary of HHS, they're calling the secretary -- and that's why I think -- because we want this to be elevated to the federal level and put in the restrictions, put in the accountability at the federal level, that's why we want to be more inclusive and more encompassing and more global.

So that's even more the reason not to call it a medical health approach but more -- I mean, I don't care if we call it the Bozo approach. The point of the matter is that we're talking about an integrated approach, but what I see we're talking about is more at federal level like the FAA.

STAFF MEMBER: We have a commissioner on the line.

COMMISIONER RUBIN: We have failed because we have not created collective responsibilities.

COMMISSIONER PETIT: I think on the question that you've raised, Judge, we don't need to address it right now, right? I think it's a good place marker. We'll come back to it. Let's go through what our material is, what are the principal themes that will emerge, what order to emerge it in, et cetera. I think that's the conversation for tomorrow morning, although I hope maybe it can be pulled up further today.

CHAIRMAN SANDERS: Yeah, we can.

So couple of things. We should go ahead and take a break right now. What's in the document was in the first -- when we talked last time --

COMMISSIONER MARTIN: Just tell me what document.

CHAIRMAN SANDERS: I was going to tell you. That's what I was getting to.

COMMISSIONER MARTIN: Oh, apologize.

CHAIRMAN SANDERS: In our conversation last time we talked about the first chapter that included things like our charge, the problem, our findings, our process and so forth. And so what I put together for us to have a conversation about is a document that is in the packet under the --

MS. TEMPLETON: Under a tab called themes and findings.

CHAIRMAN SANDERS: Themes and findings.

There are two documents in there. It's actually the second one. The heading is: Eyes on Children, an Overview of Emerging Themes. It just includes 10 -- 10 themes from my own head of things that we've heard, things I've heard us talk about, things that were included in the one-pagers and so forth. And so it's really for -- to talk about the -- what we consider as kind of themes or findings because these should really be tied back to any recommendations that we make.

And I actually think the conversation we were just having is partly the first theme that's included here, and can we get the wording in a way that reflects our thinking. But this is just to stimulate conversation.

So we -- we also have the research roundtable findings that we can talk about. I think we could, given the conversation we were having, just start with this when we come back from a break and see how close we are to actually capturing the themes or findings that we see as a commission.

COMMISSIONER PETIT: I repeat myself. I think it would be a good idea. I think it's got plenty of content in it and will channel the discussion.

CHAIRMAN SANDERS: So why don't we take a break for 15 minutes and we'll reconvene and figure out the next steps.

(A break was taken from 3:27 to 3:51.)

CHAIRMAN SANDERS: I think we'll get started again. It sounds like at the break that the public health subcommittee was done. Is that -- Susan, would you --

COMMISSIONER DREYFUS: Yes.

CHAIRMAN SANDERS: Teri, anything else?

COMMISSIONER COVINGTON: I think so. No, I think --

COMMISSIONER DREYFUS: You know, David talked about the home visiting.

COMMISSIONER COVINGTON: Yeah, he talked about our home visiting. And I think -- you know, we're not done yet with all of our recommendations. We've got some broader recommendations that we're going to try to fine- tune and make more specific. We have more work to do obviously. And I think we have another meeting planned quickly to try to re-hook up with CMS to do more follow up with them.

COMMISSIONER DREYFUS: I do think that Jennifer brought up something that, again, I don't think we're prepared to wrestle with today, but the intersection of this integrated safety culture, right, with kids going known to the system, in the system, that it isn't just those not known. We originally were created with the two groups, and that was an interesting perspective that I just think needs some further thought.

COMMISSIONER COVINGTON: Well, it's interesting because I know you don't remember this. But when we first created those two terms "known in the system" and "not known in the system," I wasn't really a fan of that either. Because even the kids that are known to the system, they can benefit from a lot of what -- we would hope they would benefit from a lot of the work that we've been doing on our group. It's not, you know, you reach this point where they suddenly are all exposed to a system of services. I think we've got to think better about --

COMMISSIONER DREYFUS: It seems like where we've evolved to, though, is that this thing we call system has within an effective CPS agency.

COMMISSIONER COVINGTON: Absolutely.

COMMISSIONER DREYFUS: But the system is not that. So -- and I've gotten to the point where I don't even know what not known to the system means anymore --

COMMISSIONER COVINGTON: I don't either.

COMMISSIONER DREYFUS: -- because these kids were known to someone --

COMMISSIONER COVINGTON: That's right.

COMMISSIONER DREYFUS: -- at some point. And that to me is the safety culture, right, that we want to have wrapped around kids. So I just thought it was an interesting thing for us to think about in terms of how we're framing this.

COMMISSIONER COVINGTON: I agree.

COMMISSIONER RODRIGUEZ: But even to the CPS agency, I mean, what we now know is they may not have been known with the last 12 months or they might not have ever had an allegation investigated --

COMMISSIONER DREYFUS: -- substantiated.

COMMISSIONER RODRIGUEZ: Even investigated, any of that, but that a good amount of them were in fact known even to the CPS system, not even broader systems.

COMMISSIONER COVINGTON: Well, one of the things we -- I consult on with our states when we're helping them do their reviews -- and a lot of the states have gone to not only for their child abuse reviews, you know, those sort of specialized teams like Utah has where they create a 12-month cutoff and they're only doing kids involved in the system. I always say, you know, the most important lessons may be -- very well be the kids that were not known to you and why you didn't know about them. And to me those are as important a lesson to learn for the system as looking at kids that they knew about.

COMMISSIONER RODRIGUEZ: But I also just want to say on David's opening story, though, for the kids that are ultra known to the system, because his story initially about the youth who was in foster care who everybody knew was struggling with mental health issues, who everybody knew was off medications where we had direct responsibility for her and then not being able to get her even services that you could get for other parents because she was in foster care, I mean, to me those are -- that's sort of another -- another piece entirely, where they're really known.

COMMISSIONER COVINGTON: Really known.

COMMISSIONER MARTIN: Ultimately.

COMMISSIONER COVINGTON: Ultra known.

COMMISSIONER DREYFUS: Really really known.

CHAIRMAN SANDERS: So we had on the agenda the research roundtable, but it sounded like before the break it made sense to go into the themes which we had for tomorrow, but these would be part of the first chapter, kind of the high level findings that we have as a commission to this point and to at least introduce the ideas. These are, again, what I've heard. They're really for debate and discussion similar to the outline that I produced last month. It really is just to stimulate the conversation. Hopefully I captured these right, but may have completely missed and gives us a chance to talk about them so --

COMMISSIONER MARTIN: David, before you start, can I -- so I think because we've had so many pieces of paper going back and forth, from this day forward when someone drafts something, can they just put a little line at the bottom drafted by David on XYZ date?

Because, I mean, I'm getting draft recommendations from here and there and I'm getting confused where they're coming from.

CHAIRMAN SANDERS: I can try and commit to that. I'll try. I think -- I think that does make sense. We can -- we can try and do that. Some of us are doing our own typing on some of these so it's not --

COMMISSIONER MARTIN: Okay. Thank you.

CHAIRMAN SANDERS: So this, then, is based on the last conversation of the component of what we would want in the first chapter. So I'll just walk through them, and then we can have a conversation however we choose, and I'll try and explain what each one means if it's not clear.

So the first is really trying to capture the conversation that we just had, is that the problem with child abuse and neglect fatalities and stated this in a positive way is solvable in a broad way when community services come together in a coordinated way on behalf of children and families. So to say this is not a child protection matter solely. It really is a much broader issue. And that the positive signs that we've seen have been when communities have come together, not -- we really haven't heard stories about the child protection agency alone solving this issue. And so that's really what it's trying to capture. Did not use the words "public health" in this, although we could choose to do that. Really saw it as more community coordinated approach.

The second is a theme that I think we've also talked quite a bit about, and that is there's a need for greater enforcement of federal child welfare policy and improved oversight and accountability around the issue of child abuse and neglect fatalities at all levels of government. And I've been struck actually in many of our conversations coming at this from different perspectives, but I've heard Dr. Bevan talk about her role in putting together different pieces of legislation and then seeing them not being actually implemented at a state level which is really striking.

And I think we've heard consistently that for CAPTA and IV-B that there has not been the kind of implementation that we would like to see. And so really that's, again, one of our findings. So it's not sufficient just to have things stated in statute. There does need to be stronger oversight at the federal level.

The third is really something that we've heard from the child protection subcommittee, that the investigation process is really based on specific allegations. Can they be proven at the time that the report comes in, not necessarily, that safety and risks are really dynamic qualities, that there could be -- what we heard in the David Rubin situation, I think that was an excellent example. At one point in time things may have been fine, but they evolved over time to really being a challenge. And the way investigations work right now is based on the single allegation and a point in time versus the longer term risk.

COMMISSIONER COVINGTON: I like this one a lot. Is there a way to strengthen it with another sentence that -- you know, saying current policies are specifically designed around specific allegations? I think what we're trying to say is that a focus ought to be on, you know, I don't

know, allegations or assessment of a child's entire history. I just think it needs another statement to follow that up with what we believe to be true.

CHAIRMAN SANDERS: The fourth is research and identify characteristics -- has identified characteristics of children who are most at risk. And so that's, I think, for me one of the most compelling findings that I've heard consistently from almost the beginning is that we -- we have a good sense of who's at risk. We just haven't necessarily addressed that group.

Fifth, this is really trying to get at the idea that there are different kinds of fatalities. Child abuse and neglect fatalities do not follow a single, simple pattern. Different types of fatalities require different interventions. So really starting with abuse and neglect, but we could go to many different levels with this, and I think we've talked a lot about the differences and just trying to capture that.

Sixth is effective communication strategies can improve our ability to prevent child abuse and neglect fatalities and facilitate accountability. And this is really getting at the finding that sharing of information is -- has been proven to be -- at least it appears to be an important component of reducing child abuse and neglect fatalities. And certainly when we've heard from different communities, that's been a component that's talked about. We really talk about separating out the sharing of information, case level sharing of information, plus the sharing of information with the public.

COMMISSIONER PETIT: David, is this where the confidentiality is addressed?

CHAIRMAN SANDERS: Yeah -- well, not really addressed. It's just that it's a finding.

COMMISSIONER PETIT: Well, what's the finding in terms of confidentiality?

CHAIRMAN SANDERS: It's not -- we don't -- I don't specifically state -- what I'm saying is that communication is -- is effective in addressing fatalities. I didn't speak specifically to confidentiality because I don't think we -- I don't think as a group we have a finding on that.

COMMISSIONER PETIT: Okay. But I do think we should discuss it. I think it deserves more than --

COMMISSIONER DREYFUS: Oh, yeah.

COMMISSIONER COVINGTON: Yeah.

CHAIRMAN SANDERS: Oh, yeah, yeah.

COMMISSIONER COVINGTON: His last sentence on there starts to address it, but I think we're going to talk about it more in our last two hearings.

COMMISSIONER RODRIGUEZ: Because it deserves it.

COMMISSIONER DREYFUS: I think if we get through them all, it puts them in context and we can talk about them.

CHAIRMAN SANDERS: The -- and this next one, I think, is we can -- I mean, we heard it from Wichita. We heard it from the communities. We've talked about that successful community-

wide efforts to reduce child abuse and neglect fatalities show characteristics of strong leadership and collective sense of urgency. I think for me that's an important finding, but that may be something that we want to debate how critical that is.

Eight, I've heard the child protection subcommittee and particularly Commissioner Petit talk a lot about this, tremendous variation across states on how fatalities are defined and measured and how that information is shared. And we could go further than that in performance and so forth, the variation across the states.

Ninth is high quality research is essential to development of data driven intervention and prevention strategies and probably could also be said we don't have as much of it as we need.

COMMISSIONER MARTIN: I think that's the point, that we don't have as much of it as we need.

CHAIRMAN SANDERS: And then the final one is near -- is about near fatalities can provide valuable insight that might help prevent death from child abuse and neglect.

COMMISSIONER DREYFUS: What's the best way to talk about this, one at a time or just each of us go through our thoughts across the whole thing?

CHAIRMAN SANDERS: Well, we have -- we have all day tomorrow. Really this was the agenda for tomorrow. So we can -- we can begin to talk about that list of recommendations tomorrow too. So I would suggest that we just open it up for general feedback, and then if we want to get more specific recommendation by recommendation, we should do that. But I would say the general reaction would be a good place to start. And are there things that are missed? Are there things that are --

COMMISSIONER DREYFUS: There's one thing I think -- I don't know that it's missing. I think it's probably nested in here, it's just not said. And I think we've heard a lot about stress. We've heard a lot about toxic stress. We've heard a lot about those stress accumulations. Right? I mean everybody talked about no one of them is causal. But if you listen to Dr. Jack Shonkoff at the Harvard center, he'll take all of this research and he brings it down into -- into two things: Reduce family stress, increase serve and return parent skill building, serve and return between parent child. Right?

And -- and I'm not sure where that sits here around -- I don't think we talked about any one thing like poverty or housing or health or -- but we know that the accumulation of these stressors are toxic within households. And there is research that says that's the correlation to maltreatment.

COMMISSIONER COVINGTON: One thing I thought about that goes along with you is No. 4 where -- characteristic of the children who are most at risk. I --

COMMISSIONER DREYFUS: Where are you?

COMMISSIONER COVINGTON: His finding No. 4, the finding No. 4 is to build into that also the families who are most at risk because it gets into --

COMMISSIONER DREYFUS: Getting that additional stress.

COMMISSIONER COVINGTON: It's not just about children. It's about the families. So I think within that we can talk more about --

COMMISSIONER DREYFUS: The Norling Foundation in Alberta, Canada, we're doing a partnership with them around the brain science. And I think they have -- they have done the best work on defining toxic stress, what they're doing to mitigate toxic stress, and when stress does become toxic. I mean, you know, stress is good. Right? We all have stress. But when does stress become toxic? And I think that has the strongest connection to the adverse childhood experience science and the trauma-informed care -- trauma conversations we're having. It's all about when stress becomes toxic.

COMMISSIONER STATUTO BEVAN: Can you send us that information because I don't think that it's a well-documented, across the board finding that stress is correlated.

COMMISSIONER DREYFUS: Toxic stress?

COMMISSIONER STATUTO BEVAN: Toxic stress. I think we -- I mean, if you want to talk toxic stress, it's one thing. But stress, unemployment, and being -- in and of themselves we can't say they're related to child abuse deaths, right, which is what we're here for. So I just want to be -- we also talked about a continuum.

COMMISSIONER DREYFUS: I think what the research has done, though, through the adverse childhood experiences study, right, and the work around trauma-informed practice is -- and what the neurosciences is catching is getting us all caught up to, is the impact of when stress becomes toxic to development and functioning.

COMMISSIONER STATUTO BEVAN: But they haven't related it to deaths, child fatalities. That's what I'm trying to get at. We have to get to --

COMMISSIONER DREYFUS: Yeah, but I think you could -- Cassie, with all respect, I think you could take any one of these things and so no one of them in and of themselves has been found to have a correlative to fatalities. There's an accumulation here. I just hate to see us not talk about what we've learned about this issue of stress.

COMMISSIONER STATUTO BEVAN: But we didn't have testimony on toxic stress. I believe you. That's what I'm saying, I'd like to see the research. I just -- I believe you. I've never seen it and I've never heard the term before today.

CHAIRMAN SANDERS: It does seem that Commissioner Covington's suggestion about looking at No. 4 and incorporating families -- what we heard about families at risk because I think we have been presented information that talks about that. Is that a way to capture what you're describing?

COMMISSIONER DREYFUS: Yes, as long as that family dynamic --

CHAIRMAN SANDERS: We can make an attempt on that.

Commissioner Martin?

COMMISSIONER MARTIN: Well, I have two points, one on that same issue. I think we heard testimony today, if I'm not mistaken, that it's not one factor that contributes to the fatalities, it's the cumulation of factors and lack of protective factors that contributes. So I think that including that with respect to families and not just children individually does help and is more clarifying.

My other point that I wanted to bring up goes back to commissioner Petit's issue of confidentiality. I think that we've heard that perceived and/or actual confidentiality bars have precluded a meaningful sharing of information that has resulted in breaks or holes or whatever you want to call them in the system that has lent itself to ultimately bad outcomes for children and families.

And so I -- I guess what I'm saying in general is if we're going to provide a recommendation, I think we have to make a finding about that issue. I don't think it makes sense to have a report with five findings and then have five recommendations that don't relate to the findings. And so I would prefer having a finding about confidentiality. And I think we've heard clear testimony from a number of sources that perceived -- what people perceive HIPAA and, you know, confidentiality -- you know, all those things may or may not, say, have been utilized at times to keep information scarce.

CHAIRMAN SANDERS: Commissioner Martin, would you -- and it sounds like from the conversation earlier separating out the sharing of information across the helping professions versus the public disclosure, probably separate those out as findings, and we will do some more work in the next few meetings, I think, to come up with a finding on the sharing of information externally, and then strengthen the language around the finding for sharing of information among helping professions. We've heard evidence that it's been damaging, that it has potentially.

COMMISSIONER MARTIN: So what I'm trying to say is I think sharing of information is different from confidentiality. So sharing of information is with Chicago Public Schools and the court, sharing of information. I think when it gets into confidentiality -- when I ask a parent whether they want to sign a consent for medical release -- medical record release or something and, you know, one of the attorneys argue that it's, you know, I don't know -- or that HIPAA precludes, you know, and stands above a consent, so HIPAA doesn't allow a consent in this. That's totally irrelevant -- that's totally erroneous, but people say that all the time when they're trying to develop objections.

COMMISSIONER PETIT: I think it belongs -- that piece that you're describing is not what I'm speaking to. That piece I think very much belongs in the case practice solving issues, multidisciplinary team thing. I asked the fatality view person here today, which I have all over the country, but I asked her today. I said, listen, if a kid is killed and the parents are convicted and they're sentenced to prison, is the department able to release information if somebody says did you know the family, how many times did you go out, what service did you provide?

We are prohibited. We do not share that language.

So who is it that -- what I would argue is the confidentiality piece is it's keeping the public uninformed about what the underpinnings are of this problem nationally. There is not enough sharing of what this issue is all about because the press does not have access to this information. And that's the piece that I'm pushing, is the confidentiality -- to benefit who, it needs to be modified from what it currently is.

CHAIRMAN SANDERS: Structurally for this section are we suggesting that that's separate from --

COMMISSIONER PETIT: Yes, it is.

CHAIRMAN SANDERS: -- the sharing? And that we want to strengthen the language around the sharing of information --

COMMISSIONER MARTIN: Yes.

CHAIRMAN SANDERS: -- because in that instance we would say that's harmful --

COMMISSIONER MARTIN: Yes.

CHAIRMAN SANDERS: -- but we've not yet, I don't think, developed a finding on confidentiality.

COMMISSIONER DREYFUS: I guess I have a question. Is the finding confidentiality or is the finding what we believe in this work needs to be big data, that we need --

COMMISSIONER PETIT: No.

COMMISSIONER DREYFUS: -- we need access to data and information, and confidentiality absolutely is one of the recommendations. It's a piece of that, but I guess I'm -- part of this to me is also technology. Right? We can have all the greatest recommendations in the world, but we also have to have technology --

CHAIRMAN SANDERS: I think Commissioner Petit is separating out the confidentiality, the sharing with the public.

COMMISSIONER DREYFUS: I don't really care just so long as the issue of big data and the issue of technology interface the modernization --

COMMISSIONER MARTIN: So I have a point that I don't think has been -- that people get my point. So I'm not saying I'm right on the point, but I at least want you to understand what I'm trying to say.

So in the area of confidentiality I think we've heard tremendous testimony about some jurisdictions and some agencies within jurisdictions are using confidentiality as a shield when it is a perceived, and it is not legally confidential information. And so I think that is a finding.

COMMISSIONER PETIT: (Inaudible).

COMMISSIONER MARTIN: Right. I think the finding is that confidentiality is often used, perceived and/or actual, to the detriment of our children and families safety --

COMMISSIONER PETIT: Yes. So take it --

COMMISSIONER MARTIN: -- right, something to that effect. And then I think -- and that's different and apart from sharing information amongst agencies for safeguarding our children and families. Because right now there's nothing to preclude me from sharing information about a child with a juvenile justice judge across the hall.

COMMISSIONER COVINGTON: Well, I think I might disagree a little bit because -- I agree with your first part, but I think and I've heard it and I've seen it that even within agencies where there shouldn't be any barriers to sharing information on a child, people create false -- I mean, people -- I can't tell you how many times, well, I can't share that because it's HIPAA. I go, yeah, you can share it. HIPAA doesn't count when you're looking at an investigation of a child abuse and neglect case. There's a state I know where child welfare will not share any records with their state child death review team. It's crazy but they use that even though -- and so -- but that's a false --

CHAIRMAN SANDERS: Where did you differ --

COMMISSIONER COVINGTON: But your second part about it's different than the sharing of information among the agencies, I think even within the sharing of information among agencies people put up artificial barriers, so I think those two are --

COMMISSIONER PETIT: I'm taking us beyond that. It's the press that educates the public on this. It's not lawmakers that educate the public. It's not social services agencies. It's the press that interprets these things to the public. They need to have access to the information. And we have scores and scores and scores, I do, we do collectively, of incidents of reporters saying they cannot access information. And we have states that say pointblank we never share this information. Some states do, so what is inhibiting the other ones?

COMMISSIONER COVINGTON: So it seems like there's two things, though. There's the public disclosure and then there's sharing within agencies. I think those are two different things.

COMMISSIONER DREYFUS: I hear the Judge saying something else.

COMMISSIONER MARTIN: See, I think there is a reason, a purpose, and a need to keep my kids' identifying information confidential. Because, quite honestly, if everyone in my courtroom does their job perfectly well and all the moons are lined up and that kid is back in that family, there's no need for the neighbors and kids at school to talk about Johnny Jones and what was going on in their home.

COMMISSIONER PETIT: Right.

COMMISSIONER MARTIN: So let me finish, Mike. Just let me finish.

That is vastly different because I, in Cook County as the presiding judge for the last 20 years, have an agreement with my press. They come into my courthouse, they sign an agreement that they will talk about my cases but they won't identify my kids. They won't say Sally Sue in the fifth grade at Pat Martin's school.

COMMISSIONER PETIT: Yeah.

COMMISSIONER MARTIN: And so all they do is protect the confidentiality of my child's name, and I can live with that.

COMMISSIONER PETIT: Well --

COMMISSIONER MARTIN: And so what I'm saying -- let me finish. All I'm saying is that confidentiality is perfect and necessary in some incidences in my opinion to protect the identity of the children. That does not preclude the press from getting information about the case, digging into the case, investigating the case, and finding out that Judge Martin was the idiot that did something. Right?

COMMISSIONER PETIT: Yeah.

COMMISSIONER MARTIN: But there is a need to protect my child.

COMMISSIONER PETIT: So I -- I agree with that completely, so there's no disagreement.

Eight-year-old kids should not be presented in the paper if they're still living, if they're still going to school. But if a kid has been killed, just using that -- so the issue right now is you've got gradations of revealing this information on confidentiality. Some states actually have a set of criteria: Under these circumstances you can, under these circumstances you can, under these circumstances can.

If you have a kid that is killed and the parents have been convicted, for the department to be able to say we're not telling you if we never knew this kid, we didn't intervene, we didn't provide services, that's wrong. That information should be publicly disclosed. The child is dead. Who's being harmed in this case?

COMMISSIONER MARTIN: I still don't want them to publish the sibs, and I'll tell you why. The Wallace case in Illinois, it's a definite case, Mike. The sibling of the Wallace kid --

COMMISSIONER PETIT: I'm --

COMMISSIONER MARTIN: Let me just finish. The sibling of the kid who was hung has spent his life trying to get his name changed just because he doesn't want to be identified with that mother and that son. So I would still say the protection of the sibs' identity, but they can have -- and they can investigate the case up and down the mountain.

COMMISSIONER PETIT: People can take a look at the specifics of what you could do to modify the current law. We don't need to say today exactly what it would be. What we can say is that the group of people -- and there already has been work done on this -- look at it, these are the situations in which you exclude, these are the situations in which you include. Keeping the public uninformed about a problem that they care about means there aren't the resources or support, the public will or the political will to take care of all the other kids that are being killed. So I'm not disagreeing with you. I'm just saying that this confidentiality thing opening up to the press needs to occur, needs to be modified. It will go before Congress and a bunch of people can put specific language together. There's stuff that's out there already, that's all. So --

COMMISSIONER DREYFUS: Commissioner Petit, what do you think about Tennessee? So we heard the commissioner in Tennessee -- I can't remember his last name. Anyway -- and he talked about how, you know, he was just kind of throwing caution to the wind and he was being very public in putting out those reviews. They're on the website. They're fully --

COMMISSIONER COVINGTON: They're redacted.

COMMISSIONER DREYFUS: -- disclosable. Pardon me?

COMMISSIONER COVINGTON: No, they redact names.

COMMISSIONER DREYFUS: But from my perspective, right, there -- again, I appreciate there's got to be some things that are kept confidential, but I do think we heard at Colorado, we heard in Tennessee where at least if they're erring on anything it's on the side of putting that information out there. Is that not close enough to what you're saying? You want more?

COMMISSIONER PETIT: Well, first, I don't know that any of us know exactly what the Tennessee law reads like, but all of the states' confidentiality laws --

COMMISSIONER DREYFUS: I didn't mean laws. I meant the agencies' practices.

COMMISSIONER PETIT: All of the agencies' policies on this I know have been recorded someplace. It leads back to the law that governs it, and it varies from state to state in terms of what they can do. The point is they have a lot of latitude. In many jurisdictions that we've seen the department has insisted on not sharing stuff. Somebody gets the information. The next thing you know you've got five star hearings before the legislature, the commissions. You've got people who are being prosecuted.

Information needs to be put out there. I'm saying there's a way to do. I don't know what the exact way to do it is right now. We need to have the laws looked at. That's what staff -- not our staff, but other staff of committees of jurisdiction or federal agencies could take a look at.

