COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

MIDDLETON, WISCONSIN PUBLIC MEETING TRANSCRIPT

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- Dr. David Woods, Ohio State University
- Dr. Eileen Munro, London School of Economics
- Dr. Mitch Pearlstein, Center of the American Experiment
- Jerin Falcon, Office of Justice Services, Bureau of Indian Affairs (BIA) District VII
- Valerie Vasquez, Midwest Region, BIA
- Kerma Greene, Midwest Region, BIA
- Dr. Mark Testa, University of North Carolina at Chapel Hill
- Amy Harfeld, Children's Advocacy Institute
- Kathleen Noonan, PolicyLab, The Children's Hospital of Philadelphia
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- Kirk Mayer, Initial Assessment Specialist, Bureau of Milwaukee Child Welfare (BMCW)
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- Kelly Oleson, Youth Services Manager, Adams County
- Julie Ahnen, CPS Services Manager, Dane County
- Eloise Anderson, Secretary, Wisconsin DCF

JULY 15, 2015

CHAIRMAN SANDERS: Good morning. Welcome to the Commission to Eliminate Child Abuse and Neglect Fatalities hearing here in Madison, Wisconsin, and thanks to Fredi Bove and the people of Wisconsin for hosting us. This is the Commission's ninth or so meeting/hearing across the country that we've held, and it's an opportunity for the commission to hear the latest research policy and practice designed to eliminate child abuse and neglect fatalities.

We have a packed agenda today, and we'll have an opportunity for some deliberation for the commission. As you can see, we have some commissioners who are going to be arriving late, flights and so forth, but we'll go ahead and get started in just a minute.

The commission was created in 2012 with the Protect Our Kids Act, which Congress passed and the President signed into law in early 2013. We have another eight or nine months or so to complete our report to Congress and the President, which will be designed to provide recommendations that will result in a reduction or elimination of child abuse and neglect fatalities.

And today we have a wide-ranging series of presentations helping to fill in information that we have heard about, but maybe want to hear more about; and we'll also have an opportunity to hear from Wisconsin about some of the practices here as Wisconsin has one of the lower rates of child abuse and neglect fatalities in the country. And we'll have an opportunity to deliberate as a commission on some key issues including disclosure later today.

So I'm going to first allow each of the commissioners to introduce themselves, and then we'll get started with the agenda. Commissioner Dreyfus?

COMMISSIONER DREYFUS: Good morning. Susan Dreyfus. I'm with the Alliance for Strong Families and Communities, formerly the administrator of the great division of First Division of Children and Family Services for the State of Wisconsin. And it is fabulous to be here with you all.

CHAIRMAN SANDERS: Commissioner Zimmerman?

COMMISSIONER MORNING: Good morning. I'm Marilyn Bruguier Zimmerman. I'm an enrolled member of the Assiniboine-Sioux tribes in the State of Montana. I currently serve as the director of the National Native Children's Trauma Center at the University of Montana.

COMMISSIONER MARTIN: Good morning, ladies and gentlemen. My name is Patricia Martin and I currently serve as the presiding judge for the Child Protection Division in Cook County, Illinois, in Chicago.

COMMISSIONER STATUTO BEVAN: Good morning. I'm Carol Statuto Bevan. I am with the University of Pennsylvania Child Welfare Fellow and Field Center for Child Policy and Practice.

COMMISSIONER HORN: Good morning. My name is Wade Horn. I'm the health and human services practice leader for Deloitte Consulting, and I formerly was the Assistant Secretary for the Administration on Children and Families in the U.S. Department of Health & Human Services.

COMMISSIONER RUBIN: Good morning. I'm David Rubin. I'm a general pediatrician from Philadelphia. I'm the co-director of our PolicyLab and our research institute there.

CHAIRMAN SANDERS: Commissioner Petit, we were just doing introductions.

COMMISSIONER PETIT: Michael Petit formerly - -

CHAIRMAN SANDERS: Your mic, your mic.

COMMISSIONER PETIT: I don't have my glasses on. Michael Petit, formerly Maine's Commissioner of Health & Human Services, many years at the Child Welfare League of America, and founder of a group called Every Child Matters.

CHAIRMAN SANDERS: And we have -- Commissioner Rodriguez will be arriving late this morning and we'll have at least one commissioner joining us by telephone.

Our first presenter is Fredi Bove who is responsible for child welfare services here in Wisconsin. And, Ms. Bove, I will turn it over to you for about ten minutes of comments.

FREDI-ELLEN BOVE: Okay. Chairman Sanders, commission members and staff, and invited guests, good morning and welcome to Wisconsin. We're very, very pleased and honored to have the commission holding its July meeting here in Wisconsin and appreciate the opportunity provided for Wisconsin speakers to share their efforts and information with you. To provide some context for my remarks -- and there are written remarks that were distributed to you, so you can track them as I talk.

CHAIRMAN SANDERS: For the commissioners, I think they're on the left side; is that -- in the pocket.

FREDI-ELLEN BOVE: Great. I did want to begin by sharing with you the purpose of our child welfare system.

The purpose of the Wisconsin child welfare system is to keep children and youth safe and to support families to provide safe, permanent, and nurturing homes for their children. Our system does this by safely maintaining children and youth in their own home, family, tribe, and community whenever possible. The system engages with the community partners and the children, youth, and families we serve to help them develop healthy connections and relationships, build resilience, and thrive.

In my remarks today, I'm going to focus on three things: First, the dynamics of a county-administered system as requested by the commission; second, I wanted to share with you some data analysis that we've done in Wisconsin on deaths and near fatalities; and, third, I want to just very briefly talk about Wisconsin's approach to safety decision-making in the child welfare system, which you'll hear more about this afternoon.

So Wisconsin is a county-administered child welfare state with the exception of Milwaukee County, which is our largest county, where child welfare is administered by the state through our department, the Department of Children & Families. The state assumed responsibility for Milwaukee County under the leadership of Commissioner Dreyfus in 1998 in response to a lawsuit.

In the balance of the state outside Milwaukee, child welfare is delivered through the 71 county child welfare agencies. We're one of 12 states that are in whole or part county administered. Of the 12, there's two, Wisconsin and Nevada, which have a hybrid state county administrative structure. Like most county-administered states, our system is financed by a mix of federal, state, and county funding.

So a county-based child welfare system has both strengths and challenges. The key strengths in my view are, first, the local county boards and county child welfare agencies are

knowledgeable about their local conditions and their unique needs and can put in place strategies and priorities to address those local needs.

Second, while all counties are required to adhere to basic -- a basic level of standards that are set by the state, counties do have the flexibility to put in place enhancements. So the result is we have up to 72 incubators where innovative practices are tested out, and it really does result in a rich learning environment where the state learns from counties and counties learn from each other.

Thirdly, because other human service systems, particularly our mental health system and our children's long-term care, are also county based, it does allow for an opportunity to forge those cross- systems collaborations more easily because they are all at the county level.

On the other hand, we also have challenges. So the key challenges in a county-based system, in my view, are the amount of resources, funding. In terms of funding, staff and service-provider capacity varies greatly across counties.

Secondly, with respect to the small and rural counties in particular, due to their limited staff, their relatively smaller caseloads, and their limited provider availability, it's difficult for those small and rural counties to develop specialized expertise; for example, with drug-positive babies. Similarly, it's very difficult for those small and rural counties to benefit from economies of scale, and so some of their functions are less cost effective for that reason.

A third challenge is it is difficult to assure consistency in quality of services across the state.

And a fourth challenge that I've observed is that it is relatively easy and low cost to initiate a new practice on a pilot basis, because you can -- we can almost always find a couple of interested counties to get a practice started, and it doesn't cost a lot because our counties tend to be small. However, it is difficult to scale up because of lack of resources, lack of widespread interest, or just sheer complexity of scaling up. So we tend in our county-based system, and I believe in other county-based systems, to get stuck in the pilot stage often.

Because we are a hybrid system, we also have some distinct advantages. So the two key ones are we're able to use Milwaukee, which is a system that we run as a pilot site for new approaches. And so that allows us to assess the practice, work out the bugs before we expand it to other counties.

Secondly, it gives the department direct exposure to the issues and challenges of running a child welfare system, and I believe that does make our policymaking then more informed and robust.

Another important factor for us that I wouldn't say is a strength or a weakness, it just is, is that smooth functioning of the county-administered system is highly dependent on close collaboration between the state and counties. So that generally does lengthen the time for development and rollout of new practices, because it does require a collaborative process. I would argue that in the end it does though lead to a more successful implementation and rollout, because we do build county buy-in during that development process.

It doesn't appear that a state versus county system, that one is superior over the other in terms of performance. We've actually looked at the federal CFSR performance measures. We

were curious to see if one system outperformed another consistently. We did not find that there was a consistent pattern there. In my view, the key differences are that state agencies with county-administered child welfare systems have to have a higher tolerance for variance across the state, and they absolutely have to have a more intense collaboration with counties.

So I'm going to segue now to our analysis of our child deaths and near deaths in Wisconsin. Wisconsin has a maltreatment-related public disclosure statute that is broader than in most states; and we are required to report not only maltreatment-related deaths, but also egregious incidents and serious injuries. Egregious incidents are things like violence, significant violence, torture, restraints, other kinds of aggravated circumstances. Serious injuries are incidents where a child has been diagnosed by a physician in serious and critical condition. So, in my mind, egregious incidents and serious injuries really represent near fatalities.

So to deepen our understanding of those fatalities and near fatalities, we did complete two sets of analyses. First, we looked at all of the substantiated maltreatment-related deaths over a five- year period, 2009 to 2013. And then we looked at the near fatalities, which would be the serious incidents, egregious incidents and serious injuries over a two- year period, 2013 to 2014. So I'll highlight the key findings.

Looking first at the substantiated maltreatment child deaths over that five-year period, 2009 to 2013, there were a total of 118. Of those a very small proportion, only 2 percent -- actually technically less than two percent, I rounded up -- of the children were in an open child welfare case and were in an out-of-home-care placement.

A larger proportion, 16 percent, were in open child welfare cases, but they were still with their families, which means that either the assessment was underway or the assessment had been completed but the family was receiving in-home services.

A significantly larger proportion, 44 percent, of the children were not in open cases but had previous child welfare involvement, and that could have been a screened-in case or it could have been a screened-out case.

And then another significant proportion, 38 percent, of the children with maltreatment-related deaths had no current or prior involvement with the child welfare system.

When we looked at the egregious incidents and serious injuries over that two-year period, there were a total of 141, and a strikingly very, very similar pattern emerged, and I won't go through the numbers. They're -- they're in the text.

So I think these analyses highlight a couple of things. They highlight that there's two very vulnerable and identifiable populations that could be targeted for services to seek to prevent child fatalities and other types of child abuse and neglect: First of all, our families with open child welfare cases where children are still in the home; and, secondly, those families with previous involvement with the child welfare system.

The other -- another key takeaway from our analysis is that it confirms that a significant proportion of children who experience maltreatment- related deaths are unknown to the child

welfare system either at the time or previously. And so this really does reinforce the principle that I know this commission has already -- is working on supporting and is already well aware of, that prevention of child abuse and neglect include -- and including fatalities is really a community responsibility and not simply responsibility of the child welfare system, and that we really need the engagement and commitment of a whole range of community partners to prevent child fatalities.

As the commission is also well aware, all states receive federal funding, the bulk of which is the title IV-E funding, which is earmarked to serve the children who are already in out-of-home care. So without getting explicit waivers, that federal funding can't be used for those vulnerable populations that I just described. The families who haven't had any exposure to the child welfare system or the families who have had past exposure but aren't currently in the system or the ones who are involved in in-home cases.

So our state and all other states would benefit greatly from federal action to increase the flexibility of those federal title IV-E funds so that we could use that funding in collaboration with our community partners to support timely and effective intervention services for those vulnerable populations.

I'll now make a few comments about our safety decision-making in child welfare. While we just saw that a significant portion of our maltreatment-related fatalities occur in families that are unknown to our system, the child welfare system certainly has a very profound responsibility to keep children who do touch our system safe from abuse and neglect, including fatalities. But again, as you all know, one of the fundamental challenges in our child welfare system is balancing child safety with the other values and principles of our system including being trauma informed and being family centered.

We know from the scientific research that abuse, neglect, or other dramatic experiences in childhood have a toxic effect that inhibits a child's healthy development of the brain; and that, as a result, a child's cognitive development, their social development, even their physical health are impaired in the short run and the long term.