COMMISSIONER DREYFUS: I think that's one issue, but I wanted to get back to Commissioner Martin because I hope what she's bringing up isn't getting lost. I will -- I will tell you having run in the public system, I can't tell you how many times, depending upon which attorney I was talking to, they all had a different interpretation of what we could and could not do. And I think there's a lot of things that have kind of accumulated over time and become kind of the old wives' tail within an AG's office or a DA's office or in my own staff's thinking about what was and wasn't the law.

And so I guess I would just like to ask Commissioner Martin to that very first issue brought up before where we're talking about what's released, right, just what is HIPAA, what are the rights of confidentiality and laws that give people their proper protection, what you would recommend -- what would you think we would recommend needs to be done to get there to be greater clarity and understanding and greater consistency of practice?

COMMISSIONER MARTIN: So one of the things that I do is when a person -- an attorney brings up a HIPAA violation or a potential HIPAA violation in my courtroom, I say you're a lawyer, you should go read the law, but based on my interpretation of HIPAA, it doesn't even apply to a

courtroom. It applies in a hospital setting. And so what I recommend you do is actually go read the law.

When I'm confronted with someone who's not a lawyer, I tell them to go check out their legal department and ask them the question. So when a state agency worker says it's a HIPAA violation, I say you should contact your law -- your legal department, because I can't practice law as a lawyer, have them give you a briefing on HIPAA, and I will give you time to do that. And if they come back with the same garbage, I will say under my interpretation of the law, and I will go down the law and give the exact language and put it in the record, and I will give them a finding that's contrary to what they asked.

COMMISSIONER PETIT: I think we're talking about two different things. We're talking about two different things. At a case level like you have and in the work going into it with multidisciplinary team, we're saying that information that appears to be confidential on an individual case like HIPAA can be shared if it's part of a committee's deliberations on how to protect a specific kid in a specific case from dying. I'm fine with that.

The piece I'm talking about is an overall system, political, media kind of thing, in which the public has a right to know how an agency is performing. And a department cannot hide behind federal confidentiality laws. So that's the piece. We have a long presentation on that by Howard --

COMMISSIONER STATUTO BEVAN: Howard Davidson.

COMMISSIONER PETIT: -- Howard Davidson from ABA on this thing, and it's an issue that has come up repeatedly in numerous forums. I'm just saying it needs to be relaxed and let the public see how the --

CHAIRMAN SANDERS: Let me just -- let me just clarify for this discussion -- I mean for this section. We can have the discussion, but this section is simply our findings. It's not necessarily our recommendation. And I'm just trying to capture what we believe our findings are. We can talk about the recommendation, but we aren't even at a point yet, I don't think, of agreement about our finding.

COMMISSIONER COVINGTON: I think --

CHAIRMAN SANDERS: I'm sorry. Jennifer, you were trying to say something.

COMMISSIONER RODRIGUEZ: Well, I was just going to say that I -- I mean, in terms of the tension with the public's need to know with -- about a child and family, I guess I am -- I am struggling to understand when the public ever needs to know anything that would identify the child or the family.

COMMISSIONER PETIT: Homicide.

COMMISSIONER RODRIGUEZ: I totally understand when you would need to know the general sort of actions that the agency took, and people who work in public agencies, they take -- they know they're subjecting themselves to that when they go to work. But I mean, it's not just siblings. It's also -- there may not be siblings that are born at this moment, but there could be siblings that are coming later on. There are other cousins. There are other folks in

that family that I don't feel like we should sacrifice. I mean, it's a person and it's their life and they don't have the ability to consent.

And when we disclose every piece of it, I mean, you can imagine if it was you and somebody was disclosing -- I mean people do it with no -- no second thought in sort of the name of improving policy, will disclose the most horrific pieces of your sexual abuse of your physical abuse. And quite honestly a lot of people look at it as entertainment. And so I don't really see that there's any tension that's there at all.

It seems to me like -- maybe if somebody has a great argument about when it is that you actually disclose actual identification information on children or a family, then you can present it, but it is some -- it is somebody and somebody's life.

COMMISSIONER PETIT: Jennifer, what about when there's a homicide and when the trial takes place of the homicide, the District Attorney and defense attorneys are going to put all this information on the table? The piece I'm talking about is on the civil side in terms of understanding how the department is managing the protection of children.

COMMISSIONER MARTIN: So can I make one other comment?

CHAIRMAN SANDERS: Just to say that this is not a conversation we're likely to resolve today. We're really looking at just the findings. We can keep having the conversation, but it is --

COMMISSIONER MARTIN: I'd like to go back to the testimony that we've heard. The only testimony that I remember off the top of my head that was talking about the press had lack of information or were not able to get access to the information is when we had a panel of press, and that was back in Florida. Everyone else has talked about how they've shared. Every director who has sat before us, haven't they, talked about how they shared the information with the press? They've given the information to the press.

And I will tell you this day and age the majority of judges side on the error of giving information. Now I'm only talking about judges, but they look at it as a presumption of open courts that -- which concludes opening the record, the court record, and allowing press in the courtroom. And the presumption is that you only close when you think it's going to be detrimental to the child or the family.

And so the presumption is going along the lines of what you're arguing for, Michael. And I just want us to go back to the testimony if we're thinking about doing a -- a finding. What testimony did we hear? Who sat in here other than that panel of press talking about they couldn't get access and the press couldn't get access to information?

COMMISSIONER PETIT: The departments wouldn't say that they couldn't have access. They're the ones that are defending it. But, you know, there is a --

COMMISSIONER MARTIN: That's true.

COMMISSIONER PETIT: There's a federal regulation that's being implemented right now, being developed right now, on child fatalities that's the result of some of the work that's been done over the last three or four years. They're developing guidelines right now on when to release

information and providing advice and guidance to the states on this. I mean it's in the works at their level right now.

COMMISSIONER MARTIN: What testimony did we hear that said they couldn't get it?

COMMISSIONER PETIT: So every day we receive testimony from the press that recounts these situations all across the country. There have been hundreds of references to it.

COMMISSIONER COVINGTON: There are a lot of them.

CHAIRMAN SANDERS: Just to go back --

COMMISSIONER COVINGTON: I think --

CHAIRMAN SANDERS: -- for a second, I think it seems like we should separate out something like public disclosure --

COMMISSIONER COVINGTON: I agree.

CHAIRMAN SANDERS: -- from confidentiality.

COMMISSIONER COVINGTON: Yes. I don't--

CHAIRMAN SANDERS: I don't know what the word is.

COMMISSIONER COVINGTON: I wouldn't separate it out from confidentiality because --

CHAIRMAN SANDERS: Sharing of information among professionals. But public disclosure I think is what you're talking about, Michael, and that's a separate --

COMMISSIONER COVINGTON: I think so too.

CHAIRMAN SANDERS: -- conversation from this -- this sharing of information among professionals, however we want to term that. We have findings for that. We don't yet for public disclosure other than the testimony in Florida.

COMMISSIONER DREYFUS: The finding is confidentiality between agencies and public disclosure. It's both.

COMMISSIONER COVINGTON: They're two different findings.

COMMISSIONER DREYFUS: Two different --

CHAIRMAN SANDERS: They would be two separate findings.

COMMISSIONER DREYFUS: Two separate findings.

COMMISSIONER COVINGTON: Because you actually address public disclosure when you talk about the second issue.

CHAIRMAN SANDERS: Right. And I think--

COMMISSIONER COVINGTON: I think we should have two findings.

At our last meeting we agreed that we would continue to hear more testimony in the future on the whole public disclosure thing, and I think we need to because it's huge in the field. We talked about it as something we haven't heard enough from. I do think we need to hear more about it from folks, from advocates pro and against to get a better handle on it.

COMMISSIONER MARTIN: I would just make sure that every finding we make we can go back to the record and show where we got that in written or verbal testimony. And, again, my question until we get more testimony on this --

COMMISSIONER COVINGTON: I think we need more testimony.

COMMISSIONER MARTIN: I don't think we've had that -- we all have anecdotal information, and we can talk about it, but I don't know if we've had any testimony offered to this commission on saying that the public has not gotten information.

COMMISSIONER COVINGTON: And at the last meeting I asked specifically that we try to make some time at our next two hearings so that we can hear more on this. And I made the point that we've got to address it because you hear it all the time out in the field. It's a big issue with people and it's a hot button topic, and I think we have to address it one way or another. I'm not sure how we're going to end up going with it with recommendations, but I do think we need more time spent on it.

COMMISSIONER PETIT: David, can we go back to your point of what you're trying to do here in terms of how this is being presented? And I just took a quick look at it myself.

In this first one is what triggered it. The way the first one is presented right now is the problem is solved in a broad array, but I think what we started with is there are thousands of preventable child abuse deaths, something like that. The current system is not equal to the task of protecting all children.

CHAIRMAN SANDERS: What -- are you talking specifically about No. 7 or are you talking --

COMMISSIONER PETIT: No, I'm on No. 1. I'm saying the way this is opening. I think the first opening that we do is we declare there are thousands of children being killed, these preventable deaths, and that the current capacity of the systems that are in place is not equal to the task on this, that there's a wide variation among the states, there are short-term and long- term cross-disciplinary strategies that would reduce it over time.

In other words, I think it's more conversational initially. I think the first piece is kids dying, and that doesn't come through with that first headline. I think you were -- I thought you were asking about just how this topic was being presented.

CHAIRMAN SANDERS: Yeah. So for the confidentiality piece, separate it out. We probably don't yet have findings on public disclosure, but we do around the sharing of information.

COMMISSIONER PETIT: Say that part again on public disclosure.

CHAIRMAN SANDERS: For the public disclosure, we probably are not at a point where there's agreement that we have findings on public disclosure, but that we'll have to have findings because it's an important issue.

COMMISSIONER COVINGTON: And I think one of the things we might want to reference, whether you agree with finding it or not, is the report that came out of the Star Foundation, wasn't it, a few years ago that really talked about public disclosure? Maybe we can get a copy of that. I'll have to find it.

COMMISSIONER PETIT: There have been a number of reports written including by the Child Advocacy Institute that is --

COMMISSIONER COVINGTON: That's the one.

COMMISSIONER PETIT: Secrets that Kill, something like that --

COMMISSIONER COVINGTON: Right, right.

COMMISSIONER PETIT: -- where they classify and rank every state's willingness and ability. It's been out there for --

COMMISSIONER COVINGTON: But I don't think we've shared it with all the commissioners. We should probably look at that.

CHAIRMAN SANDERS: I'm just saying I'm not hearing that we're at a point where I can write something that people will --

COMMISSIONER DREYFUS: No. We identified it.

CHAIRMAN SANDERS: But it will clearly need to be a finding.

COMMISSIONER COVINGTON: Can I -- can I make a comment on No. 8 because I think it's not only variation, but I think we need to state right upfront, even though it's been stated millions of times, that the numbers of child abuse fatalities are underreported, that there's widespread agreement on that fact.

COMMISSIONER MARTIN: Or that the number is not accurate.

COMMISSIONER PETIT: Well, let me ask you this on that question and -- do you recall that Jude -- is it Jude Chang responded on this when we were -- I wasn't in Oregon except by voice. But in -- and I don't know that we've done this, David, as part of our commission. But the document that Every Child Matters wrote going into this cites three peer-reviewed pieces that show the under-ascertainment was very, very significant.

We ended up using a number that said upwards of 2500 children are killed a year. The official is 1700. If you look at those three peer-reviewed journal articles, they all think that it could be 3,000 or even 4,000 on this, right? So I do think that we need to point out that disparity and that we haven't been able to close the gap on that.

COMMISSIONER MARTIN: I don't disagree that we don't know what the number is. I want to be careful how we couch it because if we're going to have an element of this report that deals with Native American children and minority children, then I want to be consistent in our reporting about it because we also know those numbers are not accurate. And I -- and my point -- this is Pat's opinion. I want to make certain that we're consistent throughout the report about what we don't know regarding the numbers. And because we don't know in

particular -- I mean, Mike, you've said it and you've cited these three reports -- two reports in particular --

COMMISSIONER PETIT: Three.

COMMISSIONER MARTIN: -- before. I've heard nothing on the issue about the numbers -- every -- a lot of people say that the numbers are underreported for Native American children. We don't even have a count.

COMMISSIONER PETIT: Can I answer that?

COMMISSIONER MARTIN: Numbers are underreported for other minorities including blacks and Hispanics. We don't even have a count, so I would err on the side of being consistent throughout the report in saying that we don't know what the numbers are, and then we can delineate the different subsets of kids that we're talking about.

COMMISSIONER PETIT: Right. And a congressional GAO study said that as well. And it seems to me that whoever is responsible on the staff for this ought to get the abstract of the three peer-reviewed articles just so you can see what that says.

And if you recall, when we were in Phoenix we had someone from the Navajo nation, I think, who was an epidemiologist. And if you recall, he said that on the reservation there were almost as many deaths as was being reported nationally among Indian children, and we specifically asked and said will you come back and show us what those numbers look like for the tribe. And I don't think he's -- he's come back yet, has he?

COMMISSIONER COVINGTON: He -- yeah, but he was talking about all child deaths on Navajo, not just child abuse death. They were able to count the child deaths. They did not equal the number of kids who died in Indian country.

COMMISSIONER PETIT: So it wasn't the 15? Has he said something to us --

COMMISSIONER COVINGTON: No. There's more than 15 kids nationally who have died from Indian country. I don't think that's what he meant.

COMMISSIONER PETIT: No. Terry Cross told us the numbers were about the same. We saw statistics that said the Indian child death rate was about equal to the national child death rate of two and a half for every thousand. That added up to about 30 deaths a year. Then we heard the Navajo epidemiologist say on our reservation there were 15 kids killed. I thought he said there were 15 kids killed from abuse and neglect.

There are only 60,000 people on the reservation, so the number per hundred thousand would jump very substantially. It would go from two to 10 or 12 or 14. He said he'd get us those numbers back. I'm wondering if we can ask him to clarify that for us.

COMMISSIONER COVINGTON: I think he clarified it for me anyways. The problem is it's just a total undercounting no matter where you go. But I think there is -- the other issue -- it's not just undercounting, but there's bias. And we've been talking about that. You know, are we counting more kids of color and counting more Indian kids because a parent who lets her kids drown in a swimming pool in an urban area who's black, that may be investigated very

differently than a suburban white family whose kid drowns in a swimming pool. So there are other issues that we're -- we've been talking about on the disparities committee as well.

So I think we can raise those issues, though, when we get into more of the findings. I think it's -- we just -- we don't know is really what it's getting to.

COMMISSIONER MARTIN: Maybe -- David, I don't know, but maybe staff can review the testimony specifically on this issue for us, I mean, because I think our findings have to be correct. And what I'm suggesting is unless we have testimony that has been submitted for -- then I would be hesitant.

COMMISSIONER COVINGTON: We did. I mean, Rachel put together a really nice piece that summarized the testimony we've gotten and that summarized all the literature. So we all -- I mean, it's been a while. It was all part of the measurement work.

COMMISSIONER MARTIN: But did Rachel's work include Native American children and blacks?

COMMISSIONER COVINGTON: No, no. Well, it broke it down -- it did break it down by race, yes, it did.

COMMISSIONER MARTIN: Great. But what I'm saying is that all the testimony we received on Native Americans, blacks --

COMMISSIONER COVINGTON: No, no, not that. I'm talking about just the measurement piece in general.

COMMISSIONER PETIT: We do have the numbers on race. I mean, federal government publishes the numbers, so you're just questioning whether or not they're valid which I think --

COMMISSIONER COVINGTON: They aren't.

COMMISSIONER PETIT: What?

COMMISSIONER COVINGTON: We don't think they are.

COMMISSIONER PETIT: I know, but that's what they're publishing, so we need to say what they -- what they say, then we need to say we don't think it's valid. We need to put out what's in the known universe on this. These are federal statistics. Right?

COMMISSIONER COVINGTON: Yeah. What I heard Judge Martin say is that it's not just a matter of saying it's an undercount but it may be inaccurate count even when we think we have the number when you break it across different age and race groups.

CHAIRMAN SANDERS: Jennifer.

COMMISSIONER RODRIGUEZ: So I have a couple of other things. I'm not exactly sure where it goes, and I don't know if we -- if we have had enough testimony on it or at all. But the discussion around how to not only reduce sort of risk factors for families but also to build their protective capacities and their resilience, and to me that includes a couple of things. You know, I mean, I think it's general, but it also, I think, includes doing a better job around actually listening to families and sort of empowering them to be able to take leadership.

I mean, I was really struck by that in this morning's presentation about -- I mean, I just keep thinking at the end of the day the reality is for families and for children that once all the governmental agencies disappear that you're left to deal with your life on your own. And so it seems like it's really important that we not just be thinking about interventions to decrease risk but also interventions that can increase families' abilities to sort of be able to manage their problems long term.

And with that I would also say that the second area that I'm thinking about under there is that in No. 1 -- I think it spells out nicely that sort of the safety net includes all of these entities, but it doesn't say much about increasing a safety net of family and community members that are not organizations that are sort of paid to be in families' lives. And again that might be something that we need further testimony on, about what interventions exist to make sure that families that are isolated get connected to family members or to other community members.

But that was something I certainly heard pretty clear testimony on when we were in Arizona as being a really important protective factor for native families and children. And I asked about it and so heard it again today, that that was a critical part of the interventions they're doing. So that's sort of one -- one area.

And then the other -- the other thing that I saw that was missing is that -- so I've been reluctant to, I think, push hard on -- on the issue around children who die while they are under the supervision of a governmental agency, either children who die under a governmental agency that's supposed to be providing habilitative services or supposed to be keeping a child safe.

But talking about the analogies with the airline industry has actually convinced me that even if it's a small amount of children, that actually it's a really important amount of children because it would be sort of akin to saying that there was a plane that was crashing and so we removed passengers off of that plane and put them on an ultra safe, you know, federal government plane and flew them and then crashed them again, which is exactly what I think we do.

And I think there are enough children who die while either in foster care or in the juvenile justice system to make that population a group that we should really be paying attention to and thinking about what do we do -- I think the fixes are different. I mean, we're not actually trying to serve foster families and get them more interventions in the same way that we're trying to serve biological families, I hope, because we should have never been placing with those families to begin with if that's the case, if we need to get them substance abuse treatment and mental health help and domestic violence support.

So -- so I think it's actually something that I would like to see some research on or testimony. I know I've asked a couple questions about it, and it's not clear that there is a discrete number, but there's certainly enough -- I see the stories all the time in the media of children who die while they are in foster care or while they are, you know, in a boot camp or reform, so I want to just put it out there.

COMMISSIONER PETIT: Jennifer, do you mean the deaths that are like in an open CPS case, for example, where the children are at home?

COMMISSIONER DREYFUS: In state custody.

COMMISSIONER PETIT: No, the state has legal custody of the child and then they are placing the child with the parent.

COMMISSIONER RODRIGUEZ: Well, I'm saying both out-of-home care and in care where the state -- where a social worker is coming to visit, where a judge is monitoring the case, where we are saying we are -- we are already on this, we know this child is at risk, we know they're so at risk that we have made an official governmental intervention and we're protecting them, we've made a pledge that we know. I feel like when those children die, it's sort of -- it's a different analysis.

COMMISSIONER COVINGTON: They do.

COMMISSIONER RODRIGUEZ: I know they do.

COMMISSIONER PETIT: The Associated Press story last October was specifically about that. I think they identified some 700 kids that were in state care that were placed with the parents -- left with the parents and the child died. Right? I mean -- and I've seen -- I've seen research before and maybe some of our staff now know it. I've certainly seen numbers before on the numbers of children in foster care that are reported killed. I mean, I think we do have that.

COMMISSIONER DREYFUS: Those are open cases that are in home where you go in for a meeting in the home, not just foster care.

COMMISSIONER PETIT: No, no, I know. I'm saying I think on both populations, whether the child is left in the home and dies and they're under state supervision and there are hundreds, maybe a thousand more a year that fit that category.

COMMISSIONER DREYFUS: I just think there is a larger public responsibility. It's like what Mark Courtney always says, you know, when the government comes in and says we will be better parents than your parents, then we darn well better be. And that there's a larger responsibility, right, when the government intervenes in a family in terms of responsibility. And I just really think -- again, I haven't thought it all the way through to being a finding just hearing it now, but I think there's something very distinctive about this group of kids who are killed who are the custody of the state.

COMMISSIONER COVINGTON: There is. And it oftentimes are those cases that absolutely drive reform in child welfare systems. I know in Michigan it was the three cases that led Dave Camp to create, you know, the first set of public hearings because those were all three kids that died in foster care. And he -- it was those three kids that led to the GA -- the first GAO report -- when the first GAO -- when the GAO report was first commissioned by Congress, it was supposed to look specifically at kids who died in foster care in the system. That's what -- the first commission.

But what happened is the GAO came back and said we can't figure out how to find those kids. It's really hard for us because of the way states count them. So they went back and looked at

all fatalities, but -- I mean they decided to broaden it. But I do think that it's specific enough. I'm not sure we've heard enough about it. I really --

COMMISSIONER DREYFUS: I don't think we have.

COMMISSIONER COVINGTON: And I think it's a really significant piece that we ought to not forget to address. I'm right with Jennifer on there -- on that.

COMMISSIONER STATUTO BEVAN: Just one quick thing I hope -- I really do hope and I've said this the first time. Then I let go, but now I'm back because there's a lot of stories in the papers about this with children with disabilities. Talk about undercounts and not knowing anything about them. It's really suspected that these kids die at much higher rates because of their disability. And I really hope that we can look at that.

CHAIRMAN SANDERS: High risk population.

COMMISSIONER STATUTO BEVAN: Yeah, The other is another negative. We sound -- I sound negative but we are charged with looking at both effective and ineffective programs at some point, maybe not in our major themes here, but at some point we are going to have to -- we've never yet agreed on one program that doesn't work as a group. And though we've heard testimony about it, we haven't -- I don't even know if we've heard testimony. I don't know if I've heard testimony of programs that don't work.

COMMISSIONER COVINGTON: We did in Colorado. There was a little bit of that, but they were sort of couching. There were some of the researchers there that described certain programs that had been evaluated and shown not to be effective.

COMMISSIONER DREYFUS: I have a problem with this fixation on programs to be candid. It's practices. It's not -- we think -- I always hear, especially members of Congress say we want to know what programs work. And when you -- when you run these systems, you're not implementing a series of programs. It's a set of practices. Right? It's almost like you're creating -- I think what we're lacking is something somebody said, I don't even know if it was on the commission or some other meeting I was at, about what we need to figure out is what is our version of standard of care, what is our version of the best practices from the time of a child coming to the attention of the community of the -- not just the system but the community, right, all the way through.

And -- but I can't liken that to a series of program interventions. That's where I break down, Cassie, a little bit is just --

COMMISSIONER STATUTO BEVAN: Programs are what we've been charged with, if you go back to our thing and look at it. And programs is what Congress funds. So I understand what you're saying, but Congress doesn't fund practices. Congress funds programs. And out of those programs, if something is not working, you know, we need to know about it so we can cut it off and fund something that does work.

COMMISSIONER DREYFUS: I guess I just need a better definition of the comprehensiveness of the definition of program because I -- I look at that and I think certainly something we have heard that seems to not work is this notion of how we think about CPS today as -- as one

person going out, the screening in, the screening out decisions. Is that a program? No. But I think we've clearly heard there's some real deficiencies in our current CPS model. So I think of program, I think of home visitations.

COMMISSIONER STATUTO BEVAN: We've heard about home visiting programs certainly with -- you know, we know them to be from some procedure. David Olds' program works. We know that. We know -- you know, we also have -- certainly have -- know about intensive family preservation programs that do not work to avoid foster care placement. Whatever the goal was -- if that was the goal, it didn't work. If the goal was something else -- I understand what you're saying.

COMMISSIONER DREYFUS: Yeah, I'm just trying --

COMMISSIONER STATUTO BEVAN: I just want to be able to answer the charge. We're charged with this, so we have to answer.

COMMISSIONER PETIT: Cassie, you're right. I wonder, though, how you're going to deal with money going to 50 states and 27 of them are doing a good job and 23 are not. First of all, I don't know how we'd find that out. But does that speak to a program that's not working or does that speak to a program that's not being well administered? I mean to look at this -- to look at this and determine whether it hits the chopping block or not, I mean, we better get going and looking at some of this stuff because I don't think we're close, in my mind, to saying let's get rid of the social service block grant, get rid of intensive care and preservation, get rid of IV-E, get rid of IV-A, get rid of IV-D, get rid of CAPTA.

I mean what is the means by which we're going to determine whether they're working or not, especially given the fact that for the nonentitlement programs the states have large latitude in doing what they want. So do you say she did a great job with her program, she didn't, now cut the program? I mean --

COMMISSIONER STATUTO BEVAN: And I'm not -- you're assuming cuts would follow. I'm not saying cuts would follow because they would be different committees. You know, I don't know. All I know is what we were charged with and we've never, ever discussed it.

COMMISSIONER PETIT: Have we done anything --

CHAIRMAN SANDERS: Judge?

COMMISSIONER MARTIN: I just want to know whether or not the cases that we talked about like the sleeping dust -- are we going to make any findings relative to those kind of cases that we said that we were going to kind of put on the side for a moment?

CHAIRMAN SANDERS: That was the goal of putting -- of stating it the way it was said in No. --

COMMISSIONER MARTIN: Four?

CHAIRMAN SANDERS: -- 4, no not 4, 5.

COMMISSIONER PETIT: Does this pertain to Cassie's question?

CHAIRMAN SANDERS: To say there are different types of fatalities, and yes, ultimately we should make different findings.

COMMISSIONER MARTIN: Okay. Okay. Thank you. I'm sorry.

COMMISSIONER COVINGTON: Can I go back to the piece about which programs don't work? I don't know if that legislation means federally- funded programs or, you know, a smorgasbord of programs. Because I think there's two ways you can go about this. I mean I kind of agree with Commissioner Dreyfus.

When I was listening to the presentation about Kansas today and Wichita, I had -- I had a moment's thought as I was listening to them that they could have picked anything from a smorgasbord of programs. I mean, they picked, what, nursery - - crises nurseries. They picked a couple other things, purple period -- Period of Purple Crying. And I was thinking to myself when they were doing that that they could have picked anything.

But what they really had was that committed community leadership that was absolutely dedicated. It reminded me of when we were at the tribe in Phoenix. They could have picked anything there, too, but they -- they just made a commitment as a community that they were going to come together in a very strong way and decide enough was enough, we're just going to address this head on as a committed community.

I think we could get really into the weeds on programs if we wanted to in thinking about which programs have been evaluated, which ones haven't been, but you know, you're looking at a smorgasbord of hundreds of those.

COMMISSIONER DREYFUS: Clarify for me, Cassie, like when you heard the -- again, the legislation says programs. So when you heard the testimony today from law enforcement about the domestic violence and the 11 -- the screening instrument that they're using in DV cases and the practice that's being used to make sure safety plans clearly are in place before they're leaving those homes, is that to Congress the definition of a program?

COMMISSIONER STATUTO BEVAN: No. But then again, you're right and I was wrong. The effectiveness of the service as described in paragraph one, that's our charge and best practices in preventing child and youth fatalities. So it says practices.

CHAIRMAN SANDERS: There's another part to it though, isn't there?

COMMISSIONER STATUTO BEVAN: Oh, wait. Duties of the commission. Barriers to --

CHAIRMAN SANDERS: So we're getting close to 5:00. We have all of tomorrow to talk about this. I would propose we adjourn in a minute or two.

COMMISSIONER COVINGTON: I think we're ready.

COMMISSIONER DREYFUS: And not all of tomorrow, right, just morning?

CHAIRMAN SANDERS: Well, half a day.

COMMISSIONER DREYFUS: Flying out of here.

COMMISSIONER PETIT: David, just related to this point that Cassie raised about evaluating good and bad and all that, I do think that we need to take note at some point that there has been no place, including today, that we haven't heard again and again and again and again the need for more resources for services for families of all types, including the agencies, including CPS. But specifically we've heard the need for more substance abuse treatment, more family intervention services, better shelter.

I mean, it has -- we have heard it every place we've gone. So I don't know how we're going to capture that. But I don't think it supports the notion that everybody is ready to cut a particular program. I mean, have we heard one program that anyone out there said don't fund that one, fund this instead? I haven't heard it.

CHAIRMAN SANDERS: I would say we haven't heard it in part because that concept hasn't been presented to us. I would argue that people make decisions every day about what resources to support and what not to support, and we really haven't heard how they're making those decisions.

COMMISSIONER PETIT: I'm talking about the need for additional resources. I'm not hearing anybody say let's stop funding mental health and let's start funding -- let's start funding sex abuse treatment.

COMMISSIONER MARTIN: David, I would make a recommendation for our deliberations tomorrow. I think we've heard on a number of occasions today that there are follow-ups that we haven't really received or we don't know if we've received, I think. And so I would ask that we can reserve -- or have a working lunch tomorrow or something where we can sit down and make an itemized list of the things that are still outstanding or they may have come in and Pat just doesn't know about them. But I think we need to take some time to really make certain we know what that list is and start tackling that a little bit.

CHAIRMAN SANDERS: I think that makes sense. I also think --

COMMISSIONER STATUTO BEVAN: There's -- sorry.

CHAIRMAN SANDERS: Go ahead.

COMMISSIONER STATUTO BEVAN: There was a sentence in here that did say including identification of the most and least effective policies and systems in practice. So we're both right.

COMMISSIONER DREYFUS: That's perfect. That's all there. That's great.

COMMISSIONER STATUTO BEVAN: But the word "programs" wasn't there.

COMMISSIONER DREYFUS: That's right, but it's not exclusive.

CHAIRMAN SANDERS: I think to your point, Judge, I also just started a list of things that we talked about today that we need to follow- up on, so I think both lists would be important to have.

Anything else that we need for today then?

COMMISSIONER COVINGTON: Can we -- can we just acknowledge the folks that hung out for the afternoon?

CHAIRMAN SANDERS: Yeah, thank you very much.

COMMISSIONER COVINGTON: It was really nice. If you have any insights you'd like to share with us, we always have open ears.

CHAIRMAN SANDERS: Thank you very much. All right. See you tomorrow morning at 8:00.

(Meeting adjourned at 4:58 p.m.)

DAY TWO—MAY 20, 2015

CHAIRMAN SANDERS: Good morning. We're going to get started in just a minute. We have several people who are going to come late this morning, so we'll go ahead and get started.

And Amy Ayoub is on the telephone.

COMMISSIONER AYOUB: I am here. Good morning.

CHAIRMAN SANDERS: Good morning, Commissioner.

So we probably have a flexible and potentially truncated agenda this morning, because we got at least some good discussion on the themes yesterday.

And so there are five things that we can cover, one that we didn't get to yesterday, the research roundtable recommendations.

Second is a document that was shared in here entitled "What's Next?" And I don't know that we have to go through the whole document, but we probably want to talk a little about the final report in the context of the White House and of Congress.

Third is we can make sure that we've covered the themes so that we're prepared to actually write them out in the first chapter of our final report.

We have the recommendations, which are simply the recommendations from the subcommittees that were submitted in the one-pagers that we can go over.

And then finally, the -- I think, Judge Martin, you had mentioned the idea of there are some to-dos that we want to go over. So we should do that.

Yes, sir.

COMMISSIONER PETIT: If I can just add a couple of things.

At some point, whether it's now or soon, we should show what the gap is between the size of the problem and the current capacity to respond to it if there is a gap. I think there is, but some people may not think there is.

But, for example, if the states were to meet national standards on staff ratios, what would that look like? Would that mean that the current number of staff is sufficient, or would it mean that you had to add 10,000 staff?

So there's a whole series of things like that that I think we need to ask, how are we going to represent that? Because in the end, this resource question is going to loom large, whether it's the recycling of resources from other places or whether it's brand-new resources.

CHAIRMAN SANDERS: And I would anticipate that would be one of the things on the to-do list, and that we probably need to think about a structure to do some things.

And I will probably suggest, particularly given some of the conversation yesterday, that maybe we don't need to continue all of the subcommittees as they've been, and maybe we need to put some work towards looking at some of these -- some of these others issues.

Did you have something else in addition to that?

COMMISSIONER PETIT: No. I think that that - - that one is critical, but also how we're going to represent what the actual problem is in the opening statement. You tackled that yesterday, and I gave you a little bit of a paraphrase of it. But at some point we have to agree, what do we think are the parameters of this problem? Acknowledging what we're not sure about, but basically laying it out there:

there are upwards of this many children killed, they die from a variety of areas, this is what they look like.

I mean, we need to show that someplace, and I think that's at the beginning. And then from that it flows, what do we recommend be done about it?

But it's -- that's a conversation that I would hope that more of the commissioners would be present to discuss.

CHAIRMAN SANDERS: Well, I think -- so before we leave today, we'll identify hopefully not a whole lot of things, but a handful of things that we need to do I think consistent with what Judge Martin had raised, and identify how we're going to get that -- how we're going to get that done.

COMMISSIONER PETIT: Yeah.

CHAIRMAN SANDERS: And both Commissioner Rodriguez and Commissioner Dreyfus will be here. They are running late.

And I believe Commissioner Horn is going to join us on the phone too.

COMMISSIONER PETIT: But on that to-do list, David, or, Pat, what you were thinking about, I mean, for me, you know, there's a number of specific things that -- for example, what the states are spending on child welfare. We have some information on it so far. I think we need to look at it and ask ourselves, is this how we want to present it to the public, or are we drawing any conclusions from it?

I mean, there are some very specific things that we've been identifying over time. I don't know where that to-do list is right now, you know, the issues that remain that we need to discuss and arrive at a position on.

CHAIRMAN SANDERS: And I think that we should go through the agenda and end up with that, because I think the idea would be that our recommendations should be tied to our findings and that we should look at where we have gaps in information to be able to say, these are things that we need to pursue.

So --

COMMISSIONER PETIT: Yeah.

CHAIRMAN SANDERS: But I think we should go through that and then close with that as part of today's agenda.

So maybe we should start with the research roundtable. And I believe we have Rachel Berger, who is prepared to give a summary of the findings of the research roundtable, or at least the recommendations.

DR. BERGER: All right. So I don't know if you guys have had a -- it's very easy now, there's three people -- if you've had time to look at the recommendations. So do you want me to go through them, or should we discuss them? Which do you think would be more helpful?

COMMISSIONER MARTIN: I think the first thing I'd like to hear kind of is the source of where the recommendations came from. So what was the process of how you guys got to where you -- not guys, but how the group got to these recommendations. And then I would like to, if it's okay with the chair, to then kind of have an opportunity to discuss each one, but just give the highlights of each one, and then see if there's anyone around the table that has comments about it.

DR. BERGER: That sounds fine. Okay.

COMMISSIONER MARTIN: But that's up to the chair.

DR. BERGER: Okay. So I guess the first -- so we actually -- if you look on the first pages, we actually talked about the process a little bit of how we got to this, but I think we can go back and say how we got the researchers at the research roundtable.

So really what we had done, at this point the focus of the research roundtable was on -- specifically on predictive analytics and on risk factors. So that was the decision, you know, that that's what we were going to focus on at that research roundtable. The thought was that there might be another one at some point later, and that's why the focus was on that.

And also we were (unintelligible word) at the KC meeting, which had a focus on predictive analytics. So we already had some international experts that were -- happened to be here.

Then the other experts at the research roundtable were taken from the authors, the main authors of many of the papers that were in the bibliography about risk factors. And then

there were also some recommendations from other staff and other -- some of the commissioners.

So that's how we came up with those people. There are clearly many, many more we could have -- we could have used. But these really -- you know, if you looked at the literature, these were clearly the experts.

So what we did was, at the time, we developed a list of recommendations. And those were the ones at the roundtable that were kind of written by hand on those big pieces of paper. Those all got typed up and we sent them out to all the researchers for their comments. We got many, many comments back. From actually all 13 of the researchers who participated, we got back all of their comments.

There were some changes, there some deletes. We made lots and lots of edits. And then we sent everybody out a revised set of recommendations and gave very explicit directions about how to rank priorities.

So we asked the researchers to rank their priorities from 1 to 10, where 10 they thought was the most pressing need. Twelve of the 13 researchers sent back their recommendations. The other one did, but it was well after, and it wasn't really following the directions. So we had 12 of the 13. And then we determined the final ranking by the number of people who ranked each recommendation in the top five.

So what we did for research priority 1, for example, it was ranked in the top five by nine of the twelve people.

So basically, we added the points. You got the most -- if you put in a one, you got ten points, then nine points, and whatever. And then whoever -- whichever had the most points ended up being the top recommendation.

And so they also -- there were a whole bunch of other issues that were raised that I wrote down here that were not specifically related to research. And we toyed about whether to put them in, but then we ended up taking them out, that these are not -- they're peripherally related to research, but more fundamental issues. And so we didn't put them in the priorities, and we just listed those.

So the first list here is just overall issues that were raised by the roundtable both in this back-and-forth, and then at the conversation between the commissioners and the researchers at the roundtable in December.

The idea that near fatalities should be grouped with fatalities I think is something we all agreed on, but the researchers felt that was important for people to recognize, but there's no research that has to be done. They agreed that those are very similar; they need to be grouped together.

Defining child abuse and neglect fatalities and near fatalities is critical, they thought, for any research, because if you don't have a definition, you can't do it, but also as a fundamental issue of how the Commission is going to proceed, because you need a definition.

They felt that it was very important to call attention to the partial view that CPS has in terms of risk and services, because fundamentally the recommendations about risk assume that a person knows the risks in order to make the decisions. So they felt like people had to understand that, at this point, CPS is not seeing all those risks, and that's affecting --

COMMISSIONER COVINGTON: Is the purpose for that -- when you say they're not seeing all the risk, is it because it's a point in time response, or --

DR. BERGER: So they said it was both. For example, maternal depression was the one that was discussed on the e-mail a lot, that we know maternal depression -- actually, Dr. Campbell talked a lot about that. Maternal depression is a very important risk, but if you're not doing a maternal depression screen, you might not recognize the risk. So it might be in the predictive analytics, but if you don't know what the answer is, you can't predict risk.

So there's this fundamental idea that we have to all understand that you have to know what the risks are in order to use even the results of the research at any point, because that's just a fundamental issue.

So the issue of linkages, as you'll see, is going to come up in actually multiple of the recommendations. And they just felt the Commission could make an important contribution simply by considering how to incentivize states to make these linkages, that the linkages can be made, that -- the big difference between now and 20 years ago is we absolutely have the ability to do this. It is not difficult by any computer -- I mean, you could literally do this without a problem.

The problem now is the barriers of confidentiality -- HIPAA, siloing, all these other things. And that fundamentally, you look at the recommendations, you have to have this data linkage in order to do many of -- much of the research that the researchers felt was necessary, and then this issue that comes to HIPAA.

And the recommendation --

COMMISSIONER PETIT: Rachel?

DR. BERGER: Yeah.

COMMISSIONER PETIT: On that other one that you just were talking about, the incentivizing of the states, isn't that something the federal government could do?

DR. BERGER: That's what their thought was, that one of the contributions the federal -- the Commission could make is to recommend to the federal government essentially to incentivize states to do this.

COMMISSIONER PETIT: And incentivize can be positive or negative, but the issue is incentivize.

DR. BERGER: Yes. I put it in a positive; but, yes, they could disincentivize.

COMMISSIONER PETIT: Well, no, it can be positive, but -- but I -- I don't want to get into a -- on this data thing, over a whole lifetime of dealing with this thing, I don't think we want to do

a "Mother, may I please" with the states. The states need to provide this information. Everything is built around this data. And if it isn't reliable and comparable, then we're stuck all the time with saying, we don't really know.

DR. BERGER: And the other issue that was raised a lot with the researchers is this issue that we've raised all the time is fatalities are so rare that in order to really get data and learn about what works and doesn't, you have to use data that's way wider than a state. You've got to use multi-state data. And the only way to do it is if all states are doing the kind of data linkages and you can compare the data from state to state.

And this is very similar to the issue of HIPAA. There was some discussion about the waiver -- whether you need a waiver of HIPAA, you know, who needs to discuss this; and there was an idea that at some point you could do a consortium of multiple states to really just demonstrate, indeed, the data you get from linking all this, including HIPAA-sensitive information, is so much better that the federal government should do this. And so that maybe there needs to be an intermediary step to show that by linking this data, you get something that's so much better.

COMMISSIONER COVINGTON: Well, the interesting thing is, you can link it once they're dead. You know, it's not -- and the point is not we're waiting too long. I mean, the rules allow for a lot of stuff one a person's deceased, but they don't allow it for when they're alive.

DR. BERGER: Right. And that was a lot of -- actually, HIPAA's a moot point. Once the child is dead, there is no HIPAA. But you can't -- the point is not -- as Chris Campbell said yesterday, the point is before the outcome of occurs, not after the outcome occurs.

COMMISSIONER PETIT: Yeah. So, David, I just wondered, just in terms of how to proceed with not just these recommendations but others -- and we haven't tested on any of them whether there's a total consensus on them or not. But, for example, in this particular piece that we're talking about, I would think that we support the idea of mandating this to the states. If we don't, then let's have a discussion about it, whether it's now or later. But I'd like to see it come forth in the recommendations that are drafted as that not states should be incentivized, but the federal government should require the states to do the following.

COMMISSIONER COVINGTON: But to even do that, though, you have to change federal laws related to --

COMMISSIONER PETIT: No -- well, no, that's fine. So what I'm saying is, you know, the federal law should be changed to allow for whatever, but I'd like to see it presented in an affirmative and an assertive as opposed to a passive.

CHAIRMAN SANDERS: And I would just say, we - - these recommendations are from the researchers to us. The document that's been shared are the recommendations that the subcommittees have made, which I do think include that strong language.

COMMISSIONER PETIT: Yeah, I'm saying is -- not go through this every time, you know, four meetings from now, but we're saying someplace it should say it must be required. I mean, I think we just build that into the language.

DR. BERGER: I think you've fundamentally got the fact that these were researchers, and they were writing this from a researcher perspective and not in, like, a, you know, you need to do this. I think it is, this is to you.

COMMISSIONER PETIT: No, I agree. I understand. I'm just saying for us, for what our staff and what our people are going to do, yeah. Okay, fine.

COMMISSIONER MARTIN: So, Rachel, before you go further, who are the -- who composes this roundtable? Who specifically sat on this roundtable?

DR. BERGER: So there were 12 overall, but we had Rila -- I don't know how to pronounce her last name -- from New Zealand, Joanne Wood, Andy Barclay --

COMMISSIONER MARTIN: Rick Barth and Emily Putnam-Hornstein?

DR. BERGER: Emily Putnam-Hornstein, Rick Barth, John Fluke. I don't remember all offhand. That probably gets to eight or nine of them. So those are the people that were at the roundtable.

COMMISSIONER MARTIN: Okay.

DR. BERGER: I think we invited 15 people and 13 were able to come. So we pretty much got everybody that we had asked for.

COMMISSIONER MARTIN: Okay. Great. Thank you.

COMMISSIONER BEVAN: I have one other thing that -- supporting what Michael said, let the record show, that besides mandating and -- like, research priority No. 2. I mean, one, I totally agree, I don't want to do "Mother, may I," and I don't want to hear about unfunded mandates, because these are all paid for.

I mean, so is there -- is it possible to consider a national child fatality surveillance system and bring everything into the federal government so that everything comes in, and then we can control -- I mean, the feds can control it. Then we would have all of this linked because we're not -- we're not asking the states to do it, we're telling them.

I mean, we -- we did that in the CFSRs. In the Child and Family Services Reviews, they were voluntary before, and they were a waste of time. I mean, they were paper check compliance. And now we require it, and we have a system for requiring it.

COMMISSIONER MARTIN: I think in the measurement group of recommendations, that is, the recommendations to work towards this national fatality surveillance system. But the point I was trying to make is that some of this is to do this well to protect kids, there has to be this data sharing before the kid dies.

So I see it as -- because it's things like looking at -- thinking about maternal depression, having access to the mother's depression history if you were a caseworker could be an important data linkage piece that you wouldn't have had, or the family health history or something. Some of that early data linkage around safety --

COMMISSIONER BEVAN: Couldn't that all be in -- or is "surveillance" a technical term meaning that it would have to be after, or can it include everything?

COMMISSIONER MARTIN: I think -- I don't think it would be --

COMMISSIONER BEVAN: Or something like that.

COMMISSIONER MARTIN: I think that it's different than a surveillance -- fatality surveillance system, because this is really having access to data about kids early and often.

COMMISSIONER BEVAN: Yeah, because it would also hopefully be able to include at some point Rick Barth's -- you know, the birth matching. And as soon as that's ready to go, I would hope that would be in something like this.

COMMISSIONER COVINGTON: Yeah. And that's a perfect example of what they're getting at before the child's dead.

DR. BERGER: Right. But it's the -- actually, it's the last one of -- it's the increased availability of data, but for practice. I mean, not just for research. I mean, the researchers were there to talk about research; but fundamentally -- I said, you've got to be careful about putting everything at the federal level, because you really need it at the very local level to be able to link these data systems very, very quickly and, as you'll see, in real time. This can't be, I set up this linkage for this research project and I put it aside. It has to be linkages that are able to be real time.

And then this idea of constant updating of risk must be a requirement. And this is the idea. These linkages cannot be static, they have to be live. And although for research purposes we might need to make them static to get the data, the researchers all say in real time, you have to have this reassessment of risk, and you can't do it on a research project.

So research priority one -- and I have to say, nine of the 12 researchers put this in their top three. So I actually found that really impressive, because you have 13 people who all have their own self-interest, they all have their own research, they all have their own ideas, but yet they all fundamentally agreed that this was the most important research priority. So they were, in a way, voting against their own -- you know, what they're -- they're actually researching themselves.

COMMISSIONER BEVAN: I was wondering, when Deidra comes back, because she was very involved with the Affordable Care Act, I am interested in these -- at one point they were called carve-outs in another document that we had.

COMMISSIONER PETIT: Yes.

COMMISSIONER BEVAN: Is this the same?

COMMISSIONER PETIT: On the subcommittee on practice of CPS. Which one?

COMMISSIONER BEVAN: It's on my number two.

COMMISSIONER PETIT: We used the carve-out language in that subcommittee. Is it in here?

COMMISSIONER BEVAN: I'm on the leverage opportunities in different public systems. Okay, the - - oh. Okay, these are our recommendations.

DR. BERGER: Those are separate recommendations.

COMMISSIONER BEVAN: So you don't have the carve-out.

DR. BERGER: We're not talking about the carve-out.

COMMISSIONER BEVAN: Okay. So -- but we'll talk about this later.

CHAIRMAN SANDERS: Yeah.

COMMISSIONER BEVAN: Sorry.

DR. BERGER: That's okay.

COMMISSIONER PETIT: Well, I mean, you guys didn't address the carve-out question. That isn't -- that isn't a research issue, that was -- that was a policy question.

DR. BERGER: Right. That was a -- it's a policy issue.

So the research priority they identified as number one is to develop, using research, a standard way to measure severity of harm, severity of risk, and even severity of maltreatment, because that's been a big issue is that when you have recurrence of maltreatment, there's no way to know whether it was a bruise that recurred or whether it was an abusive head trauma. And clearly those are extremely different events, and we need to develop these ways to measure it to an individual child, to the family, and actually to the non-index child, to the contact children. Because I think the question comes up many, many times, do you only need to remove the index child, and does it matter, depending on what the incident event was.

So that was their first one.

The second related priority is developing tools to support decision-making. And there was a lot of discussion and research how people are so quantitative. And even in medicine, we've become so quantitative. And I said -- I always go back to Tom's statement, you can't have malpractice until you have practice. And I think we really -- fundamentally, in child protection, there aren't these tools in the same way they are -- I thought that 11-checklist thing for severity of domestic violence was actually the most quantitative thing that we had seen through most of the Commission.

So they -- I think the researchers, because they are, by their very nature, much more quantitative, were saying, we need tools that are research based that support decision making.

It doesn't mean that caseworkers don't have any authority to do what they feel is necessary, but there is this evidence-based decision-making tool.

COMMISSIONER COVINGTON: So, Rachel, I thought there were tools out there that have been field tested around safety.

DR. BERGER: There are -- right, there are some.

COMMISSIONER COVINGTON: So I guess the question is, why -- what's wrong with those and why aren't they working?

A little bit of analysis around that would help me, because I keep -- every time I'm doing some of this work, you say, well, there already are tools; we've done risk-assessment tools, we've done safety- assessment tools, they've been field validated. And then the next thing you hear, we're going to throw them out.

DR. BERGER: So there are -- and I'm going to defer to Tom on some of these, but there are risk- assessment tools. They are mostly at time of intake. And part of the discussion here was at the time of screening, four months after, prior to unification. But they are based on the initial -- because CPS is an investigative agency, that they're focused on that investigation, but that reassessment of risk is probably one of the biggest issues.

So there are -- and I have to say, in Pennsylvania, we have a risk assessment and nobody likes it. We have one, we use it, the state requires it.

COMMISSIONER COVINGTON: I know. I know. I hear it all the time.

DR. BERGER: And that's not my area of expertise, so I would definitely defer to Tom on that. But the discussion of the researchers was we have to focus on multiple touch points, and the tools might not look the same because you have more history at every point.

COMMISSIONER PETIT: So let me just note on that, David, back to the question that I had raised earlier about resources, I think this is actually -- and it's key, in at some point being able to bring a mature decision-making assessment process to each case, because you're really throwing an atomic bomb into these households when you say, we might take your kids away. I mean, it's a very big thing. But in looking at this, if you had this all done tomorrow, the question of how you would implement it, train on it, supervise on it, evaluate it, I mean, is a huge undertaking.

I mean, we're talking now about the behavior of what individual workers do and what their supervisors do. So you need the tool, but long after you have the tool you have to have the capacity to bring the tool to practice, right?

I mean, so I think this resource question I'm raising, I'm looking at this and I'm saying, what would it cost to be able to do this? Not the research, but the actual achievement of the research, followed by the implementation of what the research found.

DR. BERGER: And I think that's really hard to say. Again, I guess I'm going back to other medical-type issues. When you have a research question, you don't always know what -- you don't know what you're going to find. And so if it turned out there were, like, you know, this is totally going to be fundamentally different than anything they do now, clearly it would take a lot more to implement it.

However, if it turns out that actually what they're currently doing is not that far from what -- but you just need to add this and do this and do a couple other things, it might not be such a big undertaking.

COMMISSIONER PETIT: True. Except that I'm sure that what we're going to find is it varies by state. So you could have some states that are right on top of it, they're organized in a manner they can do it, and you've got other states in which this would be a catastrophe coming in. Again, the feds specifying what kind of training, who does it, et cetera.

DR. BERGER: I think that's always a point well taken, that this is the first step.

COMMISSIONER PETIT: Yeah, I -- I'm keeping - - returning to the federal side on this thing in terms of states voluntarily participating. And if we've got a better mousetrap, then it ought to be put out there.

DR. BERGER: So I think -- clearly, I think that's an important issue once this happens, but I think the research roundtable was focused just on what we have to do to get those answers.

Some of these specific recommendations you can read. I think the one that I actually starred here as important is the use of other triage points other than child welfare. So to decide when these assessments need to be done so when the parent gets 302'd, or when there's a referral for mental health treatment, those are the -- a new, unrelated male moves into the house, those -- to figure out what those trigger points are when you should be doing another risk assessment.

So -- or if the police get a call about domestic violence, that automatically instigates a new risk assessment.

So there were some suggestions for how to carry out these recommendations just from a research perspective using predictive models, using something like the Pennsylvania Quality Service Reviews, which are already done.

Again, almost everything has to be done retrospectively because we don't collect the data enough prospectively. But with retrospective data, just like Dr. Campbell showed yesterday with LONGSCAN, you only have what people collected. And that's always a huge issue. If you know that something that's not routinely collected might be the elephant in the room, you know, if it turns out maternal depression is the most important predictor.

And I think I always remember back to the great studies about the Nurse-Family Partnerships, and then there was the one study that showed if domestic violence was present in that home, it really didn't matter what other services you gave, but the first couple studies didn't even know that that was the critical variable to collect.