So because we know that removal of a child from his or her family into out-of-home care increases trauma for the child, we seek to avoid removing children whenever possible and we seek to reunify families as quickly as possible. But at the same time, we know that there's some risk involved when there have been safety concerns previously in the home or currently in the home.

So to help balance the need to preserve children safety and the objective of maintaining children in the home whenever possible, in Wisconsin we use a modified version of the Action for Child Protection Safety model as a tool to help think critically and systematically about safety decision- making.

Child welfare supervisors are absolutely the backbone of our child welfare system. It's the supervisors that guide workers as they do their information collection and their assessment work and it's the supervisors that have to approve whether a child is removed or can remain in their home.

Because of the critical role of supervisors, we're targeting supervisors for very intensive training on safety decision-making. You'll hear from a panel of Wisconsin workers this afternoon about the safety -- supervising safety decision-making training that we began implementing in 2012, and they can talk more about that.

So, in conclusion, we strongly support the goals and the work of the Commission to keep children and youths safe so they can develop and thrive both as children and as adults. We're pleased to assist the Commission throughout these two days and in any other way, and we want to thank you for the time commitment and thought you are devoting to this very important work. Thank you.

CHAIRMAN SANDERS: Thank you, Ms. Bove. And I know that we'll have a chance to hear a little more detail about some of the practices in Wisconsin later today, but are there any questions right now from commissioners? Commissioner Dreyfus.

COMMISSIONER DREYFUS: I'm so proud of you. So I'm going to call you Ms. Bove, but I only know you as Fredi, so this is going to be interesting, right?

FREDI-ELLEN BOVE: Right.

COMMISSIONER DREYFUS: Back to the analysis that you guys were able to do, because I know Wisconsin's been perfecting its data analytics capability. When one of the things we're talking about as a commission, I will tell you I think about as a former administrator and secretary over child welfare, is that we do ourselves -- we do this system a disservice when we call the child protection agency the "system" when it is but a part of a system.

FREDI-ELLEN BOVE: Right.

COMMISSIONER DREYFUS: Was there anything in your analysis that showed -- because I always cringe a little bit when I hear kids not known to the system when I don't think of the system as being CPS. It's a piece of the system.

Is there anything in your analysis that talks about how these kids were known to someone? Families were involved with domestic violence. There was -- you know, people were involved with the family for other reasons, other parts of this thing we call the child welfare system; maybe not known to CPS, but they were known by someone.

And then the second thing, was there any analysis about were they known to someone and should they have been reported? You know, is there a reporting issue here?

FREDI-ELLEN BOVE: Right. Yeah. So I'll call you Commissioner Dreyfus, right? So thank you for your initial comments.

So the short answer is we haven't done that deep dive yet partly because, again, the data that's easily mined is sort of this more quantitative data about were they in -- previously in the child welfare system, again, the narrow child welfare system, or not. Given that it's not that many cases, we can go back and look in more detail and look at some of those fine points. I think you will get some of those insights from the panel that you'll hear from later today, because there are two county people on the panel in particular who can give you some

insights about, yes, some of those families did have DV, domestic violence issues, or were known in the community as being isolated and things like that.

COMMISSIONER DREYFUS: So just two last things. So as you think about this analysis now, it might help the commission, right, as we do it finishing up our work, is when you look at the screen-in/screen- out decisions on those cases that you talked about where the 44 percent were not open cases but had had previous involvement, so now it's a bigger in, right? Are you looking at the quality of those decisions not to look backward but for forward-leaning CQI, right? Is there something we can learn about those screen- in/screen-out decisions and what happened?

And then just the last thing I'd just add is were there others in the household; maybe not that child who died or had an egregious incident, but were there others in that household known to the child protection agency? You see what I'm getting at? It's like what more is sitting in there?

FREDI-ELLEN BOVE: Yep.

COMMISSIONER DREYFUS: So thank you.

CHAIRMAN SANDERS: Commissioner Martin?

COMMISSIONER MARTIN: Thank you so very much for your testimony. It's been very helpful. I have two questions for you.

One of the statistics that you were able to provide are the analysis of the issues that you were able to provide for deaths and near fatalities. After you started this new safety model in 2012, have you seen a difference in your numbers? Has that impacted your numbers either on the near fatalities or fatalities?

FREDI-ELLEN BOVE: So the short answer is it's too early to say. 2012 was sort of just when we started the rollout. And, again, being a county system we are -- we haven't finished the rollout. So, again, only some counties have been trained, and even in those counties it hasn't been all the supervisors.

So, again, you'll get the benefit of some direct line people who will be able to tell you sort of how it's operating on the ground, but it's too early to see it in the numbers yet.

COMMISSIONER MARTIN: My second question is of the statistics, the analysis that you've done, have you been able to determine whether some of these children or the percentage of children who are minority black and Hispanic children in the deaths and the near fatalities?

FREDI-ELLEN BOVE: So I'm going to look really quickly here. So for the -- we did more analysis on the child deaths just because that one we had done first. But now that I look at it, no, we didn't do demographic breakdown. So that would be another follow-up along with some of the comments that Susan had made that we can think about. Thank you.

COMMISSIONER MARTIN: Thank you.

CHAIRMAN SANDERS: Commissioner Horn?

COMMISSIONER HORN: Thank you. I also want to thank you for your answer testimony -- testimony. I'm curious.

One of the issues that we're looking at as public disclosure after a child's death or a near fatality and, in fact, we're going to have a little bit of a discussion about that later today as a commission. And so I was interested to hear that you have a broader sort of disclosure requirement than most other states. So I have a three-part question and I hope the answers are relatively short.

The first is what kinds of information do you release and what restrictions might there be on the information that's being released?

Secondly, how do you release it? Do you proactively push it out to the public or do you -- is it in response to public requests for information?

And then, thirdly, since you have a broader definition than other states do, are there any lessons learned about having such a broader requirement for public disclosure that you think other states could learn from and we as a commission would benefit from?

FREDI-ELLEN BOVE: Okay. So we have a requirement that in 90 days -- well, we have a requirement, I'm sorry, within the first two or five days to publish a very short report, and it's a standardized form just saying the incident happened. It has some very, very basic material; the age of the child and the county and some very, very short material. And then in 90 days we have a requirement to publish a more -- a summary of the incident, basically, and we can give you copies of the standardized publication form. It is published on our website so, actually, if you have a computer, you can go on it, so -- and people can sign up to receive those announcements as they're published.

So, for example, the media -- typically the media have signed up to get those automatically. Our legislators can sign up to get them automatically. So that's the mechanism for distribution. It's on the website. And if you're interested, you can get them as they come out. You get an email each time they're published.

So it does not yet contain confidential information, obviously, with any of the family's names, but it will describe the incident, who was involved, what type of injury it was, what the medical examiner's conclusions were, things like that.

If we do an internal review, which is at the discretion of the department, then we also have to publish the results of that re -- summarize the results of that review. We don't publish the whole review. That is part of the reporting requirement as well.

Lessons learned, it's a lot of work to have to publish all of those incidents. We've gotten better over time because we've automated more. Again, it has to start at the county level because they have to provide us the information about the incidents and it gets reported up to the state. There are some issues because egregious incident, you know, isn't a well-defined term, so we have to sort of work out the definition of that.

I think on balance it has been a helpful tool. I would say, sort of back to the similar comments that Susan was raising, I think we've also though learned that that can't be our only mechanism for finding out about quality of our system; that a broader CQI, a broader

continuous quality improvement approach is needed to understand all of the systemic issues that may be at play. So that is one I'd say caution about relying too much on the public disclosure tool.

COMMISSIONER HORN: Thank you.

CHAIRMAN SANDERS: Commissioner Bevan?

COMMISSIONER STATUTO BEVAN: Your definition of egregious incidents seems to me to fit with the ASFA definition of aggravated circumstances. How does this play out in the courts in terms of the placement of the child and the placement of siblings? In other words, do you continue to pursue reasonable efforts? Do you use a bypass for reasonable efforts in that kind of situation?

FREDI-ELLEN BOVE: I see. So I would say the two are sort of not linked in the sense that what happens under the public disclosure law doesn't necessarily control what happens in the courts, yeah. So, again, we would be following the ASFA guidelines for the court proceedings, but it could be that an incident was published under our public disclosure law that didn't fall under that ASFA.

COMMISSIONER STATUTO BEVAN: I'm sorry. But what I'm trying to get at is do you use the -- in situations like this, not discussing the privacy of it, but in situations like this, how often do you -- in your estimation over these past years is the bypass for reasonable efforts invoked, I mean?

FREDI-ELLEN BOVE: Oh, I see what you're saying. Yeah. That one I don't know. I don't know and I don't know that we would have data on that. I just don't know what the answer would be.

CHAIRMAN SANDERS: Thank you very much, Ms. Bove. You've been very helpful. Oh, I'm sorry, Commissioner Petit.

COMMISSIONER PETIT: Thank you for that testimony. A couple questions. First, it's now July of 2014 -- '15. Do you have 2014 data?

FREDI-ELLEN BOVE: So for -- yes, we do. And, again, the -- on the egregious incidents and serious injuries, we did do it up through 2014. We didn't do the maltreatment deaths review. We could update that through 2014.

COMMISSIONER PETIT: You think it's more or less, about the same as it has been?

FREDI-ELLEN BOVE: I think so.

COMMISSIONER PETIT: Let me ask you. It's -- according to these, about two-thirds of the kids were known to the department.

FREDI-ELLEN BOVE: Yes.

COMMISSIONER PETIT: And you said two percent of all the kids killed were at home in an open CPS case?

FREDI-ELLEN BOVE: Two percent of the kids were in out-of-home-care placement and out -- in an open CPS case.

COMMISSIONER PETIT: So they were not in home placement. Just two percent?

FREDI-ELLEN BOVE: Right.

COMMISSIONER PETIT: So that would be like foster care.

FREDI-ELLEN BOVE: Exactly, in foster care setting.

COMMISSIONER PETIT: And then the 16 percent?

FREDI-ELLEN BOVE: 16 percent were in their own home. So the case was open. It could have still been in that initial assessment stage and then the fatality or the injury happened. Or some of our counties, including Milwaukee, do provide in-home services. So it could be a situation where the family -- the assessment was done and then the child welfare system put a plan in place to keep the child at home safely, but sadly that plan didn't work and so the child -- it wasn't sufficient to keep the child safe and so the child did suffer the injury or fatality.

COMMISSIONER PETIT: But of that number I think you said 44 percent of the cases fit that description?

FREDI-ELLEN BOVE: No. The 44 percent were - - let's just go back to make sure I have the right numbers here -- were those that weren't open, so -- and these are separable buckets. So the 44 percent are not open cases, so they're not in out-of-home care, that's the two percent. They're not open in in-home cases, that's the 16. So then the next segment is the 44 percent that had some prior involvement.

COMMISSIONER PETIT: And were at home. It was prior --

FREDI-ELLEN BOVE: And they were at home, correct.

COMMISSIONER PETIT: And they were not currently in an open CPS case?

FREDI-ELLEN BOVE: Correct.

COMMISSIONER PETIT: And they were at home?

FREDI-ELLEN BOVE: Correct.

COMMISSIONER PETIT: So how do you explain being open previously, being closed now? They were in compliance with whatever plan you'd set up or had they ever received services?

FREDI-ELLEN BOVE: So they would have received services. They would have gotten to the point of -- and they may have been screened out, so they may not have received services. So they may have been reported. The worker looked at the conditions at the time, determined there was no reason to -- that the children were safe and didn't need to go into the child welfare system. That's one scenario.

Or they may have gone through -- the case may have been opened. The family may have received services. The children might have been out of the home for a temporary period of

time, but they were back in the home and, again, the case was closed, and then down the road, again, something happened.

COMMISSIONER PETIT: So who makes the decision on whether to go back and look at it again or not? Say no recent incidents. The child is about to die, but there was no recent incidents that had been brought to your attention apparently. Who would make that decision? Is it the supervisor, the supervising worker? Is there a multidisciplinary group that you turn to? Who would do that secondary look?

FREDI-ELLEN BOVE: So I'm not sure what you're asking. So if -- if a new incident's reported to us, then, again, we would follow our protocol, which would be the worker would gather the information and then the supervisor would review that and decide should it be screened in; and they would look at has there been past times when that family came to the attention of our child welfare agency. So they would be looking back at that history, if that's your question. We do look at that history at the time the next incident is reported.

But once a case is closed, again, they're members of the community. We don't sort of check in on them, you know, in three months or six months and say, "Are your kids still safe?"