And so that's the biggest problem with the retrospective research is you just sometimes don't have the data and you can miss really important things.

Research priority 2, again, this was a very clear consensus. You need a standard set of data elements that's collected on all fatalities and near fatalities. I think that that was a fundamental agreement among not just the researchers.

We had a very interesting discussion with two economists that David Sanders put us in touch with, and they were talking about all the analysis they could do. And I talked to them and I said, well, what about NCANDS? What about this?

And he said, we haven't touched the child welfare data. He said, it's so bad, we don't even touch it. We use some death certificates, we'll use all these other -- but we would never even consider using this data set.

Which is not really a good comment about the quality of the data that's coming out of it.

So they talked about whether and how you could -- if you could add a fatality file to NCANDS, how to define your fatality for the purposes of doing that, how to potentially link the child death review/case review system -- reporting system with NCANDS, how to link the unexpected -- the SUID database from the CDC. There was a lot of thoughts about how to do this, but everyone fundamentally agreed you have to have a standard set of data elements you collected on all fatalities and near fatalities.

And there has to be -- as Commissioner Petit had said, there has to be some disincentive for states that don't do it or some incentive to do it. It can't just be an unfunded --

COMMISSIONER PETIT: Right. Rachel, how does the -- does this link back, the collection of these standard data elements and all that, how does that go - - like, get linked back to standards?

In other words, you have to -- if you have stand -- if you say there ought to be standards, how do you link the data that you're collecting against measuring whether the standards are being achieved or adhered to?

DR. BERGER: Do you mean how do you know that the states are actually completing the data?

COMMISSIONER PETIT: What I'm saying is if they're -- let's say there's a standard, whatever those standards are, I mean, there's volumes written on standards. You have to collect data that shows whether you're in compliance with the standard or not, right? I mean, how -- how would you -- I'm just wondering where --

DR. BERGER: Oh, in terms of the data, I think they were saying, here's the -- there's 18 pieces of information you need on every child fatality. You either fill them all in or you don't. You have to collect these 18 pieces of data on every fatality or near fatality.

There was a big discussion about NCANDS itself, because fundamentally not all the kids are in NCANDS, and how we could try to work around that. But I think they were just saying it's a standard sort of elements. There's 18 data elements, and you need to put in, you know, I don't know, either the perpetrator is known or is unknown, or you need to put in the date of death, you need to put in the medical examiner's cause of death. Whatever these data elements are, they all have to be completed, or you write why you don't have them.

COMMISSIONER COVINGTON: And the model on that, you mentioned the SUID, Sudden Unexpected Infant Death Registry. That's actually built into the child death review case reporting system, and the states are funded and are expected to complete 100 percent of what we call priority variables. And they're doing it. They're -- they're collecting 100 percent on every single SUID death.

So --

DR. BERGER: I think we have the same thing in all research projects. We have variables that considered. You can't move on until you answer those. There are other ones that are not considered priority variables, because you're not going to get -- you know, there must be, you know, 25 absolutely essential, and then you have other ones where you encourage them to do but you don't require. And I think that's kind of -- that's what we were thinking about.

COMMISSIONER BEVAN: When you say a standard set of data elements and you list all these different data sources, I know that the CDR source, according to JOA, anyway, was a rich and more comprehensive source than NCANDS. So would we lose any richness -- are we going to lose anything in -- by just linking them, or are we reducing all of them to the same --

DR. BERGER: Right. That's a really good question.

So they were saying there's a standard set of what you're calling priority or quality that everybody has to have. You wouldn't lose the child death review, it's just that that would also -- those elements would get linked in if you have it.

But again, not every child is going to get reviewed by a child death review team. So for those cases, you'll still have all the data in child death review; but at least for all the cases you're going to have, you know, 25 pieces of data, which we don't even have now.

So it's not -- it's not every kid is going to get as much as on a child death review --

COMMISSIONER BEVAN: So it's the floor, not the ceiling.

DR. BERGER: It's the floor. We're setting a floor.

COMMISSIONER BEVAN: Okay.

DR. BERGER: But we don't even have a floor now. I mean, there's like a basement, but it doesn't even have -- right? So that's all we're getting. We're getting to a floor, A first floor.

COMMISSIONER RODRIGUEZ: Rachel, I think this -- my question is actually about -- back on one. But are any -- do any of the recommendations speak to the research that would be necessary to figure out if what we do for children and family works?

Like, 1(b) sort of sounds like individual practice and risk, but were there any recommendations for how we could better gather data on whether -- I mean, I was struck by Dr. Campbell's presentation yesterday that this is something that's really lacking around any sort of research about whether CPS or any subsequent intervention that we provide to families is helpful.

DR. BERGER: It's a really good question. And actually, before you came we were saying one of the issues was that this roundtable was set up specifically to discuss predictive analytics and risk factors, because the thought was we might have another one later, and we had merged it with the KC meeting where we had all these experts.

So I think the question you asked, it wasn't addressed, but it's only because of the way the meeting was set up.

COMMISSIONER RODRIGUEZ: The focus.

DR. BERGER: I will say, interestingly, Dr. Campbell, this is what she's done a lot of. There is no home for this kind of research. Right? And so she's had incredible trouble getting any funding to do it because there is no home to do it.

So I think the answer is I think we all agree that some of those things have to be studied, but it didn't come up because of the way the research roundtable was set up. But also I think fundamentally, because no one has ever gotten funded to do anything like that, and so sometimes it's hard to think outside the box into that kind of research. But I don't think we're saying here it's not needed, because I think fundamentally this is like moving --

COMMISSIONER RODRIGUEZ: Except this is a narrow scope of other research that's necessary.

DR. BERGER: Exactly. But I think we all agree that looking at whether things work is a really important research that doesn't really have a home in any agency right now.

So maybe -- that's a really interesting thought is, is there a way for the Commission to recommend, you know, certain -- I don't want to call it carve-out, but certain types of research that you feel needs to get done.

And this is kind of a -- this would be a subset of that bigger issue of what works, right? And I think that may be a different way to think about it.

COMMISSIONER DREYFUS: Is there any sense from the group of the federal agency that would be the right agency for that kind of research to be housed in so that, you know, it does have credibility, it does have the ability to span across agencies in terms of finding the recommendations? Do they have any sense about what federal agency?

DR. BERGER: I think it's a really hard question. I think -- it's interesting. So I don't know if you know, the National Children's Study actually closed recently, and there was a lot of discussion about what was going to happen with all the money that was being spent on the National Children's Study.

So there were a lot of issues. It closed before it was going to close. And I think a lot of people were really pushing hard to move it into some other pediatric issues -- trauma, trauma-informed care, a lot of -- maybe not CPS per se, but at-risk children, and it didn't happen. And there's a lot of people that are still really pushing back.

So I think the issue is there is so little money right now that there's so many pushes for that money. So it's not -- I mean, I think there are places within NIH NICHD, which is the only child-focused part of NIH, which I think this research would fit. But again, the funding levels are so poor. They're I think below 10 percent at this point.

You know, CDC, again, on the phone call -- and I don't know who was on it -- they basically said, we have no money.

And so part of the struggle, I think -- and I don't know -- I don't have any brilliant ideas of how to solve that, but -- but the answer is there isn't a good home because everybody is so tight, that nobody would take anything into their home because there's no -- they can't even fund the things they want to fund in their own agencies.

COMMISSIONER DREYFUS: I remember we were told, and I can't remember which meeting, that for every $3,000 spent on fibromyalgia research -- and believe me, I know how horrible that condition that can be; I've got a family member with that -- we only spend $200 on child welfare research. So it does belong, I think, in this report.

I would just tell you as a former state commissioner that also was doing research, you know, 4(e) was a very important mechanism for us with our university on the research Wisconsin did on youth who age out of foster care, if you all go back to Mark Courtney's original research coming out of Wisconsin. And I do think there would be reason to also incentivize states in partnerships with their universities with some kind of enhanced federal match for research on specific questions that the Commission might identify.

So I think there's this federal piece -- don't get me wrong, NIH, you know, where we're doing this higher level; but I also think there's reasons for states to be in this game as well and partnership with their universities. And I'd just like to put that on the table.

DR. BERGER: I really like that idea because it requires a collaboration, and it inherently gets rid of some of the data silos. And I think that's one of the concerns about keeping it only in the federal government is it does not require that collaboration. But for a state to get a federal match, you have to reach out to a university or to a medical center. You inherently have to get together CPS with medicine, or mental health or whoever you choose.

COMMISSIONER DREYFUS: What it does, though, is it -- for us, it put us in the game of looking at ourselves of -- you know. And so it was -- and I just think that that's just inherently important that states are actually looking, evaluating their own work in partnership with a university.

COMMISSIONER COVINGTON: I -- and I think -- I think as a Commission, when you look at our draft recommendations on the other document, we are probably going to -- I hope we make recommendations around the research question and the dearth of research that there currently is.

And I think one of the things that intrigued us was when we were at the Department of Justice meeting was how they do fund a lot of community- and state-based research. You know, I -- I was really quite astounded at that model, because you don't see that happening -- you don't see that happening at the Children's Bureau and HRSA. HRSA funds some; Maternal and Child Health Bureau funds some secondary data analysis projects and what have you, but it's minimal. I thought the OJJDP model was really something.

COMMISSIONER DREYFUS: Does this fit into that issue Michael keeps -- Michael brings up and Wade has brought up about the Children's Bureau? I mean, at some point does this start to weave into that bigger discussion about the place of the Children's Bureau?

Because I think you're right. I do think that, you know, they really are not as relevant to this research question as you would -- you would think they'd be.

DR. BERGER: I think you've kind of hit the nail on the head in terms of -- because these recommendations almost mean nothing if there's not fundamentally a discussion about how you could actually do them and how you operationalize it.

So I think these were researchers from a higher level saying, this is scientifically what I need to do. But I think some of what the Commission could add is, well, how could we operationalize this?

And I think the federal agencies that -- the researchers that we brought to the table, or almost all, have gotten NIH, CDC, other funding, which may not be the mechanism for this and may not be -- but the Commission -- I said these -- getting rid of silos by working with -- the states working with the Children's Bureau, working with -- those are I think really important contributions that kind of I think dovetail very nicely with these recommendations.

So the third one, 3(a) and 3(b) had the same number of points. One was develop working definitions of child abuse and neglect, fatalities, and near fatalities.

We heard a lot about this -- I don't even know what state, I think it was Florida -- where we heard from the Air Force, and said the reliability and validity was both felt to be important, although really people felt that reliability which is consistent over time was more important than validity. It's not as important to get every single kid, it's more important that from year to year you can compare so you can operationalize and look at interventions and outcomes.

So it's not that we don't want both; but if you had to pick, the bigger problem with the definition now is from year to year, they're counting different things differently. And scientifically, that just -- garbage in, garbage out. We can't do anything with that.

COMMISSIONER BEVAN: But if it's not that, we want to make sure we're measuring what we say we're measuring, right? And that's validity.

DR. BERGER: No, that's reliability. Reliability is the same thing over time.

COMMISSIONER BEVAN: Reliability is consistency.

DR. BERGER: Right, over time. Validity is you got the right --

COMMISSIONER BEVAN: But validity is measuring --

DR. BERGER: Yes, that's correct.

COMMISSIONER BEVAN: -- what you say you're measuring.

DR. BERGER: Yes, that's correct.

COMMISSIONER BEVAN: That's why if we say we're measuring fatality and we're not, then it's not a valid instrument.

DR. BERGER: Right. I did the words wrong. We want to make sure we're measuring the right thing.

COMMISSIONER BEVAN: Yes.

DR. BERGER: Getting every single one is not the important thing.

COMMISSIONER BEVAN: Okay.

DR. BERGER: I mean, it's nice to have every single -- it's nice to have every single one, but as long as we know what we're getting, that's fine.

COMMISSIONER BEVAN: Yeah. Okay.

DR. BERGER: So the research -- the next one, which is tied with the prior one, is the idea of linking multiple data sources. It's very linked to research priority 1, but we kept it separately.

So it's standardized. One of the biggest issues is it has to be available for research. One of the issues you'll see later, these general issues, is the difficulty of researchers getting access to data.

As Dr. Campbell mentioned, it took her seven years to get that to one of those data linkages. So to get -- it takes seven years to get it. This data is from, like, 1999, by the time you're analyzing in 2010. And the reality is, so many things have changed, you don't even know if you're measuring the right thing anymore. So there was a whole discussion of that, which I mention later on.

And then again, these linkages have to be continual. They cannot be single links in time, because that's -- in practice, that wouldn't help.

So there was agreement that linkages have to include not just CPS data, birth data, death data, Medicaid. So the importance of this was as we've always -- we talked about. Because fatalities and near fatalities are in very young children, CPS is not likely to be the most useful unless you're going to be able to link to family data in CPS.

There was also a discussion about being able to look at all investigated cases versus substantiated cases, because that's a huge limitation in most research is that you're only looking at substantiated cases. And there's a lot of data. Those actually aren't fundamentally that different, and it's very variable and over time it changes.

COMMISSIONER DREYFUS: Rachel, what about screen out, though?

I mean, I -- I always -- when I would review these deaths, you know, I would just see a pattern of screen out, screen out, screen out, even though we'd say, quote/unquote, not known to the system, so that you could go back and see calls from -- whether that child or other children within that family.

DR. BERGER: That was actually specifically discussed, this issue of screen out. And actually, it's in -- it's research priority 1(b) is the idea of how much you could get at the screen in/screen out point to actually do a better risk assessment, knowing that that is probably a very big, potentially big missed point.

So it -- I absolutely agree. We actually put it under research priority 1, but it could be under 3 because those are so fundamentally linked.

COMMISSIONER BEVAN: Rachel, can I ask -- Michael's -- or, I had asked Michael the same question about who -- who are the hotline people? Who are the very first people? What's the -- what are the skills, what is the experience? Are we still talking about a 25-year-old art history major, or are we talking about an experienced person?

Michael, I'd like you to repeat what you told me.

COMMISSIONER PETIT: Well, in some --

COMMISSIONER BEVAN: Politely.

COMMISSIONER PETIT: I mean, in some -- no, in some jurisdictions that we looked at, the intake was where you assign new workers, let them understand what's coming in here, or -- or it was where some workers were being disciplined; we'll take them out of the front line and we'll put them in the back room where they will handle the intake.

So I -- I do think that that first contact is critical. And whether it's done by CPS alone or CPS in conjunction with, say, public health or -- or a cop there, that first one coming in is the big one. And that does relate back to this notion of, are we going to adopt the fire department model that says they go out on everything. You know, when -- when you call the fire department, they don't ask you what you know about the fire, they say, we'll be right there.

It's the same thing I think with this intake thing, is what are we hearing and does it deserve an immediate responsive?

COMMISSIONER DREYFUS: I just want to say I agree that there's inconsistency, but I have personally sat next to phone intake workers with a headset on and listened to their work, and they do a hell of a great job.

So I have -- I agree that that exists, but I don't -- I also don't want it to be viewed that that's the norm. I think what we've heard here as a Commission, and I love the way the assistant district attorney framed it, I think it was him, we want people to aspire to CPS, because -- and what Tennessee is doing with 100 percent redundancy on all decisions.

I just think that as a nation, we -- we have had such a fixation because of where so much resources in terms of 4(b), family preservation support, and 4(e), kids in placement, we have lost our eye on what is the biggest predictor, I think, of the success of those two things, and that is that CPS role. And that's why I've all along been saying we're using 20th century version of CPS in a 21st century world. And I think what we saw in Tennessee is a response to try to upgrade that CPS function.

So I want to agree with you, Michael, but I just want to say I don't -- I don't want it to be a broad brush --

CHAIRMAN SANDERS: Before -- before we start on this track, we have a few more recommendations from the research roundtable. We should get through those, because we're going to talk about recommendations I think next, and it seems like this is --

COMMISSIONER PETIT: Well, on -- on this recommendation that --

CHAIRMAN SANDERS: The research roundtable recommendation?

COMMISSIONER PETIT: -- Cassie just raised, do you want me to just halt on that and you go through the rest of them first?

CHAIRMAN SANDERS: Go ahead. Go ahead.

COMMISSIONER PETIT: I just want to respond to something Susan said, but go ahead.

CHAIRMAN SANDERS: I think Susan was talking about other recommendations. So -- I'm just trying to --

COMMISSIONER PETIT: Well, no, she was just talking about the -- no, she was talking about the -- who was --

CHAIRMAN SANDERS: Right.

COMMISSIONER PETIT: And I was talking about the intake, and you were talking about the intake. So --

CHAIRMAN SANDERS: But that wasn't a -- was that a research roundtable question that you were raising, Cassie?

COMMISSIONER BEVAN: It was -- it was a research --

CHAIRMAN SANDERS: What was the question?

COMMISSIONER BEVAN: It wasn't a question, it was -- it was related to the research 1(b) priority.

So I think, you know, what David is saying is let's finish this and then get to the draft recommendations, because we'll be talking about the same thing again.

COMMISSIONER PETIT: Okay.

DR. BERGER: And again, somehow we got -- we were talking about they've included all investigative cases instead of only --

COMMISSIONER RODRIGUEZ: But -- but it's also -- it's also back to the -- the bigger question of -- since the focus of these is to intervene or not to intervene, then it's sort of -- it's both -- Susan was just saying the quality and consistency of the decision making, but it's also measuring back to does the -- how is the agency actually operationalizing that, and is what they're doing effective.

And so the two -- I keep thinking sort of the two are so intermeshed, because making a decision about whether or not -- getting the research base to decide to intervene or not intervene, but then if you don't know that you have anything that actually is helpful once you intervene, or if you don't know whether -- if you're not constantly measuring the processes by which you decide.

So, I mean, it sort of seems like there's a practice area of research, there's a risk area of research, and then there's an effectiveness.

DR. BERGER: You're absolutely right. And this group actually was less -- there were - the people who happened to be on this research roundtable were not people whose research had focused on the practice side of it, which is probably why you see -- but there really are very few people whose research has focused on that, which is a deficiency, which you've already pointed out.

So I think you're -- you're hitting the nail on the head as to why the recommendations were like this; but I don't think what you were saying is that far apart, because one of the discussions was, well, if you're going to have people at the very front lines who have less knowledge than what you might want them to have, the idea of having a very standardized risk assessment is even more important.

It's like in medicine when you have -- the LPNs have a much more structured risk assessment, and you give the RNs much more latitude because they have much more knowledge.

So as you go down -- and obviously the MDs have the most ability to make change to a protocol because they have the most knowledge. But as you move down the knowledge, kind of, ladder, the people who have the least medical knowledge have the most strict protocols and they get less ability to make change.

CHAIRMAN SANDERS: And I would just suggest that we're -- these are recommendations to us. We're wanting to get into recommendations that we'll make, which we should. And that, to me, is the next section.

So I'd just -- if we can get through these because they inform us, and then as we're -- we want to debate about the issues that we've just raised, that I think is the most appropriate as we're looking at the recommendations we're going to make.

COMMISSIONER PETIT: Yeah. So the recommendation that we're going to be making, I want to respond to Susan about in due course.

But for the moment, just sticking with this research thing -- and this relates to the question that Pat raised at the beginning about who did this -- Rachel, how much input have the states had in defining what they would like to see for research?

They -- they are the -- on the front line; they're doing the work. And I know that it's -- most of the states don't have a very strong research capacity, but what -- were they consulted on this?

DR. BERGER: So the people that were on this research table, multiple ones, like Andy Barclay, have worked with states before on research projects; but we didn't go specifically to the states and say, what is your priority in terms of research?

COMMISSIONER PETIT: No, I appreciate that they may all have individually worked with the states. What I'm saying, though, is that the states -- and this is a moving target -- things are evolving all the time in terms of what the states are dealing with. Say, for example, what families are presenting with problems now with heroin and all this other stuff. I think they need to be asked. And that may be something that we either ask David through this research subcommittee that we have, or we just ask directly for ourselves.

But we're meeting with NICWA soon, and we've got a questionnaire out to them. But it would be -- I mean, I -- with all due respect, the researchers -- we want more than somebody dreaming up something that says, this would be a good research project. And I don't mean that disrespectfully, I just don't think it should be self-defined by an individual researcher, it ought to be done in consultation with people who will need and use and apply the research, right?

So at some point, I'd like to see them get their licks in on this.

COMMISSIONER COVINGTON: I think, you know, the hearings we've had, we've -- there's been lots of opportunities for people -- the states many times have basically said where they feel there's gaps in knowledge.

COMMISSIONER PETIT: Well, I'd -- I'd like to see the list that has been composed. But it wouldn't be very hard to send something out to 50 states and say, we're looking at -- what do you have for research issues, and just have them send something to us.

COMMISSIONER COVINGTON: I also -- I think -- you know, I was at that research roundtable, and I know -- you know, not personally, but I know a lot of the work of the researchers. I mean, they've spent their careers trying to get through some this stuff.

So I don't think it's, you know, just sort of their favorite kind of hobbies or things that they're most interested. I think -- I'm impressed with this list of recommendations.

COMMISSIONER MARTIN: I'm so impressed that I'd like to finish it. So why don't we go through --

DR. BERGER: Let's do that.

So the next issue that in terms of making sure we have all the data, the idea you want to include all investigated, not just substantiated, there was a lot of e-mail back and forth about incentivizing or disincentivizing states to retain rather than expunge data of non-indicated cases. And people felt that was almost as big of a problem as not having the -- only the investigated cases.

So the expungement, we actually looked -- we went back in Pennsylvania -- Erin Dalton, who was on the Commission, was from Pennsylvania, and she went back to find out actually as a state what we did. And it was really interesting, because what the law said, what they did, the way the lawyers interpreted it, we got, like, 20 e-mails that said different things about what fundamentally they're allowed to do, but what they actually do but maybe in this time.

So I think it's not that clear from state to state, but -- getting rid of all that -- expunging that data for research purposes. Now, we agree that you might not want to continue to link it with a family because there's issues with, you know, the expungement. But for research purposes, that data is extremely important. And if it turns out in research that the non-indicated cases provide critical data, then you have to rethink the law that allows the expungement, right? So there was a lot of discussion about that.

So there were suggestions about how to carry out the recommendations, which I'll let you look at, and then there were other priorities that we decided not to rank because we didn't want to get down to ten, because the numbers started getting low.

The classification issue, we actually discussed this a lot, developing a topology of fatalities -- and, actually, Teri and I have talked a lot about this -- with its own risk factors.

For example, death due to child physical abuse is very different than a rollover death, and the interventions might be very different. And if you lump them all together, then you're not -

- you can't study intervention. So this idea of having this topology is extremely important moving forward for interventions.

There were some data-related priorities, the idea of data being available to researchers. Multiple researchers said it's very hard to use NCANDS data. It takes years to get it. A couple other of them said they had actually had grants that they had to give money back because they couldn't link the data or get the data in time to do the research. So those were big priorities for these researchers.

COMMISSIONER COVINGTON: Even going through the Cornell system?

DR. BERGER: I don't know -- you know, I'll have to go back and look at the e-mail, but there was a lot of discussions.

COMMISSIONER COVINGTON: It's the public -- yeah, I'm really curious about that, because it's their whole public use data set from there. I'm surprised it's so hard.

DR. BERGER: And then the idea of there has to be a move-away from funding specific one-time projects, that there needs to be this broader issue of funding of systems that allow for continual research.

And we even see that with a lot of the papers that we've had, because then you say, what happened after this? And nothing ever happened. So that's really important.

Primary prevention, the idea of evaluating new approaches to look at prediction and prevention of fatalities within communities. The idea of GIS, this risk terrain modeling, was thought about.

Secondary prevention, the number one -- actually, this was the last one that didn't make the top three -- was clinical guidelines for specific injury situations.

Now, this was a bias because there were a lot of clinical people on that, but the ideas for what CPS can do in specific situations that we know are extremely high risk. And we know when we look back, these specific things are high risk.

Evaluate programs to assist mothers and children with past welfare involvement. We've actually talked to Commissioner Rodriguez a lot about this. Emancipated from foster care who have children in foster care, that it's a very under-researched area. And methodology to determine which people should get which services, something we've also discussed, and standardize the way intervention programs are executed. Which is actually -- again, that's an operational issue.

The one thing I just wanted to comment, that the research that was fundamental in this area of risk factors that somebody asked yesterday was about, how do you rate multiple risk factors? That's actually what predictive analytics does. It actually does weight all these risk factors together.

And predictive analytics was the other part of this. Most of the discussion in the roundtable was about the use of predictive analytics, which is why we left it out of the recommendations, because we'd had, like, a two-hour discussion about the pros and cons of

predictive analytics. But that fundamentally does what somebody asked yesterday, which is weight different risk factors; but it's not a simple one-two. It does it in this very complex model system.

COMMISSIONER DREYFUS: Rachel, could you go a little bit more into what -- when they were talking about clinical guidelines? Because it seems to me that the longer we're -- you know, we're in this work and we're looking at the consistency and the quality of decision making, is that what we seem to need in, quote/unquote, human services, social services is what the medical community knows as clinical standards of care, that when someone presents like this, we know that we do this.

Now, I appreciate the variables, and there is always outside variables that the medical world has to factor in, so nothing's ever just check, check, check. But there is this notion of clinical standards of care. And it seems to me in CPS, you could throw all the caseworkers in the world at the issue, but that is underneath this issue of quality and consistency of decision making.

So can you go a little bit more into -- because they were talking about clinical guidelines, how they could see how research could really start to inform better intake screening, better CPS investigation, better screen in/screen out, better reassessment of safety.

DR. BERGER: So there was a lot of discussion -- there was some discussion at the roundtable and some discussion in the e-mails and -- I think we had four or five phone calls afterwards. So some of the discussion was, for example, when calls come in, a couple people had noted, you get the same question when you're a mandated reporter whether you're calling a child in for an ingestion, or whether you're calling it in for physical abuse, that the screen -- so the focus on this one was on the people that -- the situations where -- this was mostly the medical people. The medical people feel like we already know a lot, right? I think the ones with drownings, ingestions, those area little bit harder because they're more the purview of what we would say is a more pure CPS, where violence is more where there's injuries is almost a medical -- you know, there's almost a medical component to it.