COMMISSIONER PETIT: I guess I would just point out for all of us, I mean, myself included, again, the children that are going to die are largely already known to the broader system of child welfare.

So the question is how do you maintain an ongoing look even if they are not at the point where you can say there is abuse and neglect going on right now? That would be how do you monitor on a day-to-day basis? But do you have the wherewithal to go back and either randomly sample or say these 50 cases were the greatest concern to us or has any county done a look- back and said, "Let's take a look at every case that we ever served or that has been opened in the last two, threes years"? I mean, how do you maintain -- especially when the research shows that there is frequently a recurrence of abuse and neglect that may not be picked up, that it happens.

FREDI-ELLEN BOVE: Right. So, right, you're zeroing in on a really, really important point. So, I guess, I would make a couple comments.

Again, one is sort of the comment that Susan and others made; that it's not just a child welfare system that has to be concerned about those families, absolutely there. If it's a vulnerable family, ideally we should have some system to provide a safety net or some kind of safeguards for those families. Some counties do, some counties don't, depending on, again, financing and priorities. We do have in place now, which I think our secretary might touch on tomorrow, a program to provide 12 months of post-reunification support for families, because we know that's a fragile period immediately after. So that is something that through our title IV-E work we were doing in counties that are opting into that program. About half of our counties are using that program. So that provides some of that sort of check-in after the -- after the case is closed. But I think what you're saying is really we need to go beyond that, and I agree completely.

As far as what research we've done, as we are starting to look at -- just at state level what happens to those screen-out cases, did they come back and how often do they come back and

what happens when they come back? So we're trying to understand that from, again, an analytic point of view so that we can figure out are there some program interventions that we can put in place.

But I think you're getting at sort of the other piece of when the families are sort of -- yeah, after they touch our system and we --

COMMISSIONER PETIT: Of which there are thousands -- which there are many thousands of such families.

FREDI-ELLEN BOVE: Yep. Yep.

COMMISSIONER PETIT: David, one last question, if I may.

CHAIRMAN SANDERS: And we'll close after this.

COMMISSIONER PETIT: In terms of your foster care program and the children that are in the foster care and what they need, how well matched is the availability of funding on the IV-E in comparison to the needs of the children?

FREDI-ELLEN BOVE: So we don't -- I guess we don't view that we need more IV-E funding for the children that are in out-of-home care. I mean, we claim based on all the federal percentages and claiming and whatnot. We do have a system in Wisconsin where we use the CANS assessment, the Child and Adolescent Needs and Strengths tool, and that's what we use to then match with the foster home or the congregate care setting, so we do try to match in that way. And, of course, when children are in foster care, they're Medicaid eligible, so they can get services via Medicaid as well.

So, I guess, in my mind, again, we're able to keep kids very safe when they're in foster care, but that's not -- but that has other consequences because we're taking them out of their home.

COMMISSIONER PETIT: In Wisconsin -- maybe Susan knows the answer to this. Was it Wisconsin where there was a quite well-known longitudinal study done on kids in foster care what happened --

COMMISSIONER DREYFUS: Mark Courtney's work with --

COMMISSIONER PETIT: -- within the first two or three years of leaving foster care at the age of 18?

COMMISSIONER DREYFUS: Still going.

COMMISSIONER PETIT: And weren't the outcomes lousy --

COMMISSIONER DREYFUS: Yes.

COMMISSIONER PETIT: -- I mean, generally speaking, if you just take a look at the deaths, pregnancies, imprisonments, et cetera? So I'm just wondering in the quest for more flexibility for IV-E, what would you take from the IV-E system to pull forward into the child protection system, given the terrible outcomes for a lot of these kids in foster care as it currently stands?

FREDI-ELLEN BOVE: Right. So I think our hope would be that through investing on the front end in prevention, you would actually reduce the amount of kids that would need foster care. So we would be able to use that money to invest on the prevention side and not -- we would not want to sacrifice services for the kids that do need the foster care.

COMMISSIONER PETIT: Thank you.

CHAIRMAN SANDERS: Thank you very much. That was very helpful.

So as Ms. Bove is stepping away from the mic, I'm going to call Dr. Woods and Dr. Munro, who have our next presentation, up to the mic. And we know then -- we've heard a lot about the system of retrospective reviews, child fatality reviews that we have across the country. I think early on in our proceedings Commissioner Petit emphasized the need to do more prospective reviews and to better anticipate where there might be a tragedy ready to occur, and both Dr. Woods and Dr. Munro have looked a lot at the notion of proactive safety management. We heard about creating a safety culture at our hearing in Tennessee and so Drs. Woods and Munro are here to expand on that. Dr. Woods?

DR. WOODS: Thank you. I started doing this kind of stuff in worlds a little different than yours 36 years ago with a small accident in eastern Pennsylvania, you might have recalled, called Three Mile Island.

I've worked on safety and technology and people and complexity and aviation, space. I was the advisor to the Columbia accident investigation board. We looked at it in operating rooms and investigated accidents across many of these different settings; places that on the surface seem a little different and more technology, perhaps more resources to invest. In those places, we've been working for a long time to extract principles and techniques in order to create higher levels of safety in all kinds of complex human activities.

DR. MUNRO: And I've been working in England using -- I have been using David's work for many years now in England and applying it there. So we're going to do a double act with me linking his work from other areas into the child protection system. I'm also talking about how we've used it in England, and I know it's a different country. I'm also aware that although we all appear to speak English, we don't necessarily use words in exactly the same way. So if you find something I say mysterious, it's probably because my jargon is just slightly different from yours.

We also wanted you to feel able to ask us questions during the course of our presentation, because we're dealing with some fairly strange concepts for you, and so it will be better for you to say that and ask for clarification at the time rather than wait. And I think, perhaps, if you turned on your speakers, the red light would catch our attention and we'd know to stop and ask.

DR. WOODS: So we want to cover two things: One is how proactive safety management from our places and the lessons learned can apply here, and then we want to run through specific things you could do to put a report together on your side. I've been on this side on many, many different groups for many, many different agencies and industries. So it's important to give you some specific directions we think might make a difference.

Now, I start all talks on safety for the last 20 years with these two lines. It all started because in the patient-safety movement, which I helped start in the mid-'90s, I always for some reason was put on after the victims talk, so the surviving mom or dad or spouse, and everybody wants to cry. It's awful. It's terrible hearing about this one person's death. It was unnecessary in a hospital. And then I'm up to talk, right? And what are you going to say, right? So luckily the second line was my last line and I moved it up and it stayed up ever since.

So the two lines are, "The future seems implausible; the past incredible." That actually summarizes about half of this book, that one line, right? The future seems implausible. When you notice proactively signs of trouble and weaknesses and things, they get rationalized away. There's other reasons we can't do things. That won't lead to a failure. That won't lead to a bad outcome. That won't lead to harm. However, once harm occurs and we look backwards, the past is incredible. It was obvious. Why couldn't they see? They clearly are not like me. And that's the situation and the dilemma that the research is all about.

The second line is our responsibility and safety. "Our responsibility is to create foresight; anticipating the changing shape of risk before failure or harm occurs." That's our goal, right? It's not about statistics. It's an ongoing continuous effort, right? We have to anticipate, and no matter how successful we've been in the past, right, we have to continue to recognize the future might be different, the kinds of risks and vulnerabilities will change, the path to harm will change, and it's our job to anticipate and intervene before harm occurs. I don't want to have statistics, right? Statistics are failure. If I have statistics on death, I've already failed.

Now, one more comment on this one is you often will look at places like aviation and say, "They're successful. Let's copy them." I want to reassure you that aviation doesn't think it's that successful, right? They recognize, despite a record of past success, tomorrow could be different; that there are changes in technology, changes in traffic, changes in the environment, there's all kinds of changes going on that might undermine that record of past success.

So proactive safety management is now a requirement for the aviation industry and they are struggling with the word "proactive" because it turns out most of the time when you try to be proactive, you're still reactive. This failure or near failure occurred, this egregious event, as we just heard, what do I do about it looking backwards, right? And, of course, we'll talk about some of the things that happened. The little -- the little picture is just a reminder of when we say human error, right, often it is a systems effect.

So the first key idea that we lay out for the last 30 years is the idea that we have to think about the sharp end and the blunt end. And we've heard this already in the larger system government resources, the fact that you're set up by Congress, versus the practitioners at the sharp end, caseworkers, first- level supervisors, and try to understand what's going on.

DR. MUNRO: Can I just go and mention that David talks about monitored process, and in this case we are not talking about flying a plane, but about engaging with the human family. And it's a human service. It's an emotional service. And so, to me, that's one of the areas in which the literature from other areas of high-risk industries doesn't absolutely translate over, but it has some of the problems. But we do not have inanimate objects to work with. We have families.

DR. WOODS: That's right. The plane doesn't come back and say, "Gee, my cousin, that other plane, didn't get treated very well in maintenance yesterday."

This is our simplest drawing of a system. This is the simplest way we could characterize it in terms of these layers and how they interact as situations change and evolve. So we're here to talk about systems approaches, and it's all captured in this one found photograph. The system was never broken. It was built this way. If you are getting outcomes you don't like, right, that's actually a result of the way the system you have really works.

DR. MUNRO: I was asked by the UK government to do a review of our child protection system in England in 2010. So I -- this was actually one of the starting points for the way I was thinking about it and looking at the previous reformation. I knew I was in a long line of people reviewing and creating recommendations.

And what became very clear was that how every one of the reforms of the previous 30-odd years had been very intelligent in isolation. They had been answers to a specific problem. And what people hadn't realized was that you put it out into the real world and it mixes with other things and then it starts to have really unexpected consequences. And one sort of simple example of that is they started to produce guidance on actual child protection. Very sensible idea. And then they would find those pages, you know, a bit more information you could add. And so over the years it expanded from 70 pages to 400 pages with another 600 pages additional on specific issues. But it meant that it took the -- changed the way that the individual worker could engage with the family, because what became the priority in the organizational culture was process, and the really difficult part of the work, actually in getting through the front door and having an intelligent conversation with a family.

So on this report, as a result of the recommendations I made, the guidance is now down to 90 pages again, but we also have a very skilled work with families being needed. And in England, up until about 1995, child protection work had been the elite branch of social work. People had to be very experienced before they could get in. If they got jobs, they stayed in, and you would have teams of people who were robust and had been together and shared their work for years.

And by the time I was doing my review, it was the biggest disaster area in social work. Recruitment and retention were huge problems. So we had the least experienced people doing the most difficult work in social work.

DR. WOODS: So what we're getting at, as we work through these things, is a variety of factors that say the system's behavior emerges from the interactions of the different parts, right? It emerges from the interactions of the different parts. Changing out components, changing out parts, is not going to make a system work differently, right? The system is going to continue to do what it was designed to do even though that's not what you intended, and we see this over and over again; well-intended interventions that focus in isolation on components and pieces, right, having, right, missing the interactions and not producing the desired effects, and even worse producing counterproductive effects, right?

Think about the example, which is not unique to your world, of this expanding set of procedures and policies. What ends up happening, no one can keep track of all the procedures and policies or they have to make a decision which of all these procedures apply.

Now, I'm going to give -- this is a heads-up. As Eileen runs through examples from your world, at least in England, because that's not quite -- it's one sense your world, not another sense your world -- I want to, as we always do in safety, is use an example, refer to an example from another setting that's not here. Sometimes it's easier to see the principles when you look somewhere else where you don't quite know as much about the details or can't get lost in the details. I didn't pick Columbia Space Shuttle or an aviation accident like Air France 447 or some of these other ones that -- Deepwater Horizon. All of these are classics we cover in our education programs, training programs.

Instead, I picked one from a proscribed fire, right, a proscribed fire. This is the Cerro Grande Fire accident. You're going to see what students analyze using the principles from the book Behind Human Error. This is what they do when we train people to start looking, right, behind the label of human error. Look more than just at a component. Look at more than just, oh, it was those erratic other people who aren't as careful as I am.

And the Cerro Grande Fire is a proscribed fire, something you -- the reason I picked is because there's always a risk. You don't set a fire deliberately unless there's already a risk for a fire happening in an uncontrolled fashion. If you set a fire deliberately, the risk is that it could become an uncontrolled rather than a controlled one that eliminates the fuel.

In this particular case, what did we have happen? We had a proscribed fire. There was a variety of factors that went into it. Notice the -- notice the students' summary of this story and their headline. It's a story of goal conflicts. We'll come back to that. It's not a story of a person who wasn't careful and cavalier about these decisions. And it's an example we can use and at least refer to, at least give you some examples of the kinds of actions you could take.

So let's go to the simple thing here. We said what do you have to do in order to get proactive about safety, and the first thing is you have to escape from hindsight bias. In order to learn after bad events, you have to escape hindsight bias, right, and hindsight bias is this issue that we can look backwards after the outcome and we know exactly what's most important. We know exactly what was the priority. We know exactly what was the critical information.

DR. MUNRO: And I've been doing a number of case reviews in this way. And what I find quite embarrassing is that you can't stop yourself from having hindsight bias. I just know now when I think that caseworker was an idiot, I say it silently, and I know that it's a result of bias and that I need to go beyond it, but I can't actually stop myself looking back and seeing.

DR. WOODS: It is very compelling. The research is really quite overwhelming on this, and you have to take some very specific steps in order to de- bias you. These are biases, that if you want to look at the literature of causal attribution, how do people decide what's a cause, right? What you call a cause, what you call the root of the effect, is actually a process of psychological and social processes, and we laid those out in the original book 20, 30 years ago now, original version of this. We were the first ones to say the reason we weren't learning

effectively from accidents and before accidents was we failed to implement steps to overcome this compelling hindsight bias, right?

Cartoons -- so I'll illustrate this quickly. This is when we had a lot of bad publicity about the Russian Space Station and there was several failures on board the space station. You see the cleaning lady walk into the mission control center and the little guy in the corner says, "A-ha, a culprit at last."

The Cerro Grande Fire, once the fire became uncontrolled and started burning closer to residences and facilities and threatening property and life, these were the reactions from the political elite. Someone made a mistake and we need to find out who. In the case of a -- the origins of the patient safety movement in 1995 that was the Betsy Lehman case in Boston, this was a series of misadministrations in cancer chemotherapy over a two-week period. Many pharmacists, physicians were involved, as well as a set of nurses. The nursing board chairperson said to us, "System? What's a system? I can't blame a system." And we came back to her and said, "Ah, but if you only change out the nurses, the individual people, the same factors that created the conditions for the mistakes to occur, the misadministrations to occur, can recur again."

COMMISSIONER DREYFUS: Can I ask you a question?

DR. WOODS: Please.

COMMISSIONER DREYFUS: Are there any examples anywhere in this country or in the world where the media and the public have such confidence in the processes around these horrible incidents in terms of the investigation, the transparency, when information will be released; that they don't fall as quickly -- I know it's human nature, but they don't fall as quickly into hindsight bias.

DR. WOODS: So in some ways you're going a little beyond hindsight bias and to something we're going to ask you in terms of -- propose to you as a recommendation.

But the example here is NASA, right, and sort of the fact that we've had two major failures as well as some other ones. NASA has a public, independent, well-resourced, thorough process for saying what really went on for doing a deep-systems analysis. If you look at the Columbia accident report, it is not focused on the mission management team lead. It would have been very easy to say, "That person screwed up," and stop there. Instead, they looked at everything about how NASA handled risk and how they changed, and those changes were sustained. And, in fact, I testified to Congress on was NASA sustaining the recommendations of the Columbia accident investigation board over years; and we'll come back because some of those recommendations at big-picture level, all right, address some of the issues you're going to deal with when we get to the fact that you have to deal with limited resources. NASA has to deal with limited resources too. They may look rich compared to you, right, but they actually are under resource crunches too and how to make priority the same in the environment turns out to be important.

Let me draw a contrast. In 2003, within a few months of each other, we had Columbia and we had a death at Duke University Hospital in a trans -- multiple-organ transplant case, Jessica Santillan. And if you look at the difference in those two cases, you have an independent

public investigation -- note the word "independent," we're going to come back to that, right? In the other case, Duke University could not pull the trigger and commission an independent look like we had recommended in the patient safety movement, like the NTSB, the National Transportation Safety Board, and instead the only documents that we have as the public are press releases vetted by lawyers. We do not know what real system changes happened. In the end, they said it was local, it was specific, it was this one thing, and once we fix that, everything's okay. In fact -- so we don't know about the system, systemic factors. We don't know about the changes that went on in the transplant system. And that contrasts the reactions to failure and the follow-up speaks volumes.

DR. MUNRO: Can I just say as well with child protection, I think the level of vitriol in the media is less in some European countries than in the UK; and I think in America you have fairly hostile reactions too. So there are some countries like Norway and Denmark which seem to me to think that when a parent murders a child, the parent is the murderer and that's the person to blame, and so I envy them. But I don't know why it is some countries haven't developed this knee-jerk kind of intent.

But in England, I think it's also become -- it's such an embedded story line. The media know it's a great way to sell papers.

DR. WOODS: Yeah. Let me jump ahead now since we're getting to this.

COMMISSIONER HORN: Can I talk for a second? Because I'm trying to understand what you mean by that. It's not imminently clear to me. So I fly three or four, sometimes five days a week. So I'm obsessed with this television program on The Weather Channel called "Why Planes Crash." And what they do is they -- is they look at an incident and then they do sort of a deep dive and they don't say, "Charlie screwed up. Everything was great, but Charlie screwed up." But they look back and they say what happened, and then they talk about how they made adjustments within the industry.

So I'm trying to understand what you mean by does it -- you surely can't be saying you can't learn anything by -- by looking back on an incident, and maybe you are, in which case I need to read your book - -

DR. WOODS: No.

COMMISSIONER HORN: -- and figure out why that would be the case. But is hindsight bias really much more narrowly focused on, "Hey, the system's fine. It's just Charlie screwed up." Or what is hindsight bias?

DR. WOODS: I'm sorry. The formerly hindsight bias, all right, is an experimental paradigm, right? It's a set of studies, right? If you know outcome, it changes your evaluation of the process that led to that outcome, and the classic study is you take the description of a process, could be in aviation, could be in military decision-making, in anything. Here's the process. In proscribed fires, here's the process for deciding to do a set of proscribed fire. You burn out the fuel. It could be a case of what you were referring to earlier if you've got some warning signs about a family and a child at risk and the question is have we investigated thoroughly enough? Have we followed up long enough or whatever?

So you take the process description and now you attach to it in one case a bad outcome, right, and the other case you attach a neutral outcome and you ask people to evaluate the process. Now, obviously, that's a between-group design, and what you find is compelling evidence in study after study that they -- if you have a bad outcome associated with the same process, people are much more critical about very specific parts of it, so you'll have this was the reason it failed, right? And so an example of de-biasing would be not knowing the outcome.

And so in the book the Field Guides, written by one of my students, all right, this one is how you de-bias the investigation after the fact, right, so that you don't get imprisoned by knowledge of outcome, and that simplifies -- that's the next couple slides -- how it simplifies your understanding of the dilemmas and difficulties that people face. And we're going to talk more about how that works also in the next couple slides.

DR. MUNRO: It means you have to talk to the people involved at the time and get them to think back to what they were thinking and what they saw, what the world looked like to them. You can't just rely on written records in looking back at them.

DR. WOODS: So the second part of this all runs through the techniques to doing this, so there's a lot of stuff to do this and things here, and we're going to hint at a couple of those in a minute here.

So before the accident, also notice what you were bringing up is reacting as opposed to being proactive.

CHAIRMAN SANDERS: Did you get your question answered?

COMMISSIONER HORN: Part of the answer was I'm about to learn a little bit more about the process.

DR. WOODS: So the cartoons here, right, right, here's what the world looks like from a reviewer after the fact in terms of what in this case a physician's world looks like. There's a single bad outcome. They should have seen that coming. There's a relatively limited number of paths. When we drew this one out, we're going, "Wait a minute." Before the fact there's a variety of risks and tradeoffs that people are facing, and that's what we try to highlight. What you tend to miss with hindsight bias is the tradeoffs and dilemmas, the goal conflicts that are out there, the fact that you were working on other things. The example you used is we looked at one case.

DR. MUNRO: Oh, yes. You don't look at base rate. You know, you say, "They should have in this type case done X," and you think, well, how many other children would it be? You know, if you're going to -- for instance, there was one where they -- the mother had said she was going to visit a sick uncle and she was taking the child with her, and that was taken as a realistic reasonable thing to do; and within a week the child had been killed by the boyfriend in the family home. She hadn't actually gone away. And so there was, you know, you should have investigated. You should have checked. That does that mean that every time any child known to you goes to see Granny, do you have to go and get someone to call in on Granny and check the baby's there? You know, how much would it be required? How much of your budget would get used up with it?

Can I also make the point that with -- you brought out very well when you were talking about the bad outcomes in foster care as well as in families is that when you're making decisions in child protection, you're trying to work out which is the outcome with the most probable best outcome for children. It's not for certain. And so with hindsight, people tend to think you shouldn't have considered that was low probability because it did happen. But low-probability events do happen, and after the event they look so obvious, but before the event they looked like low probability.

DR. WOODS: That's the point of that opening line: "The future is implausible." Especially when you consider the limited resources and workload burdens that people are under in doing their roles.

So here's an example of -- they'll be sprinkled through from the Cerro Grande Fire case as part of the standard way we do these analyses after the fact. Different than many of the kinds of standard things you would see, we actually lay out the different kinds of roles and levels that are involved. So we make it less likely for people just to focus in on a single person just at the sharp end. And you start to be able to see what are the kinds of goal tradeoffs and goal conflicts that go on, which they highlighted by the little fire symbols in this case to try to understand it. Again, I take these in part, because this is what a student produced after going through a class and trying to understand how to go behind the label human error, right, both in a reactive, learn from failures, to generalized lessons, but also to start to learn before failures occurred.

I've got a cartoon that sort of illustrates another common belief we have. It turns out not to be right. "Fumbling for his recline button, Ted unwittingly instigates a disaster." And there's a little button there and it says, "Wings stay on. Wings fall off." And this is the idea, again, that we come back and there's a single factor that produced the outcome and that factor we can address in isolation, which we already referred to as not working very well in the systems context.

The actual finding that goes back into the -- into the '80s is often represented by a Swiss cheese diagram. You've probably all seen the Swiss cheese diagram. We can tell you what pub it was first drawn on on a napkin in 1985 in London, the Ramshead. That's an extra credit question on all the tests.

But, basically, the key point is it's multiple contributors, each necessary, but only jointly sufficient, all right, complex phrasing, but actually a simple logic. In modern -- in modern world, it takes multiple factors. People are working hard at all levels of the organization and the larger system to try to figure out ways to make it work. People are well intended trying to make it work. They're struggling with limited resources, difficult decisions to make, uncertain evidence; and so when breakdowns happen, it's multiple contributors. And when we go back to this picture on the left here, my left, you can see that we're actually not focusing on a single role, but focusing on multiple roles and how they interact in the system in order to learn.

So we're not focusing in on a single factor. Root cause misleads us. We're looking for how multiple contributors come together to create the conditions so that we can then intervene and redesign the system to steer it in better directions.

DR. MUNRO: Can I just mention that all of those factors in that slide, they easily translate into child protection. It's very, very simple to apply those concepts. And in particular, the one that -- attention distractions, one of the things that irritates me a lot in the way we typically do child death reviews is that they -- they study how that individual case was managed and they don't ask what other demands did the worker have at the time. And so you always get the impression that that case should have been the highest priority for them because we know that it led to a death; but, in fact, when you do start asking what else was going on, you can find that they actually had cases that were more -- much more blatantly dangerous, and quite rightly they made the decision to prioritize other things, and it's only with hindsight that you now think they should prioritize this one.

DR. WOODS: So in the simplification biases that hindsight's just one example of, you tend to stop working backwards. So if you start with the accident and work this way, right, work that way from the accident back through the layers, you tend to stop too early, right? This is a classic problem in causal analysis.

So actually what we recommend people to do is you start the other way. So I put up that organization chart. Why do we have them do that early? So they don't start with the accident, but they start at the blunt end. So they actually start -- notice the thing here: Blunt end, sharp end, proximal factors, distal factors. So we're looking for multiple factors and how they come together, different roles, different levels. We start in this corner, the upper left, the distal- blunt-end corner, and start trying to understand what factors went on so we don't miss them in our accident analysis. It's very easy to focus and stop down here at the proximal sharp end. This person took this action too late or this person didn't stop in the case of the proscribed fire. They should have stopped when the wind conditions changed, when the extra resources they counted on were no longer available. They should have stopped the plan. But we only know that after the fact because the fire got out of control.