So, for example, there was -- in medicine I always say, we have clinical guidelines, you're always allowed to deviate.

But there are actually some electronic medical record systems -- the one in Boston, for example -- where if you deviate, you have to write why you're deviating. And they've actually learned a tremendous amount, and it turns out that most times, the doctors were right when they did deviate. And you really have to think hard about doing it because you've got to write it down, you can't bypass it.

And so I think the discussion was more about that, to make guidelines.

When you have an infant with a bruise was one of the discussions. We know that in order to make an assessment, CPS has to have a skeletal survey. CPS should make sure the child doesn't have a bleeding problem. CPS should know.

And the reality is, we see is all the time in our rural counties. CYF will get a case of an infant with a fracture, and nobody will have ever gotten a skeletal survey.

And so fundamentally -- and it's a medical problem as much as anything else, but sometimes we have to empower -- you know, CPS is actually -- there's actually fewer people in a given CPS in our county, for example, than there are doctors who are taking care of children. And so we've tried to empower CPS and say, here's the guideline, here are the things you have to do to make an assessment, but here's all the -- this is why this is so high risk.

And so I think part of it is we don't have enough data. So what is the risk of an infant with a fracture due to abuse going on to die? We don't have good data about that because of this issue of we don't know harm. We know recurrence of abuse, but we don't know what the recurrence was.

So I think that was really the discussion of, could we look at a medical type model for -- almost a checklist for certain types of injuries, or looking back so our recommendations to our doctors when you have a child with an injury, to go back in the medical record and see if that child's ever been there before. And if we know the sibling, we go back in the sibling's record to see if the sibling has ever had a medical visit for an injury that was concerning for abuse before.

And so I think -- I don't know -- I think different CPS agencies are clearly going to be different, but they're not as protocolized to specific injuries. I would say a bruise and a burn are the same, but a bruise -- a burn from being left alone in a home is totally different than a burn that a parent, you know, burns the child with a cigarette because they're angry. But they're both burns.

And so the system now doesn't have a different protocol for assessing one which is neglect and one which is abuse, right, but they're the same injury.

So I think that was kind of the discussion was, how do we develop -- and the discussion was the ones that are simplest. Frankly, the bruise on the infant or the fracture is easier than some of the other problems. So it wasn't that the other ones aren't important; in fact, they're probably more common. But from the people on this call, this was the simpler one, because we kind of know the risk, we know the evaluation.

COMMISSIONER DREYFUS: Well, the only thing we have in the field today that a lot of folks are using is the structured decision making, right? So I think that's also something, when we think about this research question and getting to these clinical guidelines, I'm not here to say whether that model is the right or the wrong one, but there is a lot of states that use structured decision making and it was all for the same purpose of getting to this notion of, quote/unquote, clinical guidelines, something -- you know, for our world.

DR. BERGER: Right. Right.

CHAIRMAN SANDERS: We have both -- Wade Horn has joined us on the phone and Amy Ayoub. Do you have any questions or any comments for Rachel?

Are you both still on?

COMMISSIONER HORN: No, I don't have any questions. Thank you.

COMMISSIONER COVINGTON: I'm actually struck in a positive way with how many of these parallel the work that we've been doing in our committees, and I think our work is going to be how to merge some of these into our own recommendations. So I'm really happy with it. Thank you, Rachel.

DR. BERGER: I was extremely struck by how these really parallel everything that's being discussed. It really shows that research practice and policy aren't that far apart, because they're all kind of converging.

CHAIRMAN SANDERS: Anything else, then, on this?

COMMISSIONER BEVAN: Thank you, Dr. Berger. I really appreciate this. And I also think it would be really helpful if you could maybe give us one or two sort of research plans that could actually be, as we heard, lifted up from here. I mean, a research plan that you would like to see funded.

DR. BERGER: You mean a research project?

COMMISSIONER BEVAN: Yeah, but bigger than that. You know, like with several projects underneath it, but a research --

COMMISSIONER COVINGTON: An agenda.

COMMISSIONER BEVAN: Yes, a research agenda.

Thank you, Teri. A research agenda.

DR. BERGER: Okay. So I think I probably would want to go back to the people on the roundtable again to make sure that we have a good consensus on that.

COMMISSIONER COVINGTON: You know, a model would be, you know, sort of how the CDC funds the National Injury Prevention Resource Center. They pick a theme -- I think Wisconsin was doing motor vehicles - - and they fund a team of researchers. And it was at the University of Wisconsin. And they can do all kinds of things, but they're -- they're focused on specific things relating to motor vehicles; for example, crashes. And that becomes their research agenda, but they're doing all kinds of really neat stuff.

But they're part of a research consortium with a lot of other folks, so they share all that information, it gets published. To me, that -- I mean, I can't even imagine how cool it would be someday to have a child maltreatment research agenda going out around the country.

DR. BERGER: I mean, there kind of -- I mean, there are recommendations for -- I mean, the IOM has recommendations for research related to child abuse.

COMMISSIONER MARTIN: The other thing I really appreciate is that it's not a one-time-shot research project to answer this question, and then it's left alone.

I think one of the things that is so frustrating is when you have the ability, for instance, of a court to innovate and to try different things, the research that we get has been, you know, sitting around for a couple years a lot of times, and we have no direction on how to

implement it. You know, we have no sense of -- of how to take that from your folder, your book, your charts, and put it into practice.

And so with -- in addition to having it ongoing so we can continue assessing the risks as the life of the case or life of the child, it seems to me that we have to also pair that research, pair the lab, the research lab, with a practical opportunity.

So it would be so interesting, I think, if we had, you know, kind of like an opportunity or a vehicle in which the researchers then have a forum in which to talk with people who are on the ground doing the work so that we can talk about what we mean in practice.

COMMISSIONER RODRIGUEZ: Yeah. And -- and actually, I think it's even more than just giving people the opportunity to hear. I mean, I think there are certain fields that -- where the research is done, and then there's a very deliberate process on how to actually translate that research into practice.

And in child welfare, that's the most we ever get is sort of the presentations about what the research is. And some of -- and the researchers are always very, like, careful to give what the practice implications might be, you know, because they don't want to seem like they're being directive to - to systems.

But it really does seem like thinking about how we make child welfare a field that is informed by the research, and then where there's a process where there's constantly a re-evaluation of practice, that -- I mean, that's why I'm thinking I'm sure medicine has this figured out maybe better than any other fields do.

On that last one, I was thinking of the clinical guidelines. I mean, what's really interesting about that is that I think when workers learn the tools or they learn standards, they learn them rote, like, do this, check this box; here's -- we're going to train you on our new tool. But they don't learn the "why" behind it, which is actually what increases your skill and your own analysis that you need to have in your job. You don't need to just be good at the tool, you actually need to be good at sort of increasing your skill to understand risk and to understand how to work with families to -- all of that.

And so that's -- that's where I'm thinking it's sort of that bridge. All of this stuff that happens in between where the research is and where workers are doing their day is really critical, and I would love to hear from somebody about how you create a system where there's a constant integration into practice and a monitoring of.

COMMISSIONER PETIT: So these -- these comments take me back to my point about consulting with the states. So is there any interest by the Commission in asking the states what they think the research issues are? And if not, fine; I'll just bring it up at the NAPCWA meeting when I meet with the state child welfare administrators in a couple of weeks and see whether they respond. If they say, no, we're fine, good. But they may have something to say about it.

COMMISSIONER DREYFUS: There was a number of years ago at NAPCWA when I was involved with NAPCWA -- and David, you were as well -- and I'm not sure if they're still doing it, but Mark Courtney kind of led an effort where there was some regular meetings that NAPCWA

would have with researchers all about developing a research agenda, and also this whole issue of applied research. Right?

So I don't know if that's still going on, but I know back when I was real active with NAPCWA, it was.

COMMISSIONER PETIT: The Coalition to Eliminate Child Abuse, which preceded this Commission that was focusing on this, actually presented a research agenda to the Children's Bureau, and they presented maybe half a dozen or more specific research projects that were rejected by the Children's Bureau and ACF. But they were research projects that were supported by a number of national organizations, and they just didn't consider it, really.

COMMISSIONER COVINGTON: The other thing, too, is we could ask at the meeting with the SLOS -- I was thinking, Patricia, you know, we're working on that agenda -- that might be a good time to ask as well.

I personally think we should be careful to not get into the weeds in terms of specific research questions or projects, though, as we're thinking this through, that we should be thinking a little more -- that's my thought.

COMMISSIONER PETIT: True. But --

COMMISSIONER COVINGTON: Because you do get into these really specific things.

COMMISSIONER PETIT: But if you had 30 or 40 states say, we'd really like to look at what the impact of this new drug is having on our community and we'd like that to be looked at or something, I'd say, gee, if 30 or 40 states are looking for some research on something, that would be worthwhile.

So I -- and it may not -- there may not be any kind of a consensus on anything. It may be all over the place. And then at that point I'd say, you know, just don't consider it.

DR. BERGER: One thing we have to remember, this was focused on risk factors and predictive analytics. So I would say, like, in my state, one of the big questions that's come up is on newborn drug screening. Does it matter if it's heroin versus cocaine versus marijuana versus a narcotic?

And it's a research question that our state has -- and I'm sure other states are interested, but it would have never come up in this research roundtable because we focused on risk factors, partially because the Commission was so focused on assessment of risk.

COMMISSIONER PETIT: Right.

DR. BERGER: So I think part of -- I think it's good to know what they want to research, because it -- but it will give a much broader base, because what they're interested in may not relate to risk factors. Which doesn't mean it's not a good priority, it's just that wasn't the priority of our --

COMMISSIONER PETIT: Well, it may -- we may learn something from it. We may see something that says, gee, we ought to consider this.

So I agree; but the parameters that we imposed on this research roundtable, it sounds like they were limited. So I -- I would just like to know if the states feel like there's some missing piece of information that would be useful that they can't get on their own, that's all.

COMMISSIONER MARTIN: So I guess my -- my response to that, Mike, is that that's a great idea; but if we're going to go that route, then we can't just stop there.

I mean, we've all basically decided, whether we call it, you know, a medical approach, medical health approach, or, you know, integrated assessments or whatever we're calling it, that it's bigger than just child welfare and state agencies.

And so if we're really going to be true to what we're recommending and if we're really true to what we belive is the right thing, then I would suggest if we ask the states, we'd need to ask the medical professionals, we'd need to ask the lawyers, we'd need to -- so --

COMMISSIONER PETIT: Well, yeah.

COMMISSIONER MARTIN: Let me finish, please.

And I -- but I have -- and oftentimes I've talked with individual staff members about the need to engage all of these groups, whether they're the minority or the majority groups, the minority caseworkers or the majority caseworkers, to have input into what we're doing, but I don't know if I've ever isolated into research. I've asked that we make certain that we call and engage in a conversation about their recommendations and kind of how they see our work.

And what we do with the recommendations is up to us, but I think we need to include them. Because if I'm reading this remotely right, if we're trying to make them share the responsibility, share the liability, share the responsibility of keeping our kids safe, we need to get them on board to this early and often.

So all I'm suggesting is if we go to the state agencies, we need to go to everybody that we're telling is important in this link of child welfare.

COMMISSIONER PETIT: I disagree, but I understand your point of view.

COMMISSIONER DREYFUS: So on the research question, David, just one last thing.

Commissioner Martin, when she talked about some way that we convene, I have always thought why we don't, in this work, have what in the medical community is their version of grand rounds. And I've always envisioned a day when there is going to be research.

And let's just take Fred Wulczyn, right?

He's got research. And he sits in front of a group of folks, not just who are soaking it in and thinking about it, but who actively get involved in what I call the four levers of systems change. We always focus on the first one, but we never get to the other three: practice, policy, regulatory, and fiscal change.

Somehow we've got to figure out, how do we take research and analyze it enough that we're not just changing practice? Because if we change practice, it changes for this worker, it changes for this agency, it changes for this leader during this time. But until it gets hardwired

into policy change, regulatory change, and fiscal alignment, right, we're going to have the same commission 15 years from now.

So I just keep thinking, how do you get research to get a line to the level of critical analysis that's about the pulling of all four levers, not just the quick lever of do our practice differently tomorrow? Because if those other three levers don't get pulled, it's here today, gone tomorrow. At least that's been my experience over --

DR. BERGER: It's interesting you say that. There's been a lot of research in medicine now about how you get from research to practice -- regulations would probably be like JCAHO or something -- and then how the insurance companies align, which is essentially in medicine those four steps. And they say it takes ten years from the time you have a research finding until you get it into practice.

But what's interesting is the vast majority of what the research has been done has been on this first step of the research.

And I have to say that, interestingly, now, like 15 years into my research career, I started getting very frustrated that I had done all this research -- and, frankly, I have, like, you know, 40, 50 papers, but nobody's using this stuff.

So I just decided about four years ago that I needed to work on this next part of, like, how do we actually put into practice? It is -- and I do have a grant to do it, but I have realized that it is unbelievably hard to get funding to do those last three. Our system as a whole focuses on that first issue of the research itself; but getting that research into policy, regulation, and fiscal alignment is -- it's just, the focus hasn't been there.

So I think it's really well taken, because we are struggling with the same issues ten years to go from one to the other. And often there are things -- there are -- I would say that -- because it's a lab that I've worked with. There is an ovarian cancer screen that's existed for nine years and has never made it -- it's -- the research is outstanding, and we have never gotten it into practice, purely for fiscal -- it's mostly fiscal issues.

COMMISSIONER DREYFUS: But -- but I do think there could be funding that could make this happen.

CHAIRMAN SANDERS: So let me -- let me suggest that we --

DR. BERGER: Or just -- yeah.

CHAIRMAN SANDERS: We're in a potential process of beginning to have conversations that aren't moving us forward, and I would suggest that we shift to the recommendations that have come out of the subcommittees and begin to talk about where we are with that, because I think that begins to get at some of these issues.

So unless there's something specific about what we need to get from the research roundtable -- because one of the things we're going to need to do is translate what Rachel just said into recommendations that we would want to make.

DR. BERGER: I was just going to -- I think - - I think that you're absolutely right, that if the focus -- if the research focus is only on the research and not on the practice, regulation, and fiscal issues, I think you do have -- I do think it has to be broader, but this was focused on that first step because of who was in the -- you know, what the group was focused on.

COMMISSIONER PETIT: So, David, with that in mind, you said recommendations, but I think what we said yesterday is there's some unfinished pieces that we need to look at more closely.

CHAIRMAN SANDERS: I think we should first look at the list of draft recommendations just to get kind of the universe of what's -- what's come from the subcommittees, and then talk about what's missing and what kinds of things that we need to do.

COMMISSIONER PETIT: Which draft of recommendations are you talking about? You mean that piece that you had written?

CHAIRMAN SANDERS: Well, I didn't write it.

COMMISSIONER PETIT: The two -- no, no, the two pages --

CHAIRMAN SANDERS: These are the compilation of the one-pagers that came from the subcommittee.

COMMISSIONER PETIT: Yeah. Yeah. Okay.

CHAIRMAN SANDERS: So that set of draft recommendations, not the research ones.

Do you know which ones I'm referring to?

COMMISSIONER PETIT: Well, I have number -- I know what you're referring to for a document, but I have a number of -- is it this document that you're talking about, or the themes and recommendations?

CHAIRMAN SANDERS: It's 5/19/15. "Draft Recommendations" is the heading.

COMMISSIONER PETIT: Okay. So that's different than the themes and recommendations piece that we were looking at yesterday.

CHAIRMAN SANDERS: Well, yesterday was the themes, the findings.

COMMISSIONER PETIT: Yeah.

CHAIRMAN SANDERS: And this is the set of recommendations that have come out of the subcommittee. So there's no -- this is strictly what the subcommittees have put together. It's nothing beyond that. I haven't done any filtering, any translation. This is straight from the subcommittees.

And it's -- what is it, four pages? Five pages? We have the public health subcommittee, the measurement subcommittee, and child protection subcommittee's recommendations are included here.

And it seems that -- I don't know that we have to go through -- at this point go through every one in detail, but more, are there -- from what we talked about with the themes yesterday and what we've just heard from the research roundtable, are there big areas that we're missing in what's being considered right now for recommendations. Because I think we need to make sure that if so, if we believe that we've completely missed the boat on the recommendations, that we begin to figure out how we're going to -- how we're going to get back into the water.

COMMISSIONER PETIT: So, Dave, what I would need to do for myself is just take a look at this list more carefully, just spend a few minutes reading it against what I have. It's six or seven points. They may have already been dealt with within these recommendations, or they may not. There are some that I think have not, but they -- others might have been.

CHAIRMAN SANDERS: So maybe we can take 15 minutes. We can take a break during that time, read through the recommendations.

I would just say, these are just -- I just numbered them, but the first four are from the public policy -- the public health -- public health subcommittee. So perhaps Teri or Susan can just walk through them when we come back.

The next are -- the next six I believe are the measurement subcommittee. And, again, we can go through -- just walk through those.

And then the final ones are the child protection subcommittee, and perhaps the child protection subcommittee members can just go through them.

But that -- and we will have many other recommendations. This obviously doesn't include all of the subcommittees. This is just compiling what we have to this point.

COMMISSIONER PETIT: But besides the remainder this morning, which is going to be abbreviated, when is the next time that we would be discussing this? Because we're not meeting again until July?

CHAIRMAN SANDERS: At our next meeting, Right.

COMMISSIONER PETIT: Until July. So would we be discussing these between now and July?

CHAIRMAN SANDERS: I think it probably depends on how far we get today. But I think that we - - we still don't have these completed, so this is really very preliminary.

I imagine public health has some more recommendations that they will be making. Child protection may have more recommendations that they'll be making. Measurement will not. So we'll need to see how far we are from actually having a set of recommendations.

COMMISSIONER PETIT: Okay. All right.

CHAIRMAN SANDERS: But this is what we have today, so I think we should filter through these and see where we are.

COMMISSIONER PETIT: Okay. And I'm leaving at 11 for the airport. So in terms of the order in which we deal with these --

Jennifer, are you going to --

COMMISSIONER RODRIGUEZ: I'll be here.

COMMISSIONER PETIT: You'll be here?

COMMISSIONER RODRIGUEZ: Yeah.

CHAIRMAN SANDERS: So why don't we come back at ten.

COMMISSIONER PETIT: Ten is a half hour.

COMMISSIONER RODRIGUEZ: It's only 9:30.

CHAIRMAN SANDERS: Oh, is it? Oh, my watch is a little fast. 9:45. My watch is fast.

COMMISSIONER PETIT: All right. And we'll go through these.

CHAIRMAN SANDERS: 9:45.

COMMISSIONER PETIT: Okay.

COMMISSIONER COVINGTON: Steve, and another thought I had, I don't know -- I don't know how much sense this makes, but the document from yesterday with the findings, it seems if there's a way to pair them, because it seems like to go from the -- you know, we talked about some findings that we haven't addressed yet or that are missing, but it seems like within those findings is where the recommendations evolve.

CHAIRMAN SANDERS: I -- I agree. It was just more, people hadn't seen this list, and I thought it at least made sense for people to kind of be able see what's come out of each of the subcommittees to this point and have that conversation.

COMMISSIONER COVINGTON: Okay.

COMMISSIONER PETIT: Yes.

CHAIRMAN SANDERS: So that's why I thought we should go over this. But I think you're right, ultimately we need to pair them together. We'll reconvene at 9:45.

(Recess from 9:31 a.m. to 9:50 a.m.)

CHAIRMAN SANDERS: We have the set of recommendations that I had described. This is really the first opportunity, I think, that all of us have had to see -- been able to see them in one place. And so I thought it would be helpful to go through them to see if there are areas that we're missing, areas that really don't make any sense.

And why don't -- Commissioner Petit needs to leave early, so we can start with the recommendations from the back forward. If the Child Protection Subcommittee wants to just run through the eight -- I think it's eight recommendations that you've made.

COMMISSIONER PETIT: Our first one, David, is No. 11?

CHAIRMAN SANDERS: I believe that's correct.

COMMISSIONER PETIT: Are we all present and accounted for?

On this one, which -- I think what we've been saying all along is that there is not, at this point, a priority given to this issue at the federal levels, whether it's within the bureaucracy or whether it's in the political process at this point. And one of the exhibits that I'd note is the responses we got from HHS.

David, how did we all hear about that? Was that given to us in print, or was that on the phone, or what? Does anyone recall --

CHAIRMAN SANDERS: I know we have an e-mail, but --

COMMISSIONER PETIT: Do you-all recall seeing the response we got from HHS to the questions that we had sent to them? Do you remember that?

I mean, what I experienced from that was response after response was inadequate. There was no - -

I mean, was that the general feeling from people?

So that would be one --

Do we have that document here?

Amy, was it distributed to all of us, the letter?

MS. TEMPLEMAN: Yes.

COMMISSIONER PETIT: Okay. So just in terms of what was --

CHAIRMAN SANDERS: Just for everybody, we're started with No. 11 because Michael has to leave early. So we're on recommendation No. 11 of the draft recommendations document dated 5/19/15.

COMMISSIONER PETIT: So without going into this more at this point, I think what we're safe in saying is that for the moment, this issue of child fatalities is not a priority for the federal government.

So I'll leave it at that. We've got a bunch of evidence to offer with it, and I would just move on to the next unless Jennifer wants to say more about No. 11.

COMMISSIONER RODRIGUEZ: No, I actually just had a process question. Because I know we made some revisions to these recommendations since we spent all of the time at the last meeting, but I don't know that we've made revisions to every single one of these, or that the revisions are complete.

COMMISSIONER PETIT: Right.

COMMISSIONER RODRIGUEZ: Do you folks feel the need to go through these sort of one by one and discuss?

That's what I thought. We did that at the last --

COMMISSIONER BEVAN: I'm not -- but I'm not signing off on everything, I'm signing off on what you just said.

COMMISSIONER RODRIGUEZ: No, no, no, no, no.

CHAIRMAN SANDERS: Let me just give an example. This one, if we look at some of the other recommendations that have been made, there's a lot of overlap. And so I think we need to begin to think about, I mean, what are we wanting to say, and it will help to consolidate the recommendations. And there may be some that we immediately react to that this just doesn't make sense given what we've heard, but it will also give us a chance to identify some of the things that we heard the last couple of days both in the themes and the research roundtable to say we're completely missing this.

COMMISSIONER RODRIGUEZ: So you do want to go through them one by one?

CHAIRMAN SANDERS: I don't think -- not in detail, but I think just so that it -- so we have -- as we go through them, I think we'll see where some of that overlap is.

COMMISSIONER RODRIGUEZ: Okay.

CHAIRMAN SANDERS: So I wouldn't go through them in excruciating detail, but at least enough so that we're again refamiliarized with all of them.

COMMISSIONER RODRIGUEZ: Okay.

COMMISSIONER PETIT: But in 12 and in a couple of the others, you will recall we have three major pieces that we're recommending. And one is that there be two people that go out on most cases, or on many cases -- law enforcement, public health, along with CPS. Right? That's one.

The second one was use of a multi- disciplinary team process to act on the -- to act and intervene on these cases, or many of them, if not most of them, if not all of them.

And third -- and there are many others in here. But third, in terms of a specific, here's what we're urging the country to do right now, was this retro-surge look at a large number of cases that are already open.

And using -- Hillsborough County was one of the few things that we saw that actually showed -- seemed to show a cause-and-effect relationship. That's the method that they employed.

And then yesterday we heard the domestic violence people here, which was only the second one that I've heard that seemed to show a cause-and-effect relationship between -- coming into this stuff.

But those three together, two people going out, multi-disciplinary team review, and going -- taking a strong look at cases that are already open right now, cases from which we know there's going to be a majority of cases of children who were killed will be coming from those ranks.

COMMISSIONER RODRIGUEZ: I see what you mean, David. So (c) and (d) under 12 would be good examples of ones that are duplicative, I think --

COMMISSIONER PETIT: Yeah.

COMMISSIONER RODRIGUEZ: -- and that we'll get to. So maybe we can just star the ones that -- where it looks like there's some --

COMMISSIONER PETIT: And 12 we've really talked about at length, 12(b) especially.

COMMISSIONER DREYFUS: Michael, is this -- regarding CPS, will this be framed within a larger description --

COMMISSIONER PETIT: Yes.

COMMISSIONER DREYFUS: -- of how the Commission is seeing Child Protective Services and --

COMMISSIONER PETIT: YES.

COMMISSIONER DREYFUS: -- more than just about more resources, but more about the quality and the consistency of that CPS function, how crucial it is?

COMMISSIONER PETIT: Yes.

COMMISSIONER DREYFUS: Okay.

COMMISSIONER PETIT: Yeah, absolutely. I think right now we're just looking -- yes. We're all done with all of our -- we're just dropping stuff in here without all the full language that surrounds it.

But this -- this particular set of recommendations I think speaks to the immediacy question, and so I can leave 12.

Did you want to comment more on 12, Jennifer?

COMMISSIONER RODRIGUEZ: Just that, I mean, I think what's important in here that links to the research piece, any research recommendations are that, you know, the research is telling us who the children are that are most at risk, and that we need to align practice to actually support that.

So that would be (c) here right now. But I think we may want to say more about that, depending on --

COMMISSIONER PETIT: Yeah.

COMMISSIONER COVINGTON: I was thinking too, the whole issue of the concept of predictive analytics and where that fits into this, if that's something we were going to promote or support or not support. I don't know yet. But I think it begs some questioning among the Commission about what we do. We cite the examples from Tampa, but we haven't really talked in detail about whether that's an approach we'd want to promote.

COMMISSIONER PETIT: Well, that -- yeah, I agree that we certainly should talk about it, because, in my mind, that's the only thing that we've seen so far that says these are predictive indicators. And they've gone from what was a steady seven, eight, nine, ten deaths a year to zero over the last seven or eight years.

But in looking at the criteria, yesterday when the district attorney said, well, it will be good to look back, but we have to have criteria. Well, there are criteria.

The Hillsborough County one, I don't know if you've read it or not, but they have nine or ten specific criteria that you look at. And in total it says, go back and see on these families.

So if they've got 5,000 families, they may be saying go back on these 500. Right? These 500 are the ones that possess more of these characteristics.