COMMISSIONER RODRIGUEZ: Can I ask a question?

DR. WOODS: Sure.

COMMISSIONER RODRIGUEZ: How do you get that -- how do you get somebody who has a sort of high enough and comprehensive enough view of the system to actually be able to objectively look at what the blunt end -- if you -- if you start there? Because it seems like sort of everybody has their own opinion about what the blunt end systemic factors are depending on what their perspective is.

DR. WOODS: So we teach people a method to do this, right, and focuses on people in any role, in any role, right? And we start with, right, what knowledge are they bringing to bear, what's their mindset. For example, during this one, there was a bunch of pressure because there had been a recent series of arson events. So if there's arson events, there's a higher probability fuel will get started up and you'll have an uncontrolled burn, all right? So there was a lot of pressure to get a controlled burn going because of the arson events.

So there's a variety of things. We look into technique to work back and say, "Well, what's their knowledge? What's their mindset? What's their priorities, right? What are the different goals? How do they relate? Do they interact? Are they conflicting? How are they related to that?"

So we actually teach you a process to go through that. That was the origin of what Sidney, my former student, put together in this.

So our point is that we can run through all this for you here, but that these things actually exist as techniques, that these are cases. This is what a student-level performance does looking at an accident that has some similarities to your industry.

COMMISSIONER MARTIN: So forgive me, but that's kind of my difficulty. I'm having difficulty putting this in my job, right, as I sit on the bench every day. So help me. Is this statement remotely what you're talking about? So I get a case, for instance, and the worker comes in and says, "Judge, this is a dirty-house case." So everyone in my courtroom has an idea about the dirty-house case. They have a bias about what a dirty-house case looks like. And rather than giving me the facts, they're asking me to make decisions based on what everybody saw in pictures from a prior case to be a dirty-house case. Is that kind of what you're talking about, the bias, the historical bias that we rely on?

DR. WOODS: Yes.

COMMISSIONER MARTIN: Okay. And so my position is rather than telling me what I should think about a dirty house, tell me what's so dirty in this house that raises to a risk factor for this three-year- old and why I should take this three-year-old out as opposed to the pictures I saw for a dirty house five years ago. Is that kind of where we're going?

DR. WOODS: That would be an example, yes. I mean, we would bring in many other factors in going back to the beginning. So that's one of the things is where do you start, and you often revise the way you start and then find you have to work further back.

COMMISSIONER MARTIN: And your cottage cheese slide --

DR. WOODS: Swiss cheese, right.

COMMISSIONER MARTIN: Swiss cheese, I apologize. It's Wisconsin. I should get the cheeses right.

Swiss cheese is kind of like everyone has biases and the biases are accumulated, so the worker, the cop, the attorney, the judges all have biases --

DR. WOODS: No. This isn't a bias picture.

COMMISSIONER MARTIN: Okay.

DR. WOODS: Right? We run through the biases. In this one, the issue is in looking for the actual failure to occur, several of the holes of the Swiss cheese have to occur together.

DR. MUNRO: Can I give some sort of example to that; for instance, incomplete procedures. The English procedures are very much designed in reaction to the deaths of young children and yet we have a lot of teenagers who are referred into child protection as well. So there is -- you know, you have to twist the teenager to fit into the image for a six- month-old baby. And then you've got mixed messages about we must always prioritize the safety of the child and we must always meet a KPI, the key performance indicators, even though they're in conflict. You have pressure on how you use your time, so supervision is important, but the

supervisor must always prioritize these other tasks. So the individual worker on that case doesn't get supervision for a month. And then, you know, you get all of these little things so that the quality of the risk assessment and the decisions is faulty.

COMMISSIONER RODRIGUEZ: It's a perfect alignment of problems.

DR. MUNRO: Yes.

COMMISSIONER RODRIGUEZ: That line could have gone through any of them.

DR. MUNRO: Yes. And you can have lots of other cases which don't end in tragedy because something was just slightly different. You get some particular individual --

DR. WOODS: So remember --

CHAIRMAN SANDERS: Commissioner Rubin, I think you wanted to --

COMMISSIONER RUBIN: Yeah. You know, in follow-up, I'm also feeling comfortable, right? You know, we've heard a lot of testimony around safety practice. Honestly, this is the -- I find this the toughest area for me, because I'm sort of what is the recommendation? You know, what is the recommendation? Is there a lot of different approaches? We've heard a lot about aviation, the aviation industry. And I'm thinking, well, we've been talking about safety and child welfare forever, right? And so when I think about safety in a lot of the analogies in terms of human error, et cetera, in medicine, you know, we basically created a bunch of checklists to make sure when we put into central line, that we do it the same way over and over and over again. But that's an instrument, you know, that's a procedure.

When you're dealing with complex family structures and everything else, I'm not sure I'm convinced that it's a direct linear application of the same methodology. I mean, we talk a lot about standards versus rules. You get into a lot of checklists because you think there are certain procedures that need to be followed, and yet that doesn't factor in that every family and its complexity, you're really talking about a set of standards rather than rules and we want to reward standards. And I'm finding it a tension between the applications of very rigid sort of safety theory in complex environments when there's a lot of emotions and you're dealing with people, right?

DR. MUNRO: Well, I think it's some -- you're right. I mean, I would call them principles, guidance principles, rather than standards, in my language. But you then have to look at how can these be best implemented and -- you know, but they are more accurately implemented by experienced workers who have time to stop and think about cases and who have access to colleagues and supervisors to help them critically review what they're doing. So you don't just have the standard. You also think what kind of organization is most likely to enable people to apply those standards and to make that final judgment about this unique family?

COMMISSIONER RUBIN: That's where I've seen the quality service reviews. I mean, I find that to be a nice medium between over -- overly prescriptive rules, but then you -- if you're doing quality service reviews that are focused on subsets of your -- of your clients and families and they're focused on certain standards you're trying to meet, you start to change culture across the majority of your families rather than think that we can somehow pigeonhole the exact

reasons why kids die and, therefore, great checklist to prevent other kids from dying. I'm not sure we've proven that that works.

DR. WOODS: So we could talk about this for a long time. So let me switch slightly the discussion to the proactive side of this.

CHAIRMAN SANDERS: Just before you do that, I think -- did you have a question, Commissioner Petit?

COMMISSIONER PETIT: I do, and as soon as -- if I can let him answer this and then I'd like to --

CHAIRMAN SANDERS: Sounds like you're going to change just a bit to get to -- more further along in the presentations. I just wanted to make sure your question was responded to.

DR. WOODS: Let me respond slightly here. It's a little oblique to the question that you put it in the proactive mode, which is whatever policy/procedural guidance you're providing to people, right, the question is when -- is that sufficient to the conditions? You've just used the example of we had designed it all around the small children and now we have an influx of older children. Do the rules still apply? Well, we design our procedures in the aviation case one by one, and then you have a particular case that happens where it took 23 different checklists in order to handle the event and how do two people coordinate 23 checklists in a couple minutes. Turned out there were four people, because it was a transition in flight, so it went smoothly and there wasn't a problem.

So we're -- the proactive state of this is to review -- not to assume that the procedures are right, but to assume that the world is changing, the risks are changing, procedures that may have been fabulous before, whether they're in the form of guidance or prescription, are no longer a factor.

We go back to that opening line, right? It's anticipating the changing shape of risk. What used to work may not work as well tomorrow because things keep changing.

COMMISSIONER PETIT: The problem -- as someone whose flown about three million miles myself, I say keep up the good work. Don't let up. But here's what I'm wrestling with, and there's an actual dimension of this that may be something you guys are wrestling with.

The fundamental problem for me in getting the more precise identification of what we're talking about here is that there are only about two children per 100,000 that are killed, and many of the families where no child is killed look exactly like the families that did kill the child. So when you're talking about such large numbers of a population you can draw from and so few that will actually experience death among families that look the same.

I mean, to me, I would imagine you got a problem with the airline industry which says there are millions and millions of flights each year and one or two or three or four, five times a year some pilot will drive the plane into the ground. How do you identify who that pilot is out of the millions of pilot flights that there are?

And, of course, to this case the kids are actually living with the person who poses the greatest threat to them. It's not something that they get hit crossing the street. It's the person they live with that is the most danger to them.

So proactively, I mean, I'd like to figure out a way how do you shrink that 100,000 to a manageable pool that you can say, "This is the group that we're going to work with"? And that's why I pointed out when the previous person was speaking about how many were actually already known to them. That, to me, seemed to shrink it somewhat.

But, I mean, I think that's what we're all wrestling with, is how do you do this so you're not having to deputize half the population to watch the other half of the population, right?

DR. WOODS: Right. Right. Yes. You have a difficult problem discriminating or prioritizing, and that's a cognitive issue. I mean, that's what the cognitive sciences are about, trying to understand, and we'll get to that in the recommendations. Not that we have a great answer, but this is the path we would follow. This is what we do in other settings where we have the same problem.

CHAIRMAN SANDERS: Dr. Rubin, was your -- did you get your question answered?

COMMISSIONER RUBIN: I don't think there's a -- I don't think there's an easy answer to that, but I wanted them to know that that's sort of -- I imagine I'm not the only one struggling with sort of thinking about the sort of practical application of this so that, you know, I just -- as you move on, just think about that tension and helping to resolve it.

DR. WOODS: Well, this is practically applied lots of places. I mean, this is -- this is the way a lot of it works.

So the switch is now how to learn before failure. We can keep talking about reacting after the fact, but you're switching us to say how do we think before failures go. And so here's -- here's part of the way we would start.

We say study how people normally create success. Now, remember, we're not focused on a person in the home who will end up being the perpetrator. We're focused on the caseworker in the system and the supervisors in trying to say how are they evaluated? How are they getting information? How are they following up?

So we say start with studying how people normally create success, because most of the times these things don't end up in bad outcomes. And they do that -- just one second -- despite the complexity gaps that follow, the crunches and dilemmas.

So the reason I picked that Cerro Grande Fire case is when we work through the Swiss cheese multiple- contributors kind of analysis, we keep highlighting goal conflicts. More and more goal conflicts come up for different groups and how do you help people navigate those to even recognize goal conflicts? And you mentioned a goal conflict right off the bat here, which is the desire in Wisconsin to not pull children out of families because of undesirable outcomes for them, yet leaving them in the family creates risk as well. So right there is an example of the fundamental kinds of tradeoffs that you're wrestling with all the time.

DR. MUNRO: As an example, in one case where a six-month-old baby had come to a hospital with minor injury and been discharged by the pediatrician and the next day there was a hospital nurse whose job was to look at all the children under the age of one who have been seen in the accident and emergency department to send a notification to the district health visitor so that they knew this family had visited the hospital, and she was far more experienced than the pediatrician, but she wasn't so far junior to that person.

And when she read through the notes, she just felt there is something seriously wrong here. This isn't -- it worried her. And so she was scared to talk to the pediatrician, so she went to speak to the social worker who said, "Yeah. I think you should do something about it." So the two of them went to speak to the pediatrician who agreed to revise her -- to review her judgment. And so they got the baby back in and discovered there was a fractured skull.

And so that health visitor had gone to a great deal of lengths to create success despite the system. She'd actually breached sort of good manners by telling a pediatrician she'd made a mistake.

DR. WOODS: We call this -- the tag line that's popular in the last ten years is work as imagined versus work as intended. This is the chart for the Cerro Grande fire case again from a student team. Look at it on the -- on the rows it's a variety of different roles at different levels and the top work as imagined versus work as practiced, and it highlights the conflicting goals. And, again, it's to go into the details here. Work as imagined is the view from a distance. From a distance we think of -- and we tend to simplify back to the simplification tendencies -- what really goes on? What are the dilemmas? What's the nature of the work? What do they really have to do? And we'll hint at a couple of these in your world. Versus work as practiced.

And so if you look at some of the most recent books from a colleague of mine, Erik Hollnagel, this is where it all starts. It's trying to close that gap, get more information about what really goes on at the sharp end and how it -- how it usually is adequate or better than adequate and try to find the places of expertise. When you can find expertise, you want to analyze it, grow it, and share it. We'll see that more in the recommendations.

Goal conflicts, when we actually look back, again, at the multiple contributors and latent factors in the organization away from the individuals at the scene of the event, we find goal conflicts all the time. I think goal conflicts, especially arising from limited resources and high caseloads, are probably going to be very relevant in your world.