I think that would be a very, very big piece in terms of giving the public and the Congress a sense of urgency, that we think there are kids -- we know there are kids right now that are in government custody. They're open cases. The kids are at home. From those ranks is where the most deaths are going to come from.

COMMISSIONER DREYFUS: So I've struggled with this one a little bit over the last month -- and, Michael, I really appreciate you've just consistently been bringing this up -- that there are kids today that are at risk of serious harm or fatality, and what are we going to do about them?

And I think -- again, I really appreciate you bringing it up, but it wasn't until yesterday that I had my own little ah-ha moment about this. And that was, how do you -- if the Commission agrees to this recommendation, I'm not -- how would the Commission tie that activity of identifying those cases where, based on these factors, these are cases that need to be looked at right now again? How do you tie that into the larger CQI loop of safety culture that we're talking about; that it isn't just a one-time, you know, SWAT team in a state, but it's -- it's not just about those kids, but it's about the learning that comes out of it that is part of continuous learning and improvement of that system.

COMMISSIONER PETIT: Right.

COMMISSIONER DREYFUS: And I think if that -- if I -- if I saw that piece there, this makes a lot more sense to me.

COMMISSIONER PETIT: Well, it's -- you know, first and foremost it's always the individual child, right? That's what we care about. But the larger question you're raising, the systems piece, really is about this redundancy question, among other things, that that's what this would allow. What it's saying is whatever we did the first time deserves a second look, because we know from the ranks of all the children that are liable to be killed, they're going to be coming from this pool of children.

And so the quality control on that, whether it's within CPS itself or with CPS and its partners, is -- would be built into this.

So, in fact, we could even recommend that there be some kind of a demonstration project or control group set up. You know, I've talked about Texas, but it could be in a number of other places as well. Texas is useful because it's got such a large number of children who are killed that you could actually maybe draw some conclusions about.

But I think on this one, the experience in Hillsborough County is informative, and we would draw from that in pushing this piece forward.

CHAIRMAN SANDERS: And I should be clear that at this point, it certainly makes sense to discuss the recommendations to understand them and -- but not necessarily saying people are voting yes or no on any of them. More, let's get a set of recommendations that actually -- we feel comfortable hangs together, they aren't duplicative, there really is a set of recommendations.

And so --

COMMISSIONER PETIT: Right.

COMMISSIONER COVINGTON: I'm sort of -- when I'm reading these, I'm sort of thinking, what's not here that we've --

CHAIRMAN SANDERS: Right. Exactly.

COMMISSIONER COVINGTON: -- been thinking about.

CHAIRMAN SANDERS: Yeah.

COMMISSIONER PETIT: So, Jennifer, did you have more on 14 and 15?

COMMISSIONER RODRIGUEZ: No. I think we've discussed both 14 and 15.

COMMISSIONER PETIT: So one thing I need to say about 14 is if you look at the public health piece that came forward, No. 2, leverage opportunities, it starts with: Between one half and two thirds of children who die due to abuse, neglect, were not known by the child protective -- I feel that we have addressed this -- or I have addressed this repeatedly with information that says the exact opposite is true, and this keeps showing up.

And so I think that we actually ought to look and compare the data and what it actually says on this thing. The federal government says what this is, but that's not what the research says on this thing.

So at some point we're going to need to resolve that question. I'm saying the majority of children are already known to CPS. And every time that we've brought that up with people, they concur that they actually knew that the numbers that they were putting forward were a misrepresentation, not necessarily intentionally. But Oregon is the most recent example, and even yesterday when we were looking at the child abuse and neglect fatalities here.

Anyway, so that's one to come back to.

COMMISSIONER RODRIGUEZ: So I guess I'm going to take back that I don't want to say anything and just say that I think with both 14 and 15, we need to -- I would -- or I would like to align them actually to the recommendations that came out of the research roundtable. Because I think it's not just -- like with 14, it's actually not just the prevention and support services, but it's actually that there's a body of research that is needed to identify both sort of what's happening with them and the risk factors around their children, but then also what type of supports are helpful.

COMMISSIONER PETIT: Right.

COMMISSIONER DREYFUS: So, Jennifer, will that then move us to what was that really rich conversation we had about our version of clinical standards --

COMMISSIONER RODRIGUEZ: No.

COMMISSIONER DREYFUS: -- in CPS?

I guess I'm just wondering if in the CPS subcommittee's recommendations, where will that --

COMMISSIONER RODRIGUEZ: I think that's really -- that's actually really missing from our recommendations. And that's an area that I don't think our recommendations cover at all, and they should. So that -- I think that particular area is an area that we should add in.

I don't think 14 gets us there because it's so narrow, it's targeted at one population, but we should put in a big overarching --

COMMISSIONER DREYFUS: Can you describe what you think that overarching would say and what would be potentially included in a recommendation -- a set of recommendations in that area of CPS quality and consistency?

COMMISSIONER RODRIGUEZ: So it -- okay. Well, let's -- let me -- I'll say what I'm sort of thinking off the top of my head is that the overarching goal is to transform CPS as an agency into one that is research informed, that has -- that includes partnerships with universities and research institutions and includes processes for translating research into practice continually. So something like that.

And then we could put specific recommendations under that related to 4e matching, related to relationships locally with institutions, whatever we want to say about the federal government's role in funding and prioritizing research, and if we have ideas about where it should be housed.

I know Rachel said that's a difficult question, but at least that that second piece around the research practice, that we would say, we see that's missing, we know it's not resourced right now, it's not prioritized, and that we have to have that in the CPS system in order for it to be effective.

Does that make sense?

I mean, we could try. I'm wordsmithing off the top off my head, but -- but why don't we, between now and the next meeting, try to put some stuff together maybe with Rachel -- we'll work with Rachel to do it -- and then come back with another recommendation.

COMMISSIONER DREYFUS: I just always get to - - from the point of the community calling in, right, and there's a responsibility of CPS and how the community is educated and informed about when to be calling in and how to do that. The quality of that -- that experience from there all the way to decision making, to then reassessment of safety and risk throughout the life of the case, is just something that we don't put enough attention on. Right?

And so I just -- I guess I'm just hoping that -- that that gets pulled out.

COMMISSIONER RODRIGUEZ: The standard of care kind of piece of it.

COMMISSIONER DREYFUS: It kind -- it kind of gets to that, but I just don't think we've gotten under the hood enough of that part of CPS that is critically important.

I just remember that intake and that initial assessment person, yes, their work is critically important, but so is that case manager once a child is either in home or out of home in their continuous reassessment of safety.

And so I just want to make sure we don't fixate on just that initial call-in, intake and the quality of that initial investigation, but it's that ongoing assessment of safety that continues throughout the time that child is either in home or out of home.

COMMISSIONER RODRIGUEZ: I think we've focused on it up to this point in terms of thinking about supervision, in terms of thinking about sort of review of decision making and internal quality control audits. But now after the last discussion, I think that it probably needs a research element in it as well.

COMMISSIONER PETIT: Tom just gave me the most recent findings and recommendations. And I don't know, David, if whoever drafted this document of 5/19 that we're working off right had the most recent ones, but I'm just going to pass them out to you, because some of them -- not to do anything with them at this point, but to show that some of the language and some of the concerns that are being raised are already built into there.

But sticking with the document that you drafted, I think the next large one is No. 16, the law enforcement piece, which we've discussed and there seems to be considerable agreement that they ought to accompany CPS in certain kinds of investigations.

COMMISSIONER RODRIGUEZ: And I think this is another one where there's some duplication --

COMMISSIONER PETIT: Yeah.

COMMISSIONER RODRIGUEZ: -- with other recommendations.

COMMISSIONER PETIT: And then on 17, which was -- I think 17 is one of the foremost findings -- I'm going to wait.

On 17 -- I think on 17 --

What's that?

COMMISSIONER COVINGTON: So we were just given a new set?

COMMISSIONER PETIT: It was a revision of the -- it's a revision.

CHAIRMAN SANDERS: Let's just include -- let's just go from the one we were going off of so that --

COMMISSIONER PETIT: Right. That's what I said, yes. Let's just go with that.

CHAIRMAN SANDERS: -- we're not getting confused by multiple versions.

COMMISSIONER PETIT: Right.

So looking at 17, that carve-out one, 17(b), that carve-out doesn't belong with that. That's a different resource question.

CHAIRMAN SANDERS: 17(b)?

COMMISSIONER PETIT: 17(b). That speaks to the child protection system response capacity varies widely. That first recommendation is should permit a carve-out. That's a resource question and isn't really -- these issues are -- these recommendations, (b), (c), (d), (e), don't necessarily respond appropriately to No. 17.

I think, just to stick with it for a moment, one of the strongest statements I think that we should make is this luck, the draw of randomness in terms of whether kids are living in the right state. Some states do much better than others. And that is going to beg the question of what the federal role should be in all of this thing.

And so, Susan, when you mentioned a few minutes ago when we had an earlier conversation about you had been in some places where you'd seen excellent work being done on the intake. So I wasn't generalizing about --

COMMISSIONER DREYFUS: Oh, I know.

COMMISSIONER PETIT: -- some are and some aren't. The point is, they're all over the place. Some are terrific, some are terrible. And if you're a kid who is faced with being killed, you should not have to worry about whether or not you're living in a state that has a good intake system or a bad intake system. They should all meet the highest quality standard, which ends up begging the question of, do we view this as these kids, all of them in their totality are American kids first, or are they Mississippi or Vermont or Utah kids first?

And that is going to, I think, be an important point, and there's a lot of reasons for why I think it should be the former, not the latter.

CHAIRMAN SANDERS: So are you suggesting that what's under 17 -- that 17, the heading is the right heading, but the --

COMMISSIONER PETIT: Yeah. It's the right heading; it's the wrong content. And I don't know if Tom corrected it in the last one. It may be corrected in that version that you have.

CHAIRMAN SANDERS: Let's just stick with what we have.

COMMISSIONER PETIT: Yeah. So the recommendations here are not -- you know, we need to just retool this thing. This carve-out thing is a question of resources.

And this thing that you were talking about earlier, Jennifer, is actually contained in (c), some of it, is making resources available.

And, David, you were talking about that yesterday, when the --

And I think you were too, Pat.

When the government opens a case, when the government insists on going in to a family, beyond the fact of finding whether there's something wrong or not, they have an obligation to bring resources to make that -- to -- to address that.

COMMISSIONER MARTIN: Mike, I apologize for belaboring the point, but I want to make certain I'm clear. So under 17, the title of that recommendation is correct, but (b) through (e) needs to be moved to another --

COMMISSIONER PETIT: Yes. Yes.

COMMISSIONER MARTIN: Okay.

COMMISSIONER PETIT: But what (b), (c), and (d) offer -- and let me just look at (d) and (e). Yeah, these -- these four belong someplace else. These --

COMMISSIONER MARTIN: Okay.

COMMISSIONER PETIT: These four are about resources meant to address problems. And No. 17 is a finding that says there is a huge disparity in the capacity of the states to address these issues.

COMMISSIONER MARTIN: So then my suggestion is why don't we go to 18 --

COMMISSIONER PETIT: Right.

COMMISSIONER MARTIN: -- and then leave 17 to be filled in, to be announced later, okay?

COMMISSIONER PETIT: Correct.

COMMISSIONER MARTIN: Okay?

COMMISSIONER PETIT: Yes.

COMMISSIONER MARTIN: Okay, great. Thank you.

COMMISSIONER PETIT: Jennifer, yes?

COMMISSIONER RODRIGUEZ: Yeah, that's fine.

COMMISSIONER PETIT: Yeah. And then the -- 18 gets back to a lot of the discussion that we've had. You just addressed some of it, Susan, in terms of quality assurance issues, but -- and we've -- we've got a lot of material that we've received on this. I don't know if this adequately states it, but --

COMMISSIONER BEVAN: Can I just say that somewhere along in your CP -- somewhere along in here, or somewhere along in all of our recommendations we have to say that child safety is paramount?

COMMISSIONER PETIT: Yeah, I -- I agree completely.

COMMISSIONER BEVAN: Okay.

COMMISSIONER PETIT: The language that I've always used is that if you're going to err, you err on behalf of the child. So we're never going to get this completely right, but if you're going to err --

So for my part, just because I'm going to be leaving, I'm just wrapping this up, David, But just my little checklist, there is this resource question that we have not yet addressed how we're going to deal with that. We haven't decided yet how we're going to evaluate which programs should be expanded, which ones should be killed. That hasn't been addressed.

The state commissions, I think we need a walk-through of what the state commissions actually found. I think Tom or somebody gave us a comparison, but there are very specific recommendations made in a dozen states or so that are blue-ribbon panels that are specifically charged with reducing child mortality, child homicides.

We have not looked at those ourselves and said, sounds great, let's adopt them, let's adopt of half of them, or they're wrong on all accounts.

I mean, I think we received a document, I think all of us received a document, but I don't think we've had a chance to talk about it.

Is that right?

COMMISSIONER BEVAN: That's the summary document from all the research?

CHAIRMAN SANDERS: Well, not the -- no, no. Not the summary -- no, not that one.

COMMISSIONER BEVAN: Commissions?

COMMISSIONER PETIT: Tom reviewed eight -- I believe it was eight commissions and summarized the findings of those -- or compiled the findings.

COMMISSIONER DREYFUS: They weren't just all federal, right?

COMMISSIONER PETIT: No, no, no, no, they weren't all federal. And they're not going back 25 years to what was reported in the national advisory, these are just in the last year or so or two, there have been 10 or 12 states that have appointed commissions specifically in response to a child being killed, and then they put forward all this stuff on there. I think we just need to take a look at it together.

COMMISSIONER COVINGTON: We got the document that I think summarized all the recommendations.

COMMISSIONER PETIT: Just in wrapping it up for me on this thing, the business of laying this out, personally, I think there's not a lot of statutory change that we're looking at, from what I've been reading. There's a lot of administrative stuff, and then I think there's a resource question.

And then lastly for me is this accountability of the feds and the states. I don't think we've adequately addressed yet the accountability of the federal agencies to the Congress or the state agencies to the federal government. And so I don't think that's been developed enough here.

Jennifer, do you want to add any more to this on our CPS recommendations?

COMMISSIONER RODRIGUEZ: Well, I just want to say that, I mean, I definitely have in mind some things where I think we're missing recommendations. And so I am not -- I'm not sure -- I don't think that -- I actually don't think that they're covered in some of the areas. And some of them we talked about yesterday as being -- so if we have them up there, no need to flag them again here.

CHAIRMAN SANDERS: So I believe I've captured them for our to-do list discussion. And so at the end we'll go over that and see how comprehensive that is and what we want to do about it.

COMMISSIONER RODRIGUEZ: Okay. Great.

And then I think also rematching this to the research roundtable and some of the things that -- the recommendations around the use of -- the development and the use of tools for CPS agencies, as well as sort of the three areas of research that we talked about. I think that's missing as well. There's a little bit in here, but not enough.

COMMISSIONER PETIT: So just to -- in closing for me, with any of the other Commission members, is there more information that you're looking for regarding any of the recommendations that we're proposing at this point in terms of any, you know, back-up stuff that you haven't seen enough stuff, or is there something else that's missing?

COMMISSIONER DREYFUS: Well, I just think there's two for me. And I think Jennifer hit the one, but I just want to repeat it again. There's got to be more about -- about this -- CPS, as I was describing it earlier, about the quality and the consistency, and I don't think that it's just about more resources.

COMMISSIONER PETIT: Right. Right. Correct.

COMMISSIONER DREYFUS: So I just hope that's really recorded.

And then the second thing for me is, I don't know where I stand on this, but this issue about, are these federal -- are these American children first and Utah children second, I don't necessarily see it as either/or, right, but I do think it is a policy conversation, right, that I just want to know that whatever we say, we all understand what we're saying.

COMMISSIONER PETIT: Yeah. Susan, I think you're absolutely right. I think it is a critical, critical question when you have the federal government being able to go into a place like Ferguson, and they can take a look at what their local and state system of justice is, and at some point the feds can override it. And I think that that is missing in this thing right now. There is very weak accountability by the states to either the federal government or even to their own citizenry, on some of this stuff. So I think it's a discussion that we need to have if we haven't -- and I know we haven't exhausted the topic in any way. But I think that's going to be a principal point of contention when anything goes before the Congress.

Was there anything else that anybody is looking for?

COMMISSIONER COVINGTON: I just -- I guess had an overreaching question. And it's partly hearing Commissioner Dreyfus say for -- since we've started this, that she's hoping the Commission will recommend a 21st Century CPS model kind of to replace the 20th Century model. And I'm -- I'm just -- in thinking about it globally, have we done that with what we've got here in terms of recommendations?

COMMISSIONER DREYFUS: The closest I feel that we've gotten to that conversation is when we're talking about this safety culture and aviation and what is what we know to be the rigor that sits underneath evidence-based public health response, right? That to me is the closest we're getting to how I envision a 21st Century child protective services response in our country.

So I'm kind of hoping that as we -- and I think yesterday's conversation was helpful in terms of for our committee, as we think about this, this isn't about public health, public health agency, but the science that sits underneath public health response, as well as the work that Chairman Sanders is going to be bringing us more fully into in terms of aviation and what health care has done around safety culture.

To me, I just hope that we can -- because I think there's a framing in that that a broader audience will get and understand, especially with Congress, and I'm hoping that there's a way that our recommendations are written in such a way that they are sounding similar to what are those best practice approaches in those types of safety cultures, in aviation, health care, public health.

COMMISSIONER PETIT: Susan, I think you're absolutely right, and I think that Teri is right as well. But you also heard Rachel talk about these policy changes being implemented over a ten-year period.

Actually, I believe that many of them can be done more quickly than that, depending on how an organization is run and what the political climate is like.

But whatever it is that we're talking about, the public health model and all of the future, starting right now, whatever, there's still this immediate question of children right now; and we're not going to be able to bring that everything in the 21st Century. What we're going to be able to bring to that is an examination of what situation those kids are in. Are they in safe places? Do we need to reconsider it? Was it the 25-year-old social worker said, oh, I think it's fine, it's no problem; the guy just got out of prison and he's actually turned a new leaf. Well, we'll see about that.

So the immediacy question I think can't be ignored. That -- that's right now, not ten years, nine years, but right now.

COMMISSIONER COVINGTON: Well, I think we state that pretty -- I think we state that explicitly in the report that we're going in multiple different ways to look at this.

COMMISSIONER PETIT: Right. We got -- we got several -- right. That's all.

COMMISSIONER COVINGTON: But even the kids right now, my thinking is, you know, what can be done to sort of revolutionize the system to really make those kids safer right now?

COMMISSIONER RODRIGUEZ: That's right.

COMMISSIONER COVINGTON: I mean, it doesn't mean you have to be ten years down the road. I just want to make sure we're really capturing what we really think we've identified as making those kids safer right now.

CHAIRMAN SANDERS: And, Teri, I think it's a great question and part of the reason why I thought it was going to be helpful for us to look at what we've actually put forward and how does it compare to the big questions that I think we have about where we are now. And I would just say that we don't have the kind of science in child welfare that we I think might have hoped to have to be able to say, this is where we go with this.

I think we have some examples that aren't scientific of communities that have done good things. I think we can look at those things. But I'm more and more convinced that we can look to other industries and really learn from what they've done to shortcut our way to getting to a different kind of future. And I think -- and I don't think we've kind of captured that in here, but -- but I think we -- I think we can.

COMMISSIONER PETIT: But, Teri, the three things that I think are the three principal, immediate things that are contained in our recommendations, all three of them do one thing: they bring more eyes, more hands, more perspective to the cases, and is the judgement the right judgement.

So it's not just social workers, even experienced social workers, it's also pediatricians, it's also law enforcement officers, it's also mental health people. Right? That's what we're saying. And right now, we've heard again and again and again, high caseloads, understaffed, inexperience, et cetera. And what we're doing is we're addressing that, which is an immediate public safety issue.

CHAIRMAN SANDERS: So, Teri, do you want to touch on the first four recommendations? Actually, you can probably go through the remainder, since I think --

COMMISSIONER COVINGTON: Oh, the public health ones?

CHAIRMAN SANDERS: Yeah.

COMMISSIONER COVINGTON: We're not, you know, the -- the upstream prevention ones.

Well, we went through these, you know, a couple meetings ago, I think, and our one comment is we're still -- obviously still doing a lot of work on them. And these are really kind of broad-based almost themes, in a sense, because I think we have a lot of work to flesh out in terms of coming up with specifics on them.

But the first one is really Dr. Rubin's major pet recommendation out of all of this, which is he really feels that we need to go to the states with some federal leadership and mandates and really have the states create a comprehensive state plan that's going to specifically address the prevention of maltreatment fatalities.

And, you know, we haven't really -- we haven't really come to decide where and how we think that that could best be done. We've had some conversations about things like creating

performance measures into title IV -- title V block grants, working through CAPTA, which we all know is really underresourced and may not be the place to go with this, because we've already seen what states do with any of the CAPTA mandates since they're so underresourced. But I think the whole point is to really have states take a very serious look at creating a state plan that would integrate -- that would be an integrated multi-agency response.

COMMISSIONER DREYFUS: Commissioner Bevan, this is where I think you could really -- your -- your committee could help our committee. And that is, we -- we just landed on the maternal child health block grant, but -- but what we're trying to achieve -- before we get to the mechanism for achieving it, what we're trying to achieve is something that the federal government's doing that's saying to states, we want you to have a plan for how you're going to eliminate child abuse/neglect fatalities in your state.

But the piece that I think this doesn't get at that's really important is -- and just because those working in state government know when we do these plans, you start identifying the gaps and the barriers, not just in, quote/unquote, your own agency, but in your interconnected partners. And there is -- and that analysis isn't just always about what the state has to do. You identify barriers that are happening at the federal level as well.

So there's got to be some connectedness between this activity at states to say -- because one of the things I think Chairman Sanders has reminded us over this -- over our time together so far, we really have not found any place that has a plan. Right? I mean, Wichita was the closest, and there's gaps in that.

So -- so we're saying one is incentive or funding, or something that says states have a plan. But the important thing is what they do with their plan on these interconnected system partners that we know are critical and the identification of where there are federal gaps or barriers that need to get raised up.

So if you could -- I mean, we just landed on MCH, but --

COMMISSIONER COVINGTON: And I'm not a fan of having it land in any one place, personally. I really think it's got to be --

COMMISSIONER DREYFUS: I think it's CDC too.

COMMISSIONER COVINGTON: -- it's got to be interconnected. Well, except CDC doesn't really do grants to states where you could work through that.

COMMISSIONER DREYFUS: I'm just thinking of credibility of -- but anyway, just --

COMMISSIONER BEVAN: I'll just quickly say that obviously this would be -- this would go to at least three committees and it would be disaster. If you had it written the way it is now, it would go to three committees. You can't pass anything on out of three committees.

We were talking at breakfast about the summit idea, and I have done before with the President and the heads of all agencies a meeting around issues and said -- and basically had the President say, you know, okay, you know, the Department of Justice -- and not -- no appointees, no -- it's the either the head of the agency or don't come, you're not represented. I mean, it's -- that's how high level it is. Everybody's got to be around the table. And then you

have a very tight agenda that says, this is the kind of thing we need. We need to integrated plans at the state level. But given the way Congress -- the patchwork that Congress is, we can't get at it from Congress, but you can do it at the regulatory level, and it would -- and I'm saying as president, you know, do I have to issue an executive order, which was brought out to us, or, you know, will there be some agreement at this table?

And that's --

COMMISSIONER DREYFUS: That's the help you could give us on this. Because I think -- I guess I'd just like the Commission to be focused on what we're trying to achieve, not the mechanism we've created for achieving it. So I think that's where you could help us.

COMMISSIONER COVINGTON: In many of our recommendations, we haven't quite figured out mechanisms yet. And that goes with the second one as well. We really haven't fixed out mechanisms, but we --

CHAIRMAN SANDERS: So just -- just for a second, Teri.

COMMISSIONER COVINGTON: Sorry.

CHAIRMAN SANDERS: This theme of strengthening the federal role is one that's going to be, I imagine, not limited to this one recommendation. It clearly isn't even at this point. It just may be something that we want to think about how to structure it going forward with this being one piece, and maybe these are all regulatory pieces that can be -- but that there's some way that we figure that out.

COMMISSIONER PETIT: Okay. Back to No. 2.

COMMISSIONER COVINGTON: No. 2 -- and, Susan, jump in if you would like to take the lead on presenting any of these.

This one is really thinking about how you -- it relates, in a sense, to data linkage as well, but how you use multiple systems to identify high-risk families and -- and kind of being -- starting to get really data smart about it, because there are all of these systems that are already in play, and it really ties into some of our findings around integrated systems and approaches around kids.

COMMISSIONER DREYFUS: So this is about those kids that have never been called in to Child Protective Services. This is what we heard yesterday, a family with nothing, and the next thing you know, at 2:30 that day, a child gets shaken to death.

So this -- but this is where we're saying, but they're known to someone. Right?

COMMISSIONER PETIT: But in this case, Susan, they are known to child protection. They -- they are known. So we've sent out memos on this before showing what the federal criteria are for being --

COMMISSIONER RODRIGUEZ: She's saying this recommendations about children who aren't.

COMMISSIONER PETIT: I know. And what I'm saying is it's not true that between one half and two thirds of children who die due to abuse and neglect were not known to CPS.

COMMISSIONER DREYFUS: You brought that up earlier, and this is -- this is what we've been using, and I think what you're saying is validate what we're saying, are those kids not known. Because I will tell you, as a former child welfare director, I'm sitting here saying when people say "not known" does not include kids that were screened out at intake, they were known.

COMMISSIONER PETIT: Right.

COMMISSIONER DREYFUS: So I think we've got to -- again, we keep having these definition problems, right? But we've got to get clearer on what is going to be the Commission's view.

COMMISSIONER PETIT: Yeah.

COMMISSIONER DREYFUS: But let's just say we're in agreement, just for the sake of moving forward. So just assume we're in agreement on what that says. What we're trying to say is that these kids are known to someone. There -- there was -- there was hopefully some prenatal care that would have identified potential parent risk. There was -- there were potentially emergency room visits.