This is an example from anesthesiology that's in the book about the way a variety of conflicts come up. All through the Cerro Grande Fire, our deeper analysis than the typical one allowed us to see these different goal conflicts. Every time we find a goal conflict, we can find a point where we can change the system and make it better. We can help people resolve that goal conflict.

Back to your point, Commissioner Rubin, there is no prescription to tell you how to resolve a goal conflict, right, but we can help people perform better in the face of conflicts in terms of what information they need, and also we can define in advance what do we think is a good and thorough process for resolving that conflict in this case; even though later, with

knowledge of outcome, it may have turned out to be the wrong thing to do, at least because the outcome wasn't good. So we come back and say in advance this is how we want you to handle the tradeoff, right, and that turns out to be very, very important in building positive systems of accountability.

So we look at how people study success, but I want to get to the -- that's the big picture that doesn't -- that's not very satisfying to you. That's a method. That's where we would start. That's a project we would ask you to fund, but you don't have the resources.

COMMISSIONER PETIT: Pleased but not satisfied, yeah.

DR. WOODS: Yeah. Yeah. So I think we can get at it more by discussing the five areas we had for recommendation.

DR. MUNRO: Well, one is about reinventing investigations so that we are using these kind of methods and thinking. And in England, we are now doing that, but you can't do it overnight because you have to build up a group of people capable of doing case reviews in that way, and it's -- it's a very different skill from the way that they are traditionally done.

But we are now getting to the position where we're becoming able to start to collate the findings of those case reviews so that when we have a case review, it's off the local management of the case in our local authority, and we have multiagency case reviews. So we look at what the police were doing and what the schoolteacher and what the family doctor did, but they're at the local level only.

But by having this common methodology, we're now becoming able to pull them together to see what are the problems that keep occurring throughout the country rather than just in one local authority. And I think that will be -- that will be very valuable as we develop that.

DR. WOODS: So one of the things that goes with this is why aviation works is because we have sets of these. It's not just the single one. Let's take the crash in San Francisco, for example. So when the NTSB looks at this, they're looking at a wide array of these kinds of investigations and results. So it's not just looking at single events, but building up a set of cases that you can work through to understand what are these systemic factors that are kind of coming into play in another case. So that we can do things now, right, so they aren't coming into your court where it's already -- we've already had harm.

COMMISSIONER PETIT: Can I ask a question of what you just raised? You mentioned the National Traffic Safety Board.

DR. WOODS: Transportation Safety.

COMMISSIONER PETIT: Transportation. I don't think there's any equivalent or anything that is exacted out as an equivalent. If there is such a responsibility within the federal government, I don't know where it rests. But how important is it that there is this overarching national vehicle for evaluating these things, I mean, if everything crashes? So if they limited themselves to just, you know, one state, they wouldn't have that much information through the whole country.

DR. WOODS: So it doesn't have to look exactly like the NTSB. It's not going to transfer to your industry or other industries directly for many reasons. But the key lessons do apply, and the first one is independence. So NASA in terms of safe accidents doesn't use the NTSB, but they do use independent groups like yourself looking at this. And independence -- we can't stress that highly enough. Not that people in an organization looking at their organization aren't working hard to try to understand it, but, again, you're subject to a variety of pressures that tend to narrow the focus and make it particularly difficult to highlight some of those latent organizational factors, the real systems factors. You tend to focus in on narrow and specific things to just this case that are trying to patch holes in the Swiss cheese when the holes keep moving around expanding, contracting, whatever. You're chasing the holes. You're never going to catch up.

DR. MUNRO: I will say we need to have public credibility, and I think the public are just very skeptical about in-house investigations.

COMMISSIONER DREYFUS: Dr. Munro, I just want to ask you a question. You commented on in the UK that having -- being able to look at all these local cases, as you've talked about them, you're starting to extract data out of that, right? What -- what seems to be happening more or less if there's some larger data?

DR. MUNRO: We are -- we are now in a position to start collating it and I am applying for research funding to do that, yes.

COMMISSIONER DREYFUS: Okay. And is there technology that sits underneath that?

DR. MUNRO: I use NV, the software, for qualitative analysis since that's all quantitative. That's all. And it's England, not the UK.

COMMISSIONER DREYFUS: England, sorry.

DR. MUNRO: Must not insult the Scots.

DR. WOODS: So there's many things we can talk about how to do this. I tried to illustrate with some of the samples from the Cerro Grande Fire analyses, that these are things we're teaching in a variety of settings to do this. But very quickly -- and I think it's actually pretty critical. But if we're really going to start change, as you see the other areas of recommendation, we have to reinvigorate and reinvent the accident investigation process to look at these systemic factors and get away from seeing a single component. That person isn't as careful as we would like. They missed the obvious signs. They made a bad choice.

And it demonstrates, as you'll see in some of the later recommendations, that all layers and levels of the organization, all roles, are jointly committed, right, to the goal of identifying, prioritizing, and minimizing the chance of harm to kids.

So let me give you a quick example. After Air France 447, I was one of eight international experts to go in and revamp Air France's safety management processes. We had a year to do it and we didn't -- we started off and said, "Oh." Because we started looking to all the practices, we went real quick and said, "Wait a minute. We don't need a year for a few of these recommendations. CEO, you have to take charge of safety. Safety has to be critical priority for you. Can't be delegated to others."

And so things like accident investigations they're saying we're willing to learn about what the organizational factors are. We're willing to change aspects of the organization, where it invests resources, and see that we're part of the change process. Not simply that those people are bad and have to do something different, we're all in it together changing all the time being sensitive, creating foresight about what risks are out there that might create harm to kids. And if we're all in it together, we can get somewhere. And we can't build that campaign, we can't build that safety culture shift, until we start to look at accidents, the bad cases, in a new way. This is far from sufficient, but I think it's a necessary first step.

COMMISSIONER PETIT: Can I just say in thinking about what you just said, and I think it's very important, it's exactly what needs to be done, and I don't know how many airplane situations come to the Board's attention each year, if it's 5 accidents, 10, 20, 30, 40, 50.

But in thinking about what we're doing, and I'm trying to translate this over, there are millions of children that are brought to the attention of authority, each one of them deserving some kind of a process like you just described; so, you know, wrapping yourself around that, and then all the different jurisdictions that are involved with all the protection of children.

DR. MUNRO: Can I say there's a lot of ways to learn besides in reaction to a death. So in some cases, you will find doing a study where you look at chronic neglect of under five-year-olds or something like that and you look at how all of the cases are being handled in this way. Then you get a broad lesson both about what's working well and what are the ways in which we're letting these kids down. And, you know, death is only the worst outcome, but there's a lot of children who go through, get known to us for being maltreated, but stay at home and are mildly maltreated and are mildly harmed rather than killed.

COMMISSIONER DREYFUS: So when I think about all those doors and all those potential paths through the Swiss cheese, right, I think about Gary -- Dr. Gary Melton from the Kempe Center that presented to us in El Paso, Colorado, and he kind of reminded this commission to be very careful we don't continue to make the fatal attribution error, and thinking that if we just change conditions for this child and we're not changing the context within which they live their lives every day, that's what makes this field messy, because when I had Dr. Mark Courtney look at all child neglect cases in the State of Washington, what it looked like, we're the social determinants of health. It didn't look like what we were or were not doing. It was housing. It was economics. It was -- it was a much broader picture that was, "Wow, as a child welfare director, I've got a big external job to do, not just an internal one."

So do you feel like this review, this kind of process, would just continue us being fixated on the CPS agency or will we start looking at this broader public health context?

DR. MUNRO: No. It would -- it will be the wider context. The English system is slightly different from yours, in that although there's a social work child protection service, it's only one element of the child protection service; that everybody else has a duty to be involved in safeguarding children. So we already do include them in the process, but there's a growing policy around trying to coordinate the agencies that are working with -- having an influence on family life so that they are jointly promoting good, healthy family life rather than actually putting in factors that make life tough. And, you know, I'm sure you've done some studies of actually checking all the contacts that a family has with all of the public agencies and looking

at the cost of that and thinking we could actually send these children to the most expensive boarding school at half the price. So it is -- it really is important not to think that just one agency can change the quality of life of children.

CHAIRMAN SANDERS: I would also raise the question for the Commission as we deliberate around this. I think you'd raised some great questions, Commissioner Petit.

But I go back to what Fredi Bove talked about with those children known to the system, not known to the system, and I'm not sure we looked at the right variables or we've had the interplay of variables that we've considered in trying to shrink that population. I mean, there could be some things that are still differences between the 38 percent that weren't known to the agency and the 62 percent that were that could help to drive us to better decision making. And I think actually, Dr. Rubin, you've raised the issue of missed appointments with primary care physicians and some combination of visits from law enforcement, things like that, that I don't know that we've actually studied in a way that said we can take the six million investigations and narrow that down to identify better who's at risk.

COMMISSIONER PETIT: I think that's a very good point. A question I've been wanting to ask -- not now, but over the course of what we're going to be doing -- is there a difference in the way that death occurs with kids known to the system versus kids not known to the system; that is, known to the system more physical abuse, not known to the system more neglect. I don't know. But, I mean, I think it would be worth taking a look at there may be lower-grade cases that are not being brought to the table. Kids are still at risk of dying. They're just not due to some aggressive boyfriend that's just gotten out of prison and is back in the home. It's the mother failing to watch the children while they go in the trunk of a car. I mean, those are different intents and motives that are going on there.

DR. WOODS: The second one, I think, plays out a little bit of the example you just mentioned about, some of the indirect indicators you can use. Missed pediatric appointments was the example mentioned.

So where do we get those ideas in other cases and other agencies and industries and companies we work with? We get them by going and talking to the people and observing how or finding the cases where they succeed. What are the hard cases? How do you make it work? How do you deal with those? And we try to focus on what creates success. And then you get these examples of all of a sudden you go, "Oh, well, I figured out something was going on because, right, I noticed this discrepancy."

And now notice the second thing. I followed it up as in the earlier example Eileen mentioned. I could follow it up. I went to another person. I went and made a second effort to shift the routine way this was handled normally; and right there you start to see a culture change, right, which is how you create an environment where that's supported, where that's encouraged, where that's rewarded rather than tamped down, right? So it's not simply noticing that the success comes from noticing this indirect indicator that correlates nicely, but also the process of how do you use those, and what are the barriers to using those? And then you start to get ideas. When you say, "I had to work around this, I had to work around this; well, I do this, but the other people don't because they're too busy and they just stick with the routine, they're not going to get yelled at or blamed because they stick with the

routine and they documented well. So they're okay, but I went further. I stopped going further because I kept getting beaten up or because my documentation wasn't up to snuff for the other people," right? And so all of a sudden you can start to see some of the things that would eliminate holes in the Swiss cheese would make some of those defenses work better, or become more proactive, start to erode and decay, and that's why we often use the phrase "drift to failure," okay? That you have a bunch of things that were sort of working, right, and that they erode and decay, right? As change occurs, there would be some of these other culture and organizational pressures come into play. And if we just focus on the sharp end, we just focus on the last player in the cooking of the lethal stew, as one of my colleagues from England likes to say, we miss all the other ingredients, and often those are the places where not only can we change, but we can change in a way that has a scale effect.

COMMISSIONER DREYFUS: Does that process start to reduce the goal conflicts? So does that process of understanding those best ones and how they handle it, does that start to give you as a policy maker the roadmap for where you have inherent goal conflicts so that you can systemically change that versus just anecdotally addressing it?

DR. WOODS: So goal conflicts can be fundamental or created, right? So some of the them are created by the organizational policies and some of them are fundamental other things. And so in cardiovascular, there's some fundamental tradeoffs on how you manage a sick heart. No matter what you do, it's built into the way sick hearts work and don't work. So you have some fundamental tradeoffs that are out of your control and some that may be -- and you have some tradeoffs that may be in your control, so there's that distinction.

But one of the things we want to do is help people know in advance. So in proactive you help define what are the criteria for being sufficiently thorough even though you're under pressure to be fast and productive, right? So what's thorough enough given you're always under pressure of workload and limited resources to get enough stuff done? And so this is what it means to be thorough and these are the flags that tell you, "I need to shift from being more efficient to being more thorough," right? So there's always a tradeoff between being efficient and being thorough in a real system with limited resources, and we need clear criteria to help people know, "When should I be more thorough? When do I spend more time on this case? When do I prioritize this one versus a different one?"

And so if you help them make that judgment and get flags together and say, "This is one you should be more thorough," and then even if it turns out badly, right -- and it could be badly because you're wasting productive resources. You didn't really need to investigate that case, right? That happens much more often than the reverse which is, "Oh, whoops, you intervened early in one that was headed for true disaster." Usually it comes back, "Well, there was a bunch of other things you could have been doing, a bunch of other cases that should have been treated as a priority."