You know, Kentucky uses Medicaid encounter data real time looking at ER visits, ER visit to this hospital, this hospital, this hospital. Hey, let's piece this together.

So I think what we're trying to get at here is the connectedness of law enforcement and health care and education and child care and home visiting and prenatal care in trying to create a safety net for the kids who have never been called in to intake.

COMMISSIONER COVINGTON: Well, I would argue it's not even -- it's also kids who may have been known. So it could be the child who'd had a prior CPS report, but then they come into an emergency room three times with fractures and it keeps getting -- you know, the story keeps going off as --

COMMISSIONER DREYFUS: I think this will strengthen reporting. I think what you're going to see here is you're going to have CPS agencies saying, we've got more calls coming in. And I hope that's the case.

COMMISSIONER PETIT: The most recent -- first of all, there was a memo that was sent to every member of the Commission showing what the federal criteria are for classifying something as known to the agency. Do we need to send that out? I mean, do you recall seeing that?

There was, like, ten points that said, you know, a referral doesn't count as being known, an investigation doesn't count as being known, an investigation with substantiation isn't known.

COMMISSIONER COVINGTON: Where was that coming from?

COMMISSIONER PETIT: From HHS.

COMMISSIONER COVINGTON: Oh, I'd love to see that, because that's all -- that's interesting in terms of definitions.

COMMISSIONER PETIT: And then -- and then in Oregon recently, you will recall that the secretary said to the Commission, none of the children were known to the department. And we said, listen -- and what they were using was if they had seen them within the last year.

And then when we asked the question, what if it was more than a year ago, say it was a year and one day, 10 out of 12 were known to the department.

COMMISSIONER COVINGTON: So could we -- to kind of move through this recommendation, can we maybe ask staff to help us look at some definitions around known and not known and what that means?

COMMISSIONER PETIT: Tom has some material on that that we've been drawing from.

COMMISSIONER COVINGTON: Okay.

COMMISSIONER DREYFUS: But I do hope the Commission takes away from this that it's not just that clarification, right?

COMMISSIONER PETIT: Yes.

COMMISSIONER DREYFUS: It is this idea that it is a larger, shared community responsibility about the safety of children and the identification of risk for children and doing something about that.

COMMISSIONER COVINGTON: And, actually, this --

CHAIRMAN SANDERS: Do you also feel like the -- I mean, Jennifer raised the issue earlier I think on recommendations 14 and 15 of connecting it to the research roundtable. Do we feel that this is clear enough, the -- who's at risk, that we can just implement something, or do we feel that this also needs to be connected too?

COMMISSIONER COVINGTON: I think it has to be a little bit connected in terms of a risk profile.

COMMISSIONER PETIT: Yeah, one issue is that a lot of these kids who were not known have exactly the same characteristics as the children who are known.

I mean, that's --

COMMISSIONER COVINGTON: Absolutely.

COMMISSIONER DREYFUS: I mean, one thing that we don't have right now from a, quote/unquote, predictive standpoint is what did these kids look like earlier? Right?

I mean, you look at Hillsborough County, right, they're looking at what's happening with kids that they know about in the system, and I don't know where we would go back further.

And I think Marc Cherna in Allegheny County is getting at this with his work with New Zealand where he's going -- he's going back into prenatal care and working with obstetricians in the earlier identification of moms at risk to build parent skills and start home visiting earlier, not later.

COMMISSIONER PETIT: Junior high school.

COMMISSIONER COVINGTON: I kind of -- as I've -- as I think about this, I sort of would like to actually take out in this recommendation trying to distinguish between kids known and not known in the system, because I think -- I think it becomes sort of irrelevant. I think we really want to use multiple systems to help us -- and multiple sharing across systems to identify kids at risk, period, whether they've been in the system before or not.

So I -- there's a part of me that thinks we should --

COMMISSIONER DREYFUS: I'd love to hear the commissioners' view on that, because, you know, we started off -- and, again, we evolve, right? So if it's not the -- you know, we progress.

So, you know, we started off with kids known and not known, you know, as a way of segmenting our committees, and -- I think we talked about this yesterday. I don't have a problem with doing that, but I do hope that we -- we raise a larger attention that identifying kids at risk is not just the responsibility of Child Protective Services.

COMMISSIONER COVINGTON: Exactly.

COMMISSIONER RODRIGUEZ: It's almost like the committees are children who are involved with child protective services or not yet involved in whatever -- I mean, because that's -- our recommendations really have to do with the functioning of the CPS agency, and your recommendations have to do with sort of everybody -- how all the systems work together and everybody else, regardless of how you classify involved or not involved, trying to make sure that all other agencies - - I mean, it -- it does almost seem irrelevant to me the distinction between the two for purposes of what you're trying to do and what we're -- I mean, I think our subcommittee is clearly focused in on the workings of this one agency who has the clear investigatory sort of responsibility at the end of the day, and who's also taking the next steps for the families that it's working with. But your -- yours, it just doesn't matter. This is --

COMMISSIONER COVINGTON: I agree.

COMMISSIONER RODRIGUEZ: Because I think some of -- in my -- under your scheme, some of the families that come in through the CPS agency will come back and your recommendations will impact them.

COMMISSIONER COVINGTON: That's right. Exactly. And it could be siblings who had been involved, or it could be parents, or it could be nobody.

COMMISSIONER PETIT: But it's also -- if -- if these -- whatever the number of kids are that are coming to the attention of other systems, if those children are suspected of being abused and neglected, they're supposed to call CPS.

So one of the things that I'd be interested in is, are they not calling CPS? Did they not think it rose to the level of suspected abuse or neglect? Because that's the legal vehicle we have right now for the protection of these children.

So there is an issue about mandatory reporting, and there is an issue about public education, calling in referrals, which is very -- which varies greatly between the states, among the states. Some have high reporting rates and some have low. It's a function of public education, media, et cetera.

COMMISSIONER DREYFUS: So, Commissioner Bevan, another question for you. So I -- to this topic of this section, I served on a legislative committee in Wisconsin on mandatory reporters coming out of what happened at Penn State when every state legislature had a legislative group. And one of the things that was really one of those new insights that we gained was on this issue of mandatory reporters.

So I appreciate that some states, everyone's a mandatory reporter, right? They've just said everybody's a mandatory reporter. But we know that there are those professions -- licensed, regulated professions -- that I think have a higher responsibility. Not that it's not everybody's responsibility, but a higher responsibility. I think of lawyers, I think of teachers, I think of doctors, just to name a couple.

Well, one of the things we have right now is that if you're a child welfare director, you bear responsibility for training mandatory reporters in your community, and whether or not they are competent or not is nothing that their licensing entity ever checks on.

So my husband's a judge, right? He's required -- there are certain things that he -- Judge Martin, you know this. You're a judge, too. There are certain competencies he's required to maintain, and he has to take -- there are certain classes he has to take every so often, right, to maintain that level of competency that he's supposed to have.

What we realized is that we don't do that in this work. We basically hope that people came to our training, we hope that a teacher is competent in their mandatory reporter training, and that they maintain that competency over time, refresh it; but nothing requires it by their licensing entity.

And we're thinking the responsibility shouldn't be on CPS to make sure people are trained and competent. They may have to create the curriculum that's used, but the responsibility should be on the licensee and on their licensing entity to make sure they're competent and that they refresh those competencies over time.

So that's -- I know that's -- but that, again, would be a very specific policy question.

COMMISSIONER COVINGTON: Well, No. 1, you know, 4(e) training dollars are there at 75 percent match. There's no limitation on how many times you take it. It's not utilized very well.

We do have judges involved in terms of the people that are named under the 4(e) training, so I don't think it would cost any more money if we did it.

I would like to know, though, the bigger question on mandated versus not mandated. For example, in Utah, they don't mandate specifically anybody. Everybody's a mandated reporter in Utah.

So is the substantiation rate, which is now, what, like, 60/40? Like 60 not substantiated, 40 percent substantiated? Does that rate differ by who's the mandatory reporter? I don't know. But I would hate to see more calls go into the hotline and then just raise the level of unsubstantiated reports, because then we wouldn't get anywhere.

So I think there are a lot of issues that you're raising.

COMMISSIONER MARTIN: So my question would be, I don't disagree that that's probably a better process, at least for the agency, but how is that -- that in and of itself going to reduce fatalities? Because you're still getting trained. It's not where if it's under one -- if the licensing board requires the continuing education, or the agency requires, the difference, I don't see how that's going to impact the safety of our children, the fatalities of our children. And maybe I'm just missing the point.

COMMISSIONER DREYFUS: Yeah. So what we talked about is -- and we even got further into schools of medicine, right, needing to -- needing to -- that this needs to be part of the training of doctors, as an example. I'm just trying to fast forward here. It was a much bigger conversation, but as an example.

I think we get fixated on this mandatory reporter/non-mandatory reporter versus what we know to be this constellation of people that likely have their eyes and ears on kids in a community, right, who we need to make sure are competent. And not just to pick up the phone and call, but competent in that mandatory reporter role, right?

I think what I've always found is, yeah, so what, you call, right? It's the quality of the information that you're able to provide. It's your -- it's how you -- it's how the agency can get back to you, right?

I can't tell you how many times I literally had, with all respect, teachers in Milwaukee that just wanted to fax us their referrals. I'm sorry; that's not a quality report. Right?

So I just think there's a bigger question here about the shared responsibility, those people who are licensed and at a level that they do have connection and contact and eyes and ears on kids, and yet there's nothing that says one is you have to be competent in this role, and you have to be re -- like, some of the states have created in their curriculums where there is a test, a test that you take that you're basically validating that, yes, you have these competencies, and that nothing requires it -- once you've had it once, nothing says you've got to do it every three years or --

I hope that helps, but --

COMMISSIONER COVINGTON: I just think it fits into this, and I just wanted to see --

COMMISSIONER PETIT: Just to reinforce that, Susan, I mean, for us, we used to give grants to the state supreme court and they would conduct annual trainings for all judges in the state on child abuse and neglect as part of their annual training. DAs did the same thing. And we got a new teacher that comes in who doesn't know one thing about anything related to child abuse and neglect, you're training them on here's when you are required under the law to make a referral to CPS or your school superintendant, whatever it happens to be.

I mean, they don't know -- some people think that you have to believe that it exists rather than suspect it. I mean, that's a training question that helps people say this kid is being referred, as opposed to, we're not going to -- you know, she doesn't seem to be in that much trouble, or I don't think I have a duty or responsibility to do it.

COMMISSIONER DREYFUS: So just to close it off, I'm just trying to put on the table, is there a higher level of responsibility and accountability than what we have now?

COMMISSIONER PETIT: There is.

COMMISSIONER COVINGTON: All right. The third one really -- I've got to read this.

This is an interesting one, and we've talked with CMS about this. I don't know if we'll get anywhere with them, but we want to talk with them some more. It's really trying to create services around the family unit rather than have them be child centric -- or, not child centric, but looking at trying to create funding structures and what have you where the child is looked at within a family unit rather than an individual person.

So --

COMMISSIONER DREYFUS: This is the Oregon CCO -- if you remember the Oregon CCO that presented to us, and they use a family well-being assessment.

COMMISSIONER COVINGTON: And it's really -- it's beyond even just assessment, because we were talking, you know, if the mother -- if the child comes in, and a lot of their harm might be related to mental health needs of the fam -- of the mother, how can you tie the mother's health, the provision of mental health services into the care of the child, for example, and to look and seeing if we can really kind of radicalize some ideas at the federal level around funding streams that would tie family units together rather than have them be individual.

So --

COMMISSIONER DREYFUS: Right. And this is where we're asking that --

COMMISSIONER COVINGTON: We have some more work to do on this.

COMMISSIONER DREYFUS: -- Dr. Jack Shonkoff at the Harvard Center for the Developing Child come to the Commission meeting in New York to present to the Commission.

And just to paraphrase Jack -- and if you go to the Harvard Center, you can read all the papers they've put out on trauma, toxic stress, brain development of children. It really comes down to where Jack just goes like this (indicating). And that is, you've got to decrease toxic stress, you've got to decrease stress in a household or you've got to increase parent serve and return, the resilience, the parenting factors, those two things. And I think, in a nutshell, that's the kind of recommendations that would be coming out of this section.

COMMISSIONER COVINGTON: And I think we heard yesterday from some of the folks in Utah that this is sort of the approach that they're trying to take with some of their families, that it's not just about getting the kid out -- and, Jennifer, you've talked about this a lot; you

talked about this yesterday -- it's not just taking the child and putting him in foster care and forgetting about all the services that everybody needs.

COMMISSIONER DREYFUS: So, Commissioner Bevan, where this -- the policy piece comes in here, and we talked about this with CMS, this is where Dr. Shonkoff, when Commissioner Rubin and I had a call with him, this is also where this whole issue of two- generational billing came up in Medicaid. And that would be, I'm a mom with maternal depression and that my treatment includes my child.

COMMISSIONER BEVAN: Right.

COMMISSIONER DREYFUS: Right. That it -- that -- and that there's the ability. Because what -- what the research is showing is that if I'm a child being raised by a parent with maternal depression, I'm having -- my development is being impacted by that, and that it isn't just a focus on mom, get mom's depression better, the kid will be fine, the child too needs intervention and support.

So this starts to get at that as a potential recommendation area.

CHAIRMAN SANDERS: So a couple of things. This, then, becomes part of the -- one of the elements that's required as part of a Medicaid plan? Is that -- or is it a redefinition --

COMMISSIONER COVINGTON: We haven't teased it out that far yet.

COMMISSIONER DREYFUS: We met with CMS. They were fabulous. And --

COMMISSIONER COVINGTON: They were intrigued.

COMMISSIONER DREYFUS: And between our staff and us, there's continuing conversations about, you know, where they see the potential, but that's the conversation we had with them.

CHAIRMAN SANDERS: The other thing, I was just comparing notes with Cassie, because it seems like this is the -- I mean, this is a component of the President's budget with candidates that offers the purchase of services under 4(e). So it's a little different, but it's -- but that's out there.

COMMISSIONER COVINGTON: Yeah. So really, 3 and 4 are completely linked. We've pretty much just covered those as we've been talking. And I'm sure we'll have some more to play with as we continue our conversations. And we hope to fine tune these in much more detail than they are now, but --

CHAIRMAN SANDERS: Do you want to just quickly go through the measurement ones? Because there's --

COMMISSIONER COVINGTON: Yeah. The measurement ones, we really -- presented them in pretty fine -- we presented these as is when we were in Vermont, you might remember. And it's going through 5 through 10. They sort of -- it's almost chronological.

The first one would be to think about improving the counting fatalities for multiple purposes, including preventing abuse and fatalities, looking for successful interventions. Because if you

can't count them right, it's really difficult to understand whether your interventions are working across different causes of death, and then using the counting to help identify policy change as necessary.

And then finally, being able to better count deaths to try to determine culpability as appropriate, which would address all of the different judicial systems.

COMMISSIONER MARTIN: So one of the things Rachel talked about today was kind of classifying deaths. And --

COMMISSIONER COVINGTON: That's -- that goes right into this as --

COMMISSIONER MARTIN: Okay. All right.

COMMISSIONER COVINGTON: Well, if you -- if you get into No. 7, it's really developing a very standardized classification system, which would really help sort out all of the different -- and where we really run into the most trouble is with the neglect deaths.

I think -- you might have remembered when we were first presenting this, you've got a scale out here which is the -- you know, the horrific and I meant to kill my kid, I did something horrific, all the way through to, you know, I did something stupid that ended up hurting my kid, and there's -- there's multiple gray areas in between. There's bias in between, there's all kinds of stuff in there.

So --

COMMISSIONER PETIT: So, Teri, how are you going to represent -- have you guys been wrestling at with what the number is or the range is that we're going to actually present to the public?

COMMISSIONER COVINGTON: There is a range --

COMMISSIONER PETIT: Because there's the federal number right now, which is completely --

COMMISSIONER COVINGTON: I'm of the belief we do not give them a number, personally. I mean, we can show them number -- I don't think as a Commission we say, this is the number we've accept.

COMMISSIONER PETIT: Well, no, but we can say is, this is a range.

COMMISSIONER COVINGTON: Yes.

COMMISSIONER PETIT: We think it's at least this much, and as much as this.

COMMISSIONER COVINGTON: I think we can show them numbers that have been obtained from different systems and how those numbers were obtained.

I think we heard from Dr. Schnitzer at our -- one of our very first meetings. She's just finished some work with the -- with the National Center for Health Statistics comparing death certificates and child death review reporters. She's coming up with a number that's even higher than anything else we've seen.

COMMISSIONER PETIT: Right.

COMMISSIONER COVINGTON: I actually was hoping to get her on a conference call, at least, with the Commission.

COMMISSIONER PETIT: Yeah. All I'm saying is I think we need to show that there is credible research that suggests that the numbers are much higher than what is reported to the federal government.

COMMISSIONER COVINGTON: It's -- and I think we present that in our -- in the report. But I'm -- I'm hesitant to say this is the number, because that number -- I don't trust that number either.

COMMISSIONER PETIT: Yeah, I -- I don't know -- I don't think anyone's suggesting -- I haven't heard anybody suggest a number, but I do think we need to say that the 1,517 is completely worthless, and it's closer to this range and this range based on the best research that's been done so far.

COMMISSIONER COVINGTON: Yeah. And all of that's in publications, so we can pull that out.

COMMISSIONER PETIT: Yeah. It's double or triple.

COMMISSIONER COVINGTON: So that -- the first one is really coming up with defining the purpose. The second one is consolidating federal responsibility and leadership into one single agency that would lead, provide oversight and guidance in the development of a national surveillance system that really builds on the current public health maltreatment -- what we would call a public health child maltreatment fatalities registry, and it would also expand and standardize fatality reporting into NCANDS.

So NCANDS would be a piece of a national surveillance system, but only a part of it. There would be a broader-based surveillance system, which would include an expanded definition.

Seven was --

COMMISSIONER MARTIN: Teri, can we just go back to the number issue? If we're going to put in a range and put in any kind of figure, I think, for the most part, we have to seriously consider whether or not we also have a caveat that this number excludes Native children.

COMMISSIONER COVINGTON: Oh, absolutely. I think that's -- that's my concern about presenting a number is it's got -- it's fraught with problems.

COMMISSIONER MARTIN: And that's why I'm saying -- because even today, we heard that some Native children are -- or yesterday heard some are included in the Utah number, and other states have not clearly put --

COMMISSIONER COVINGTON: No, the numbers -- the numbers are fraught with problems.

COMMISSIONER MARTIN: So I -- I really am not of the opinion that we need to --

CHAIRMAN SANDERS: So the -- I think today is for some of the conversation, but not -- we aren't -- we aren't making any final decisions now. And I would be hard pressed to push a number, but that --

COMMISSIONER COVINGTON: So would I.

CHAIRMAN SANDERS: -- doesn't mean that we don't end up there.

COMMISSIONER COVINGTON: So would I.

CHAIRMAN SANDERS: But I think -- but we're not looking to make those decisions today.

COMMISSIONER COVINGTON: But I think in the report we outlined the problems in numbers, one of them being gross undercounting of specific populations or overcounting in populations. Huge variations among states. So I'm -- I'm all about what you were just saying.

CHAIRMAN SANDERS: And I think what you said yesterday is, again, one of the -- one of the challenges or opportunities we have is to make sure there's consistency.

So if we're saying one population is an undercount and another's an overcount, I don't know that we know a number from -- from those statements. So I think -- so I think whatever we say, it has to be consistent through it.

COMMISSIONER COVINGTON: The third is -- or No. 7 is to feed into that registry, you really need to create a classification system and a uniform definition that would be used by -- that everybody -- we would have universal use and acceptance of that definition for the purposes of reporting.

And I think part -- what's important with that is it doesn't mean that you're creating a definition that has to be used uniformly by law enforcement when they're deciding whether they're going to charge a family or by the courts when they're going to convict or by CPS when they're going to substantiate, that we're looking for a definition that would be more all-encompassing. And it doesn't necessarily preclude individual agencies having more precise legal definitions.

COMMISSIONER MARTIN: Or, wording it another way, a definition for counting in measurement purposes, right?

COMMISSIONER COVINGTON: That's right. That would be the purpose.

So then, you know, the whole point of this would be then to really build a fatalities registry, and to expand def -- and to standardized reporting into NCANDS. I don't know if you remember, but we created sort of a flow chart in terms of how we envision that happening.

An important part of measuring is improving the system of child death investigation and death certification by developing standards of investigation. If you don't investigate these well, you don't have the information to be able to count them well. So --

COMMISSIONER DREYFUS: Can I ask a quick question on that?

COMMISSIONER COVINGTON: Yeah.

COMMISSIONER DREYFUS: So one of the things we heard, and I think it was in Colorado, was it's one thing when you're in an urban area and you're the medical examiner and you see -- you can maintain your competency through repetition. When you get in rural areas, right, you lose that.

COMMISSIONER COVINGTON: We had some thoughts on that, which would be, for example, all suspected child abuse cases would go to regional forensic centers. That's a model that's being used in a number of states. Missouri requires all deaths of kids under 14 have to be seen by one of their five pathology -- their forensic centers where they have medical -- they forensic pathologists.

So we have some sub sort of work under -- under that. You know, no longer will the coroner in a small corner of a state be able to look at a baby in a casket and say, this is how the baby died.

That would be our goal. I can tell you some stories about that.

The next is that states have to report child abuse and neglect fatalities into NCANDS that would -- through the state's public -- health or public health agency, using a medical examiner to make the final determination.

That goes to some of the things you were just talking about, Commissioner Dreyfus.

And, really, we were -- we hope to develop new standards of investigation that they would have to have used.

And I think that's it. That's -- we got through 10. That was -- that was it on the measurement.

I mean, these -- we have more to -- but these are the general themes around them.

And I -- if I recall, when we presented them in Vermont, people seemed to be pretty much okay with them as they were. So -- but they -- we're -- we'll work them up.

CHAIRMAN SANDERS: I think it was that there was more information that would be needed, and that we would -- I think the conversation that we have -- and hopefully we'll be able to have it next meeting -- is with a document in front of everybody that now includes a set of findings, includes a set of recommendations, and then -- and there is some interim work. I think the last thing we should probably do is kind of, what are the major areas that we have to cover between now and the next meeting?

And so then we'll be able to actually speak from the same document and have it as close to proposal form as -- as possible, and we can decide how we want to move forward from there.

COMMISSIONER COVINGTON: And, you know, credit to Rachel, because she really helped -- I think helped all of us when we did this. This was the first group that we did -- sort of create a framework for how you, you know, kind of summarize the literature, summarize the findings, summarize our testimony as we came into this.

There are a couple people I'd still like to hear from, whether it's at our meetings or even through a conference call. I'd like to hear from the folks in Alaska, who are now trying to field

test the civilian version of a case registry surveillance system using the -- you know, we call it the Air Force model where they've standardized and field tested definitions. So they're in the process of that. I'd really like to know what their experience is on that. And I would like to hear from Dr. Schnitzer on the results of her work where she really feels she's expanded the number considerably and why that happened, and what -- what she brought into that, because it might help give us some other information to help us.

COMMISSIONER DREYFUS: Who is she? Sorry.

COMMISSIONER COVINGTON: She presented to us, I think -- well, maybe when we were in Washington, D.C. She's an epidemiologist at the University of Missouri, a professor there, who has published extensively on this surveillance of maltreatment, including having several large grants from the CDC to look at different maltreatment studies.

She actually did a study -- she actually tried to use public health. She has tried to also create a system that looked at morbidity and serious injuries and found it was much more difficult to do than fatalities using multiple data systems. A lot of her work is involved in using multiple data systems to get to numbers.

COMMISSIONER MARTIN: I have a procedural question that I think I've asked before, but I think I've forgotten the answer.

So the committee that is looking at minority children, Black children, Hispanic children, we've had some speakers talk with our subcommittee about how implicit bias has impacted counting of abuse and neglect deaths and why that is and the whole bit.

And so when the subcommittee makes their recommendations or their -- brings their findings to the Commission, I'm wondering where -- where a recommendation fits.

Let me state it this way. In our final draft of our report, do we indicate having -- or do we anticipate having recommendations that come from the data collection group in the beginning, and then CPS in the middle, and then -- do we have -- are we going to categorize them like that, or not?

COMMISSIONER DREYFUS: No.

COMMISSIONER MARTIN: Okay. Okay. Then that answers my question.

COMMISSIONER DREYFUS: I hope they all weave together.

COMMISSIONER COVINGTON: That's why I really like the emerging themes, because I think as we do the emerging themes, the different recommendations fall in under there.

I mean, I think -- you know, I was on the call on the bias piece, and there's some real important pieces that need to go into the discussion on measurement.

So I think it's that -- I mean, it's going to be an art form, right, for us and the staff to do all this weaving together, but --

COMMISSIONER MARTIN: Okay. Thank you.

COMMISSIONER COVINGTON: We're putting a lot of pressure on staff. You're on it.

CHAIRMAN SANDERS: So from yesterday and today, I am -- and this was your recommendation near the end of the day, Judge Martin, about, so what are some of the things that we need to do? And I certainly have a list of things that I'd propose, but did you have something specific that triggered that for you?

COMMISSIONER MARTIN: I -- I don't have anything specific. I think what it's come out of is the fact that there are some times we were putting forth comments about what recommendations might look like, but we just didn't have any testimony, in my memory, that would support those facts.

I mean, they may be facts that we all know, but we didn't have anything in the record to support it.

And so what I wanted to make certain is that when someone looks at our final report, they can actually -- if they've read through all the testimony we've received, they can check off, I heard that, I saw that.

COMMISSIONER BEVAN: But, Patricia -- Judge Martin, your own -- your own subcommittee that you just discussed has not testified on the errors and the bias in the data so that we do need to have -- or, I don't want to stick with just the witnesses, in other words, because I think we'll miss out on certain things that we need to have.

COMMISSIONER MARTIN: So they're scheduled for coming in in New York. That's when the panel is going to testify. And the bias information that the subcommittee heard verbally, she may be one of our speakers, but we will have information on the bias, whether it's her or someone else.

CHAIRMAN SANDERS: I do think, though, the point that there are other sources of information that we've gathered is important.

I mean, I think -- so research information. There may not have -- there may not have been testimony on it, but we may have been presented five research papers on something, or there may have been information that came to us in another way that came to us collectively that we had a chance to actually hear.

I think I would distinguish it just -- not just the testimony. I think there are multiple sources.

COMMISSIONER MARTIN: So I stand corrected. I think it has to be on the record, though.

So if we had five reports that we discussed, that's fine, right, as a collective group because it's on the record.

I think if we got individual --

CHAIRMAN SANDERS: That we actually had as part of an agenda, or that we had the opportunity to receive and all read and --

COMMISSIONER MARTIN: I think so long as we've used them in discussion as a collective commission, an agency -- I would have to read the Public Act law again, but it seems to me so

long as it's contained in the record that we got report 1 through 5 and we as commissioners looked at it and discussed it and came to a conclusion that one of the findings out of those five reports is "A," then I think we're okay.

CHAIRMAN SANDERS: So that -- and I guess we'd have to think through this.

So the GAO report on -- that focused on measurement, we -- we heard testimony -- I don't know that we had conversation and agreed to its conclusion, but I think, though, that we received the report, we've had an opportunity to hear summaries, we've had an opportunity to hear testimony. I would say that's information that --

COMMISSIONER MARTIN: I think that would be fine.

CHAIRMAN SANDERS: Yeah. Okay.

COMMISSIONER DREYFUS: Isn't the issue just one of citing? I mean, I get a little bit nervous if it's just about what -- who's actually sat before us and testified, or conversations we've had in Commission meetings. But -- but if we're citing a report, and the Commission is all looking at the whole report right before it goes out and agreeing with those citings, is that enough of a validation of the facts sitting under -- of the -- of the research or the data -- or the research that sits underneath why we're bringing up what we're bringing up as a commission with recommendations?

COMMISSIONER MARTIN: So I think there are two issues. I think one issue is we need to review the Public Act law to make sure we're complying with that. But in my humble opinion, it seems to me that it would be very difficult to justify making a finding or bringing forth a recommendation if the whole body has not had an opportunity to hear or review or question on those issues.

And so it would seem to me that if it's not contained in the record, it would be difficult for us to justify how we came as a body to -- or a collective group to that conclusion.

That's just, you know, what I would -- what I think is personally appropriate. But I think we also need to make certain that we satisfy the law and look at the fed -- the public act, because it doesn't make sense to have a public act and not have everything offered and available to the public to review. I mean, that just doesn't make a lot of sense to me. So I would think that maybe staff might be able to do that for us.

CHAIRMAN SANDERS: So let me run through some of the things, unless others have major other areas, that -- that I think emerged the last couple of days from the themes and recommendations that it seems are - - that we would want to do some more work on.

I think one is, I do think we need to have some work done on what doesn't work. I think that Congress was very clear in directing us to at least consider that. And I think we need to -- we need to do that.

And that may be -- we may want to think about, do the current subcommittees all need to continue as is? Do we create a separate one to look just at this, but some way of getting at that.

I think second, the issue -- and I'm not sure I can capture it as eloquently as Jennifer did, but I think we need to do more work on the special nature of the relationship that the -- when a government agency takes responsibility for a child and the child dies, and understand some of those dynamics a little better.

I think that's partly captured in the work of the CPS work group, but I'm not sure it's completely captured with that.

I think this issue of public disclosure, which we talked a lot about yesterday, we can do it as a full Commission, we could have somebody take a look at it and bring some ideas to us; but I think there's more work we need to do there.

The question about resources, I'm not sure sequentially when it needs to happen, but it seems clear that we're going to have questions about, does -- do we request a lot of money, do we not request money, those kind of things. So I think we'll -- we'll have to figure out where.

I think -- and this isn't -- this isn't a new, separate activity, but I think as we look at the recommendations -- and Teri I think captured it exactly right -- the recommendation should tie back to our finding. Our finding should tie back to things that we can say as a Commission, we -- we came to this conclusion based on this set of -- this information. And so we need to continue to look at, does that happen?

I mean, because we've set out the recommendations separate from the development of the themes and the findings. Now that we have a set of findings that we at least are -- I think generally are on the same page about, then let's make sure that the recommendations are tied back to that and that we can say those findings are tied to things that we've heard as a Commission.

COMMISSIONER DREYFUS: Can I ask a question on the what works, what doesn't work? I mean, one of the things Judge Martin continues to remind us of, rightfully so, in these meetings is that we have seldom had the ability for anybody to sit in front of us and say, and this has led to the reduction of fatalities.

So we've heard some really promising things, like, I think of Tennessee and 100 percent redundancy, but they didn't have data that then showed and that resulted in a reduction of fatalities.

So this issue of what works and what doesn't work, sometimes I'm also wondering if it's -- some of it is what works in some other industries where safety is the paramount issue and -- and how that crosswalks to what is not working in our industry, to put -- use that term "industry," in our industry. I'm trying to get a little broader understanding of what works and what doesn't work to -- because nobody -- I haven't seen anything that says, when you do this, you have a reduction in fatalities.

COMMISSIONER MARTIN: So one of the things we talked about a long time ago -- and, you know, the meetings are running together in my mind, so I can't really remember where we were. But we talked about this idea of whether or not our report would recommend that there be an experiment, there be a pilot, there be some kind of work put on the ground to see whether or not that can be evaluated and it actually does reduce fatalities.

And, you know, I don't know how to legally do that or politically do that, but it seems to me that our report would make these findings, we would make these recommendations based on the findings; but in order to really know whether or not there's been a reduction, we would have to, you know, at least pick five jurisdictions of different -- you know, and then have an evaluative tool to make that determination. Because you're right, there's nothing that's come out and said this is the -- this is the kernel of truth, this is what works.

COMMISSIONER DREYFUS: I suppose there's Hillsborough County. I guess as I'm thinking in my mind about what we've heard where -- where there's, you know, that presentation. But other than that, you're right. I mean, we -- we really haven't had people being able to make the clear crosswalk.

COMMISSIONER COVINGTON: And even in Hillsborough, those numbers were so tiny.

COMMISSIONER DREYFUS: Right.

COMMISSIONER COVINGTON: I'm not sure I would --

COMMISSIONER BEVAN: We have to call it as it is. We don't have that research. We don't have it, and we don't know what specific intervention will eliminate child abuse and neglect fatalities.

COMMISSIONER MARTIN: And that to me is one of our findings.

COMMISSIONER BEVAN: That's a finding.

COMMISSIONER MARTIN: Because I'm quite -- when I started this work, I actually thought we were going to find things where -- I really did.

COMMISSIONER BEVAN: I didn't think so, no.

COMMISSIONER MARTIN: I thought we were going to find jurisdictions, you know, specifically designing projects and programs to focus on reduction of fatalities, and I thought there were going to be risk factors that geared and directed you straight to fatalities. And unfortunately, that's not what we found.

So I think that is one of our global findings. And because of that, then the necessity for actually evaluating what we found is even more important.

CHAIRMAN SANDERS: So a couple of other things. We need to spend a little time on -- and I think it's very little time at this point -- connecting the research roundtable recommendations with any recommendations we make. Because I think we tied a couple of them together right now, so that may be something we don't have to do.

This issue of clinical standards and thinking about child protection practice differently, I don't think we've done much on that, and it seems like that may be something that we want to spend some time on.

And I -- I think, saying that, consistent with what you said, that by this point it would be nice if we had, you know, these are the things that a child protection worker does that reduce the likelihood of a later fatality. We don't have that yet.

So I think this is -- we need to explore it further, but we may come up with really very little.

COMMISSIONER DREYFUS: I have a question on that. So would it weave into that one, Chairman Sanders? Something that I've been thinking a lot about, and that is the absence of big data and technology systems.

I mean, we -- I think about SACWIS, and I think, you know, SACWIS is already outdated in terms of modernization and, you know, that intake worker being able to sit there on that phone and look up law enforcement and look up ER utilization and look up, right, than just what's coming on -- that they're getting on the phone. But this whole issue of big data and technology, does that fit underneath the CPS modernization, or is that something in and of itself?

Because it's not about public disclosure. I get the difference between confidentiality and disclosure. I'm just talking about big data and the technology piece.

COMMISSIONER MARTIN: Isn't that sharing of information on some level?

COMMISSIONER DREYFUS: Well, but you need -- you need the technology systems that will allow that to happen.

So I -- they weave together, but I just don't want to lose --

COMMISSIONER COVINGTON: But you need technology.

COMMISSIONER DREYFUS: -- that piece.

I mean, I was just blessed in Washington state with an incredible data warehouse capability that --

COMMISSIONER COVINGTON: Doesn't exist everywhere.

COMMISSIONER DREYFUS: -- doesn't -- yeah.

CHAIRMAN SANDERS: I think it's part of that -- of the -- the issues around confidentiality. Because I think what we heard was not just sharing information but sharing it in real time. There are a variety of things that I think really lend itself to all seven just because of technology.

COMMISSIONER DREYFUS: So that would potentially -- not that I'm saying it's a recommendation, because I don't know, but that would potentially lead us to -- about technology.

COMMISSIONER MARTIN: It's a piece of it, for sure.

COMMISSIONER DREYFUS: So like a modernization of SACWIS that allows for this kind of integrated data.

CHAIRMAN SANDERS: Yeah. And I hate to keep raising this issue of the FAA, but the display was really impressive that they know the risk factors for airline crashes and they have the data integrated so they can tell from different data sources, plus they have the visual capacity to actually look at planes landing in different airports at different times.

COMMISSIONER COVINGTON: Did they put you in the simulator?

CHAIRMAN SANDERS: They had one there.

COMMISSIONER COVINGTON: Did they?

CHAIRMAN SANDERS: Both a cockpit as well as a tower. I mean, it's

COMMISSIONER COVINGTON: Where was this, by the way?

CHAIRMAN SANDERS: It's in Tysons Corner.

COMMISSIONER COVINGTON: Where?

CHAIRMAN SANDERS: Tysons Corner.

COMMISSIONER COVINGTON: Oh, okay.

CHAIRMAN SANDERS: And for a child protection agency to have that kind of information I think would make a remarkable difference.

COMMISSIONER COVINGTON: I like the airplane model stuff. I always just say to people, kids aren't airplanes, families aren't airplanes. I mean, they're so much more complex in terms of systems.

CHAIRMAN SANDERS: But knowing that somebody has missed five appointments --

COMMISSIONER COVINGTON: That's right.

CHAIRMAN SANDERS: -- and been reported three times to the child protection agency that you don't know now, I mean, but if you had that information at the point of screening or when you go out for an investigation, it could make a big difference.

COMMISSIONER COVINGTON: It could be huge.

COMMISSIONER BEVAN: I hope that we can get there very quickly and not -- because I know how long it takes us to get, like, a conference call and, you know, everybody to agree. But I just think that, you know, we just need to go quickly. Because we can't -- if we're going to use that, then we have to know a lot about it and feel more comfortable, and we can't just do it at the end of the process.

COMMISSIONER COVINGTON: Right.

COMMISSIONER BEVAN: Like, before July would be great.

CHAIRMAN SANDERS: Commissioner Horn.

COMMISSIONER HORN: Can you hear me?

CHAIRMAN SANDERS: Yes.

COMMISSIONER HORN: As long as we're going -- as long as we're going kind of off into other areas, I was just having lunch the other day with a professor at the University of North Carolina at Chapel Hill on a different topic, but it was about artificial intelligence. And one of

the things he was telling me about is that they're now using the whole idea of, like, neural networks, but from computer technology and artificial intelligence to sift through all of the medical data that allows hospitals to now come up with better diagnoses than they would -- than a doctor could ever possibly come up with, based upon, you know, our limited capacity to sort through complex sets of information.

So it seems to me that there is -- there may be something there when we start to talk about the -- it's not that we don't lack for information about people involved in the child welfare system or information about people prior to a fatality, but at -- and, you know, one possibility would be to say a promising -- something to look at would be the application of things such as artificial intelligence when it comes to examining complex data sets in order to make much refined predictions about what is happening in people's lives and who might be at risk.

CHAIRMAN SANDERS: Thank you.

So that's the list that I have. I mean, there are other things that could potentially go on, but those seem like the most important things.

COMMISSIONER DREYFUS: Let me ask Commissioner Martin, did you see in these themes -- something you brought up yesterday that I wrote down -- and Cassie, you brought this up. And I guess it's just where would they weave in. Maybe they're not their own, but where do they wave in. The building of resilience and protective factors for families came up when we were talking about this yesterday, and then Commissioner Bevan brought up those kids who are in state custody but are living with disability, the whole issue around disabilities. So I'm not sure where they fit in, but I think they need to get parking-lotted somewhere.

COMMISSIONER COVINGTON: You know, I was thinking about disabilities -- and I know we're not trying to fine tune these recommendations right now, but I'm not happy with the prioritizing on kids zero to five. I know they're the more vulnerable population; but when you think of a ten-year-old with a disability, she's as vulnerable or he's as vulnerable as the infant sometimes.

So I -- I'm concerned that we talk about prioritizing age groups in our recommendations. I'm not -- I'm not real happy with that.

COMMISSIONER MARTIN: So one of the things I was thinking about, when I think of disabilities, I typically think of disabilities that children are born with. All right?

COMMISSIONER COVINGTON: Well, that's not always the case.

COMMISSIONER MARTIN: But when I was thinking of head traumas the other day, these children rarely, rarely, you know, come out on the other end without permanent disabilities.

COMMISSIONER COVINGTON: That's right.

COMMISSIONER MARTIN: And so these are disabilities that are caused by abuse and neglect. And so I'm wondering -- not that there should be different treatment, but I'm wondering, are there different ways of helping those children? I don't know.

But I do think we need to get someone in here to tell us a little bit about how kids with disabilities fare and what their numbers -- as bad as the numbers are universally, what their numbers look like, and kind of what are the factors.

You know, I -- I would presume the more disabled, the more risk it is, but I don't really know that.

COMMISSIONER COVINGTON: It depends. Yeah, different disabilities.

COMMISSIONER MARTIN: And then --

COMMISSIONER COVINGTON: Kids with trach tubes I'm sure die at much higher rates because trach tubes fall out.

COMMISSIONER MARTIN: Right. Right.

COMMISSIONER COVINGTON: I mean, intentionally or not. I mean, there's different kinds of disabilities that put kids at risk.

COMMISSIONER RODRIGUEZ: I mean, speaking for the CPS subcommittee, I know that this is an area where it goes back to the predictive analytic sort of piece of it, and also the research.

So we could certainly change the language of the recommendations to say that we should be aligning risk assessment with what the research tells us about which children are most at risk.

COMMISSIONER COVINGTON: There you go.

COMMISSIONER RODRIGUEZ: And, I mean, part of that is age. I mean, that's what the data is saying. But, I mean, we're not holding up kids zero to five just because we like them more and think they're cuter, but it's -- you know, because it's really the research is telling us that there's a number of risk factors, including age, which I think makes that recommendation more solid anyway to sort of tie it to.

COMMISSIONER DREYFUS: To the resiliency protective factors question, is that -- is that going to come out of research, the research area? Is that -- because I -- again, I don't think this was just about assessing the absence of them; I think this was also assessing for them as well as how do we develop them.

COMMISSIONER BEVAN: I agree.

CHAIRMAN SANDERS: So let me then -- a couple of things to figure out next steps. Let's start with those last two that you just raised, Susan. Do we want to -- how do we want to approach those, the disability and --

COMMISSIONER BEVAN: I have a risk and protective factors section in the policy that includes race, disability, age of mom, Native American income, substance abuse, and then whatever we can find as protective factors, which we didn't list.

CHAIRMAN SANDERS: So thinking in terms of what's in policy right now?

COMMISSIONER BEVAN: Well, what we know. We're trying to figure out who are we talking about, who are the families and who are the kids, which is sort of -- but I'm sure we -- I'm sure others can come up with -- and then we can just compare notes.

COMMISSIONER DREYFUS: So where I kind of went with it after Commissioner Rodriguez spoke is it seemed to me that the issue of disability fits within the predictive modeling, the issue of risk factors.

So I -- so that seemed to answer that to me. I'm not saying it's the answer, but it's what answered it for me.

But on the issue of protective factors and resiliency, I think that's an area that literally researchers are still really baffled with.

COMMISSIONER BEVAN: But same with predictive analytics.

COMMISSIONER DREYFUS: But what --

COMMISSIONER BEVAN: I remember Emily Hornstein saying very clearly that we cannot separate, you know, kids by severity. And since we can't separate by severity and we can't separate by risk, we can't really do predictive analytics.

Am I wrong, Dr. Berger?

DR. BERGER: I don't know -- can you turn on my microphone, Rachel?

I don't remember Emily saying you can't stratify by severity. I'm not sure what you mean by that.

COMMISSIONER BEVAN: But by risk. In order to do predictive analytics, you need to stratify by risk, and I thought it was also severity, but I must be wrong.

DR. BERGER: I don't know. I don't remember her talking about severity, only the risk issue.

COMMISSIONER BEVAN: And that -- and so far we haven't been able to use predictive analytics in the area of child fatalities.

DR. BERGER: Right. But I think her argument was she's able to stratify, and we can say, you know, using data such as the New Zealand data, we can identify the highest risk kids based on, for example, the birth data. But then the question becomes, what do we do with that data? Because a lot of those kids are not CPS involved.

COMMISSIONER BEVAN: Right.

DR. BERGER: But we have no ability to ever predict on severity, because we don't collect -- if they're not dead or near fatal, we don't collect that data.

COMMISSIONER BEVAN: Okay. Thank you.

CHAIRMAN SANDERS: So it sounds like there is a mechanism to deal with both of those, I mean, that we'll -- we'll have further conversation about.

The government agency issue, Jennifer, is that something the Child Protection Subcommittee could look at?

COMMISSIONER RODRIGUEZ: Yeah. And look at in terms of identifying what next steps need to be to get it done.

CHAIRMAN SANDERS: And do we want -- for public disclosure, do we just want to wait until the next couple of hearings and then hear people, or is there anything before that?

COMMISSIONER COVINGTON: Uh-huh.

CHAIRMAN SANDERS: And what doesn't work? Do we -- how do we want to approach that? I have things in mind, but -- of what doesn't work, but that's just me.

COMMISSIONER RODRIGUEZ: Let's hear -- I would love to hear your thoughts about how to approach it.

CHAIRMAN SANDERS: I don't know how to approach it, I --

COMMISSIONER COVINGTON: Do you want to go on record and say what doesn't work is the question.

COMMISSIONER MARTIN: Maybe not in this meeting.

COMMISSIONER COVINGTON: I know what doesn't work, too, from my own perspective, but -- only because I've seen it multiple -- you know, you see the same things -- in looking at death reviews, you see the same issues come up over and over and over again.

COMMISSIONER RODRIGUEZ: I'm trying to think what the strategic, scientific way to approach what doesn't work actually is.

COMMISSIONER COVINGTON: I don't know. I don't know. What did we hear yesterday, anecdote is more important than the data?

COMMISSIONER DREYFUS: But might there be something, like, sitting in Hillsborough County that sat underneath where they ultimately ended up that sat underneath -- because they looked at child fatalities, right? They looked at child fatalities over ten years that started getting at -- did -- did that start getting at what doesn't work or what were those recurrent themes?

COMMISSIONER COVINGTON: Yeah. And I -- other states have done that, too, through the --

COMMISSIONER DREYFUS: So I guess I'm asking that. Does that start to --

CHAIRMAN SANDERS: I think that it makes sense to maybe look at a handful of states that have done some similar things and see.

COMMISSIONER DREYFUS: I think -- I think Commissioner Covington is right. I mean, in the -- in the deaths that I've had to review on caseloads that we had, there are themes. I mean, it's just the recurrence of the same themes over and over again, but have they ever really been captured?

Now, I think Ombudsman reports, right, oftentimes start capturing those things too.

COMMISSIONER COVINGTON: Let me -- I'll offer -- and maybe if a staff person wants to work on this with me -- to pull up some states that I know have done some really nice analysis around their reviews, and we can see if we can capture some of it.

CHAIRMAN SANDERS: Yeah, that would be great.

COMMISSIONER COVINGTON: I mean, for me a lot of it's anecdotal, but --

CHAIRMAN SANDERS: That would be great.

I think those are the major things. And we did not get to a couple of things, but I think that's fine. We can --

COMMISSIONER COVINGTON: Oh, we didn't talk about the Department of Defense. Can I just say where we're at with that? We sent them a nice list of discussion points. It's quite a long list, actually. And we sent it just to the family advocacy program at the department's central -- at central command at the DOD. They -- they're looking at it. They want to talk with us some more about the discussion points themselves.

They're convening all of their family advocacy program managers at the same time we're going to be in Wisconsin, but they really want to have a discussion with those managers around those questions, and then they're going to try to reach out. But they have to run everything up through command, so everything takes longer, as you can imagine.

And then they want to have a conversation with us to kind of mull through those, and we thought we would do that for anybody on the Commission that would want to be interested in that.

We're not sure that they can actually make it -- provide testimony, because at the two remaining hearings we have, one, they're having their big meeting, they're having their fatality summit at the same time we're in Wisconsin, and they also don't know if they can get up to New York. So we thought we could do it as a conference call, first of all, to have a conversation with them. So we'd want to open that up to any other commissioners that would want to be part of that. It's Dr. Rubin and I that are doing that with them.

And then from that, we'll formulate some recommendations that would be specific to military families and their structure.

And I -- I'm trying to think, did I send -- I know -- Liz has our list. I don't know if I've sent it to any -- if it's gotten disseminated, the list of questions that we sent them. I'll forward that in to you guys.

CHAIRMAN SANDERS: So we have a couple more meetings scheduled. We're also trying to schedule conference calls, which I know everybody got the -- some kind of query about that. And we have many more things that people are requesting for the next two hearings, and we have time. So I'll end up just having to decide what we do. I'll send out something soon -- as soon as possible. But it will be based on the -- what we -- the conversation we just had about

themes and recommendations, and we'll try and figure out other ways that we can hear from some of the people that are recommended.

COMMISSIONER DREYFUS: So I have a question. Judge Martin brought this up yesterday, I brought it up. And when we were asked as commissioners about Wisconsin, New York, and ideas. And I don't know if it's actually during the Commission meeting, or maybe it's the night before, but we make sure it's posted correctly or whatever we've got to do; but I do think it would be amazing for us to sit down and hear from the folks on the ground. And when I -- before I started this work with the Commission, I did that in Milwaukee, and the Bureau of Milwaukee Child Welfare put together a group for me a folks on the ground -- intake, investigation, in-home, out-of-home care, foster care, private providers, as well as public sector. And I've gotta tell you, it's really interesting -- and I still have the list of what their insights and suggestions were. And, David, one of them was from one of the -- one of the case managers who talked about safety culture, who talked about health care. And here we are now talking about aviation.

I mean, everything they told me, I could, like, draw connections back to everything we seem to be talking about and recommending. And I -- I just don't know that we've heard that -- that voice yet.

COMMISSIONER RODRIGUEZ: This also makes me think that another way to approach what doesn't work is actually to hear from clients, to hear from birth parents.

COMMISSIONER DREYFUS: Who have had kids die? Or --

COMMISSIONER RODRIGUEZ: No, not who have had kids die, but who have received services.

COMMISSIONER DREYFUS: I'd like to hear from people whose kids have died.

COMMISSIONER RODRIGUEZ: And sort of more than just sort of one or two at a hearing, that -- I mean, there could be an opportunity to do a focus group or sort of a meeting with a number of them who can talk about some of the services, or maybe there's a different way to gather information in addition to what we're already planning to do around what -- what doesn't work. Because I think where I've gotten the most information about things that are not helpful is actually talking to the people that were the recipients of them.

COMMISSIONER BEVAN: You bet.

COMMISSIONER RODRIGUEZ: So, I mean, that --

COMMISSIONER COVINGTON: I agree with that. I would really just want it to be really focused. Because I think sometimes it goes off into areas that aren't as relevant to what we're doing.

COMMISSIONER RODRIGUEZ: I think that actually has to do with the preparation and the strength of the facilitator.

COMMISSIONER COVINGTON: It does. Yep.

COMMISSIONER RODRIGUEZ: But --

COMMISSIONER COVINGTON: And the people that we ask to speak. I think it would be great.

CHAIRMAN SANDERS: Anything else that we need to cover?

COMMISSIONER BEVAN: I'm still going to look at federal laws that have failed to launch. So my failure to launch are things like -- failure to launch laws are --

COMMISSIONER DREYFUS: Wasn't that a movie?

COMMISSIONER BEVAN: -- you know, ask for provisions --

COMMISSIONER COVINGTON: So we have a -- one hour was -- I looked at the planned agenda, and it looked like one hour was put for that. Is that enough?

COMMISSIONER BEVAN: For what?

COMMISSIONER COVINGTON: For the whole accountability piece. Is that what you mean by failure to launch, or is that different?

COMMISSIONER BEVAN: It's different.

CHAIRMAN SANDERS: You're referring to the request for time on the agenda?

COMMISSIONER COVINGTON: Yeah.

CHAIRMAN SANDERS: Yeah. We'll -- I would just say those are the requests at this point. I'll have to figure out how to --

COMMISSIONER COVINGTON: But is failure to launch the same as accountability among the agencies and states to not do what's in law?

CHAIRMAN SANDERS: I think the accountability issue was the --

COMMISSIONER BEVAN: Yeah. Well, it's what works and what doesn't work. Accountability has more to do with what entities -- how they hold states accountable. You know, how they --

COMMISSIONER COVINGTON: So what -- what's failure to launch? I'm --

COMMISSIONER BEVAN: Failure to launch is the current laws that exist that have not taken off.

COMMISSIONER COVINGTON: Okay. Okay.

COMMISSIONER BEVAN: States have not picked them up.

COMMISSIONER COVINGTON: All right.

COMMISSIONER BEVAN: Like the bypass and reasonable. It's things that would have helped -- on the face of it would have helped prevent a death. Again, we don't know, but it appears on the face of it that it would have.

CHAIRMAN SANDERS: All right. I think we've gotten a lot done. Ready to adjourn?

MEETING ADJOURNED