And so how do you do that in a way that builds this positive forward-looking accountability rather than comes back and says, "You wasted resources or you picked the wrong case." So, again, it's supporting the decision making at the sharp end recognizing they're under limits and they're under squeezes and -- which is what this recommendation is about.

COMMISSIONER RODRIGUEZ: So I think I'm still struggling with the same question I had earlier. I like the idea of a consistent sort of objective analysis. But when you're evaluating what made something work, how do you know what you don't know to look at? So, for example, if there might be a factor in child protection, like it might be a personality trait of a parent, like there's, let's just say, for example, a sense of humor, might be something that gives a parent sort of more capacity, but we wouldn't be looking for that similar variable across cases because we don't think in that way or it could be a smaller living space or there's just so many things that we don't -- we only know what we know. So I'm just --

DR. WOODS: So in proactive safety management, what we actually look for is how do you discover those? So we look at your system and we -- for proactive safety management and say what new things did you discover? What new indicators did you find? Are you still using the same ones you used ten years ago? What are the key things that tell you to prioritize one case over another as an example?

So we don't look at the specific one; like does everyone use, you know, missing pediatric visits. We come back and say which ones have you discovered? Which ones did you disseminate? Which ones did you analyze and find effective and how did you modify them and disseminate them? That's what we study in proactive safety management, because, right, if we wait until we know about something, we're going to tend -- it's going to -- we're only going know for sure when we're reacting to specific cases which probably have harm. What we want to do is notice things early.

So what we try to encourage in a proactive -- this is actually what's going on in aviation today to continue to maintain and increase safety levels, is this effort to go out and measure not how well you found item X. We monitor for X. But how well you discovered you should be monitoring for X and Y and what's Y and why did you come up with that new indicator and do you have a process for doing that? So proactive safety management starts to take on a little more of an abstract quality about how well you as an organization in interactions across the different parts of your organization can do discovery, and then dissemination of what good things you discover.

COMMISSIONER RODRIGUEZ: And can I just ask you from your perspective, have folks in the child protection agency been good at thinking of sort of things to look for and successful cases that are outside of their realm of what we typically look for?

DR. MUNRO: Yes. When we do these reviews, we have a -- well, an interview with an individual worker and we put on the table a list of possible factors for them to consider so that that's encouraging them to think more broadly about the factors that influence them. And the thing that really surprised me was how grateful many of those workers were to have the opportunity to talk through in detail how they had made their decisions at the time; not 100 percent of them. But the vast majority are used to feeling terrified of a child death review and they found this was actually a learning process for them and it made them think about their practice and learn from it. You know, I think there's a lot of capacity in the sector to use this way of working and willingness to use it. There's a lot of courage there because people take on jobs in this area because they actually want to help children.

DR. WOODS: So right now, time, let me hit the last couple. A third area we came up with is the conflict between documentation and actually working and providing services to at-risk children or families. And the question I ask whenever I go into a safety organization is how much of your available energy of your safety group, personnel, the time, the financial things, goes into documentation versus carrying out and discovering, doing the discovery process you just talked about, and versus helping children? And we often find that most of the energy is already dissipated in documentation.

DR. MUNRO: Well, in England, at the time that I did my review, a big study came out of the use of time by social workers, and they were spending 70 to 80 percent of their time in front of computers. And it wasn't just documentation. It was such a terrible software program. It was very laborious and time- consuming to put data in. But, you know, it came out at around that time, and the general public just said, "This is mad. How can you possibly protect children if you don't have any time to go and visit a family home and talk to them?" You know, it was just grotesquely out of balance.

But we have a real difficulty in helping the sector define what documentation is needed to provide a better care because documentation has become kind of a safety blanket. You know, if I've got it documented, we have people who say if it hasn't been written down, it didn't happen. So I do suggest they stop writing down anything about child abuse and it won't have happened. But, you know, it is mad thinking. But it is -- it's created by a level of fear.

And so part of the cultural change is about getting a shared realistic idea of the fact that we're working with uncertainty, that you may be doing your best, but you're never going to solve everything. You may have great interpersonal skills, but that doesn't mean that you'll get on with every family. But creating a shared dialogue about what is the level of good enough practice that you can -- because then it can release your creativity and your full involvement in the work without this terrible paralyzing anxiety that so many people have got, which has been a major factor in losing all the experienced workers.

DR. WOODS: So we end up really with this one, that set us up very nicely, which is, in the end you're really talking about a systems change, a culture-change process. They're always difficult, requires a campaign. We have to design, energize, and sustain a campaign. It starts at the top and it has to catalyze the participation and energy across all the roles in the system and in the expanded view of the system.

We're all in this together and we're all committed to making things work better. We're all committed to sharing information to make it work better for the case.

COMMISSIONER DREYFUS: I just want to remind the Commission this is what Commissioner Henry shared with us in Tennessee, he and his team, of how they're creating this culture of safety. And Commissioner Henry, right, it is starting with him; and if you go back and think about the presentation they made to us, what they're doing with their data, how they're dissecting it through what he called forward-leaning CQI, getting out of the blame-and-shame game, right, and into how do we make this system perform better for kids. And he talked specifically about analyses that came out of that about what -- how -- about worker time, right, I mean, and it precipitated some budget requests and different things that they're doing.

But I just wanted to remind the Commission that we've heard a lot of this coming out of Commissioner Henry in Tennessee.

DR. WOODS: Well, I just found out last month that they, Tennessee, had been using this stuff and they're doing projects and building on these kinds of ideas.

COMMISSIONER DREYFUS: It's impressive.

DR. WOODS: One of his was staff at a recent meeting.

COMMISSIONER PETIT: Yeah. I would also note that issues of litigation, politics, and press are right in the middle of all of this. And part of this stuff, all the transparency of the work that's being done, and to the extent that it's not transparent, those three processes I just mentioned, legal action, politics, and the press, are all over these departments because they believe they're withholding information. We're going to have a discussion on that later today. But for my part, the better the public understands this, the more likely they're willing to support things that aren't absolutely going to guarantee that every child be protected. And if they think the departments are hiding something, then they want to find out that they're hiding something, and that's when we're under the fire.

COMMISSIONER DREYFUS: And don't forget the litigation, right? So you ask them about documentation and saying, "You know, look." But I can tell you having run these systems, preparing for Child and Family Service Review by the federal government and not knowing all those case files are exactly what you want them to be because you don't know the random samples they're going to be pulling; important. And looking at the price tag on litigation, like when I was in Washington State, I talked about 25 and $30 million settlement on these cases and a documentation in that file was crucial.

DR. MUNRO: So it's -- documentation matters. But it's about trying to streamline knowing that you've got limited resources and you've got to allocate your resources to help with children as well as documenting, because having great documents that show that you've done a lousy service isn't really good enough.

COMMISSIONER RUBIN: I'll return to -- you know, I don't think we've met a system that hasn't said they're working on safety in one way or another and they're working a lot and some of them are working more diligently across a model like you guys present today, like Tennessee, for example, and other places. But everyone is doing something around safety. You know, the different foundations that are working with communities or doing stuff they -- and that's been the nature. I think where the -- where the -- where I think in my mind where some of the -- some of this kind of meets practical or standardization across practice and I -- I swear I have nothing proprietary with qualitative service reviews, you know. But those qualitative service reviews in some ways are proactive management and a review can identify those attributes of a system performance and child well-being that you want to measure as a standard across all systems. But what the qualitative service review does is actually indicated and reported actually up in the press and asks the question are they following this standard of practice, but you can identify the attributes for that practice.

I'm trying to see is there a recommendation - - you know, is that what we're trying to do here, to standardize that kind of practice, or is it really a local item?

DR. WOODS: So what was -- proactive safety management in aviation is supposed to. It gets diluted, but it's supposed to look at not your good intentions that you started out with. Everyone talks about starting to transfer and utilize some safety approaches. So the issue isn't that you don't have good intentions and programs and growth and change going on. What proactive safety management says is do you have good ways to show that that is actually producing effects? Are you following through?

Let me take an example from your world, which is you introduced incident reporting -- adverse event reporting into your hospital, right? Proactive safety management would come back and say, "How many of those adverse event analyses led to changes that were more than be careful or change a procedure or policy?" And you went back and reviewed that and you found that very few of them dealt with systemic factors and produced systemic changes in the institution, that would be a failure under -- right, for that organization under a proactive safety management.

If you had a safety practices checklist, that would be a success. We had adverse event reporting. We got this many reports, right? We had this many -- we closed that many reports. We're doing great. The proactive safety management review would come back and say, "No, no, no. You're doing terrible because you're not learning and implementing effectively from your adverse event reporting system." So that's the difference. It's not having something. Proactive safety management says you're looking at is that producing results. Am I getting discovery? Am I dealing with tradeoffs and goal conflicts, right? I can't deal with them all, but tomorrow I can deal with one, right, and the next week I can deal with another one, but that's where five comes in, right? We had to put this one on the list too, right?

We have to acknowledge that this is a chronically under resourced world. Every world we work with has too few resources to handle all the priorities and issues they should deal with. And there are opportunities to innovate ways to cope with this conflict -- fundamental conflict that you're under because of resource limitations.

Building teamwork, integrating -- we find so much value. I wish we had time to talk about it. When you can integrate diverse perspectives, you don't have to have the single best expert. Very nice studies documenting this, right? But if you can integrate perspectives effectively, you can use new technology and web-based techniques to integrate and get extra reviews, let me get a double-check from someone. What's one of the most important things we did in patient safety, even if the implementations are a little diluted, is double-checks, right? Timeouts were supposed to be a way to get a double-check. It gets diluted, but the intent is to get a double-check, right? And we can run through that, you know, in a whole variety of ways, that you could do respecting the limited resources and getting a big boost in effectiveness once you know the critical priority decisions that people are struggling with.

COMMISSIONER RUBIN: That's the Tampa model that we heard earlier in that double-checking and how they built in that review, yeah.

COMMISSIONER MARTIN: But also the multidisciplinary approach, right?

DR. WOODS: Our last slide.

COMMISSIONER PETIT: Can I note? This morning the news, again, was catching us all up on air- bag safety. And now there's a new company that's involved and they're going to release untold millions. But the company that's principally in the line-of-fire right now has produced 51 million air bags and there have been eight deaths. And our Congress, the White House, worldwide forums, let's study this thing. The number of kids killed in this country each day is about eight, and it just generates a much different political and media kind of response.

DR. WOODS: So our ending is, for proactive safety, it just really starts as trying to understand the difficulties and tactics people use to cope with difficulties, and we can think of that in all the roles in the expanded view of the system, not just at the sharp end. This work is precarious. There's uncertainty, dilemmas, and risk, and they're built into the nature of what you do, and they can't -- we can't make them go away.

Pushing initiative down and helping coordinate initiative in the different roles who work directly with families and children in order to maximize their ability to react quickly and to maximize the information we gain in order to continuously improve.

Building reciprocity, how do we help the different roles and the different units and levels work together in a common commitment, as I indicated, with the idea of a safety campaign?

And, in the end, the bottom line is we have to continuously listen to the sources of expertise out there and reinforce and build on those sources of expertise.

And then the ultimate for proactive safety is update. Even if you did it perfect yesterday, right, proactive safety management is you have a mechanism to test is it still perfect tomorrow.

DR. MUNRO: I think we also have to be willing to -- we have to be willing to consider changing any part of the system. You mentioned the problem of the federal review coming in and looking at the documentation. We now don't allow inspectors just to come in and look at the documentation. They have to talk to the workers involved. They have to observe practice to get a view of how the agency functions. Because by only looking at documentation, they were distorting priorities and also getting inadequate pictures. So this way of working brings everything into the frame and, you know, where something is creating problems, then we need to think about can it be altered.

COMMISSIONER DREYFUS: I just want to clarify. The federal reviews do include interviews with workers, with families, with system personnel, with judges, so that the federal review in America is much more comprehensive than just a documentation review.

You said at the beginning, "The future seems implausible, the past incredible." We sat in Utah and had a district attorney, was it -- oh, an attorney general, attorney general, and he said, "I strive -- we need to strive for the day when people aspire to child protection." I think what you've just laid out is how to create the organizational culture that people will aspire to work within, stay within, grow within. You know what I'm saying? And I know that seems implausible to us, but yet we sit here today, and I can't sit here today and say I am just thrilled to death that the two CPS agencies I oversaw in terms of the quality of the culture and the consistency of the work, right? So I just -- I think this is fabulous and it fits in beautifully with what we just learned and how you put in place, again, as Commissioner

Henry said, just this forward-leaning continuous quality improvement culture in an organization. And God knows CPS in this country needs it. So thank you.

DR. WOODS: We need to define it that we're all in it together.

CHAIRMAN SANDERS: Let me -- I just have a final question for Dr. Munro. So, you know, I know we've seen success in other industries and, actually, in the airline industry seen the reduction in fatalities and so forth.

Since you've been doing -- since your report came out in Great Britain and some of the work you've been doing, have you seen any improvements in safety that are measurable?

DR. MUNRO: Well, the government accepted all my recommendations in 2011, but because the government acts very slowly, it was only by 2014 that they had made the big changes to the statutory framework that then allowed for a different work at the front line. And now I'm working with ten local authorities, the government's funding a number of projects to help them use that greater ability and creativity that they've got now. And certainly, I mean, I'm working with signs and safety and implementing how the organization has to change in order to really support that kind of way of working with families. And we've only been going six months, so it's -- it's too soon, but it is being evaluated. So in a years's time, I can give you some information; but in three years' time, I could give you even better information.

CHAIRMAN SANDERS: Did you have one last comment?

DR. WOODS: Well, it will trigger more discussion. We're out of time. There's lots to talk about.

CHAIRMAN SANDERS: Will you be available for the rest of the morning, at least?

DR. MUNRO: Yeah.

DR. WOODS: I'm staying until after lunch.

CHAIRMAN SANDERS: If there are questions, we'll make sure to pursue them. So thank you very much.

I know that Dr. Pearlstein was going to be a little bit late, and I see that he's walked in, but we'll take a -- we'll take a break right now for 15 minutes and reconvene, let Dr. Pearlstein catch his breath, and come back with his presentation, and issues affecting American Indian children later this morning. Thanks.

(Recess)

CHAIRMAN SANDERS: So we will continue with this morning's agenda. And we have the opportunity now really for one of the first times as a commission to talk about family composition and the impact on how it leads to neglect fatalities. And we have Dr. Mitch Pearlstein, who I've known for a number of years, ready to present, but I'm going to see if Dr. Horn has -- I know he knows him well -- has any introductory comments you'd like to make.

COMMISSIONER HORN: Sure. Thank you very much, Mr. Chairman. And first of all, full disclosure, you know, we like transparency in all that we do. I've known Mitch for 20, 25

years. We've actually been co- editors on a book called "The Fatherhood Movement: A Call to Action."

And so I am not a dispassionate person when it comes to Mitch Pearlstein. Mitch is someone who I have incredibly high regard for in a variety of different topic areas. He's sort of a Renaissance man when it comes to public policy and doesn't dabble. He goes deep in lots of different areas. But one place where he has gone deep is really in the consequences of family fragmentation and looking from a really research perspective, empirical perspective, on the consequences and correlates with family structure.

So it's -- I think this is an important issue. We've seen a lot of data that has shown -- that indicates that family structure has some relationship with child abuse/neglect fatalities. And so I thought it was important that the Commission hear from somebody who's got deep subject matter expertise in this topic area to stimulate our conversation. So thank you, Mr. Chairman.

CHAIRMAN SANDERS: Dr. Pearlstein?

DR. PEARLSTEIN: Chairman Sanders, Commissioner Horn, great pleasure to be here. Thank you both very much. I will repeat my nice words in a moment.

Chairman Sanders and members of the Commission, my name is Mitch Pearlstein and I am founder and president of Center of the American Experiment, a conservative and free-market think-tank in Minneapolis. More of the pertinent point this afternoon, I've been writing about family fragmentation and related issues for a long time now, particularly in two books published in the last four years, from Family Collapse to America's Decline: The Educational, Economic, and Social Costs of Family Fragmentation in 2011, and Broken Bones: What Family Fragmentation Means for America's Future in 2014.

More to the personal point, my wife, the Reverend Diane Darby McGowan, and I adopted a little girl almost 20 years ago. She was then five and had already lived through and in more than a dozen short and long placements including a failed adoption. She also was sexually abused while in foster care. Diane and I had had additional involvements with the child protection system in Hennepin County, but those are another day.

And if I can insert here, I received a call from my daughter a little bit before midnight telling me that -- she was crying that her daughter, our granddaughter, is in the custody of child protection in Brown County, South Dakota, which, again, is another story.

As for today, I'm honored to appear before the Commission to Eliminate Child Abuse and Neglect Fatalities, and thank Commissioner Horn for the invitation. And it's also, as I say, wonderful to see Chairman Sanders again.

I'm routinely told it is not good form to open presentations with caveats rather than assertions, as critics claim doing so sounds defensive. But what's needed is empathy and care when the subject is the connections between family fragmentation on the one hand and child abuse and deaths on the other. So let me offer very quick caution before I get to the heart of my remarks this morning.

I will not suggest anything over the next few minutes that will be of any immediate help in significantly increasing marriage rates, which I do believe would lead to less child abuse and fewer child deaths. This absence of a potent solution is the case, for no other reason, than no one anywhere has shown how to increase marriage rates in large-scale ways. This failure only increases my recognition of the severity of the problems this panel faces as well as my respect for your taking them on.

Healthy and violence-free marriages are the only kind I urge, with an emphasis on violence-free.

Millions of kids growing up in single-parent families are doing well while millions of kids growing up in two-parent family homes are not. As Michael Novak, a theologian, has written family life is "so personal, so complex, so angular, and many sided."

I am not indiscriminately beating up on single parents, as millions are raising their children heroically and successfully, as did my wife after her divorce 30-plus years ago.

And it's only fair to acknowledge that I'm also in my second marriage. I used to say I was in my second and last marriage, but Diane didn't like the locution, so I now say I'm in my second and ultimate marriage.

Yet having allowed all the above, the fact remains that as long as the United States likely has the highest family fragmentation rates in the industrial world, we will make far too little progress in protecting children with this Commission making far too small a dent.

Some numbers and trends that I trust you're familiar with: 40 percent or more of all American children now come into this life outside of marriage with the rates higher, often much higher, for different groups and in different communities. For instance, the nonmarital birth rate for U.S.-born African-Americans in Minneapolis was 86 percent in 2014. It was 87 percent in St. Paul.

In 2009, 75 percent of white, non-Hispanic children and 86 percent of Asian children in the United States lived with two parents. Pretty good. This was in comparison to 67 percent of Hispanic children and only 37 percent of black children. But keep in mind that significant numbers of two-parent teams are actually composed of a biological parent and a stepparent.

Cohabiting relationships have exploded in the last few decades. This is pertinent insofar as such ties tend to come apart, especially in the United States, faster than do marriages.

While teenage birth rates have indeed declined significantly in recent years, teenage girls who do have a child rarely marry the baby's father.

And while divorce also has decreased, at least for well-educated men and women, overall divorce rates are generally estimated at between 40 and 50 percent.

Yes. I fully recognize that "stuff" happens, but children are not well served by any of these data and patterns and they're certainly not left any safety.

More specifically, what are scholars learning about the interplay between family structure and the issues you're contending with? In the interest of time, because you're familiar with

the contours of such research and because my central aim, once again, is focusing on what's not said and acknowledged rather than what is. Here are just two findings.

As reported as early as 2002 in the Journal of Pediatrics published by the American Academy of Pediatrics, "Children residing in households with adults unrelated to them were eight times more likely to die of maltreatment than children in households with two biological parents." That's eight times.

Other researchers have found that, "Although boyfriends contribute less than two percent of nonparental care, they are responsible for half of all reported child abuse by nonparents." Which, at the risk of rudeness, leads to a finding of my own.

Using the indispensable "find" feature on my laptop, I reviewed 15 sets of minutes and highlights from previously held hearings of this commission, searching for any of six words: Marriage, marry, marriage, unmarried, fragmentation, or breakdown. I found a total of two references to the word "unmarried" in minutes for the Commission's hearing in Denver and one nonpertinent reference to the word "marry" in minutes for the hearing in Portland, Maine, and that was it.

This actually parallels an ongoing series of events in The Twin Cities. Following a Star Tribune expose last October about how children in Minnesota are falling through child protection cracks, more than 50 times over the last decade to their deaths, Governor Mark Dayton charged a task force with investigating why this had been happening and recommending ways of stopping it from happening again. To be clear, each of the more than 50 girls and boys was already in the system. They were all known by child protection officials.

I wrote at the time that I assumed the task force would cover a lot of ground in subsequent months and then write a report containing more than a few point words. But I also predicted they would never say a word about how fragmented families had anything to do with anything. Best I can tell I was absolutely right.

Why the sidestepping of the obvious? Journalist Heather MacDonald talks about how, for a growing list of politically correct reasons, it has become increasingly difficult to "valorize the biologically two-parent family." Serious discussions, moreover -- this is back to me -- about child protection beget, or ought to beget, serious discussions about the racial aspects of child safety as black children are much more likely to be harmed than other children. Yet completing the point, not too many people or governmental entities are eager to participate in such discussion. With many respects I understand why.

If this were another occasion, I would propose several ways in which to reinforce and in many instances re-institutionalize marriage in the United States. But in the interest of the clock, let me suggest just one: Retrieving our voice about marriage. While the importance of fathers is now widely recognized, more widely recognized than it was - - than was the case for several strange decades starting in the 1960s, many people resist stopping short before getting to marriage and its distinctive and essential contributions. I would say this is manifest in the transcripts noted above. This does not serve children at all well.

Decades of rigorous research have demonstrated that boys and girls growing up in two- parent families, always on average, do better than other kids in every realm and in every way I can

think of, very much including avoiding abuse and deaths. Are we not obliged with as much courage and grace as we can muster to face up to the meaning and consequences of massive family fragmentation head on? I say we are. Thank you very much.

CHAIRMAN SANDERS: Thank you, Dr. Pearlstein.

DR. PEARLSTEIN: Thank you.

CHAIRMAN SANDERS: Any questions or comments?

COMMISSIONER PETIT: Thank you for those comments. First, I just want to acknowledge that the statistics that you enumerated are ones that I think are about accurate. I mean, they are the same kind of numbers that I've seen with respect to that. The question is what do we do about it?

And when we start talking about minorities and disparities, we also need to talk about economics and we need to talk about imprisonment. We need to talk about a host of things that accompany that.

What is it that you're actually proposing when you say -- and I believe that the outcomes are better in two-parent households than in single-parent statistically. But what is it that you're actually proposing or recommending?

DR. PEARLSTEIN: Commissioner, thank you for the question. I'm generally at about 22,000 feet, which was no excuse for not answering the question, and I will. Retrieving our voice, let me give you an example, and I'll get to questions of criminal justice, and my guess is we agree on that. And I'll also talk about, if you're interested and if there's time, the obligation of religious institutions and leaders to get more involved with this.

But in 2008, when then-Senator Obama was running for president, he gave a wonderful Father's Day homily/campaign speech at a church in Chicago which was very well-received by everybody in the church and elsewhere. He spoke eloquently, passionately, powerfully about the importance of fathers. Never once, however, did he use the word "marriage." Never once did he refer to marriage. We have to get over that -- that hump, it seems to me, fully, fully recognizing how difficult all of this is.

COMMISSIONER PETIT: But when you say that, do you mean that we need to get over it and be able to talk about it as a household phenomenon or is there a legal remedy or is there -- I mean, what is it that you would do that would have it back on the table for conversation? What is it that's being proposed?

DR. PEARLSTEIN: Well, at some level, Commissioner, it is simply saying if we have this problem of ramping family breakdown, we have so many kids doing so poorly in so many ways in large part because of that, are we not obliged to at least recognize, talk about what may be at the root of this? Other people cite other roots. This is the root I cite.

What to do about that more specifically, we have to make boys marriageable men. There are to many kids, too many boys in this instance, who are doing terribly, as we all know. What can we do to help them educationally and occupationally and other ways to become marriageable in the eyes of properly discerning women?

One of the areas I focus on where that is concerned is education. More specifically, I'm of the mind that many low-income kids, many kids growing up in very tough situations, would do better; not all of them, but many would do better in a religiously animated school. Hence, I am talking about vouchers. I believe passionately in expanded free choice for everybody, especially low-income people, and the way to do that, for the most part, is vouchers and/or tax credits or educational savings attempts.

COMMISSIONER PETIT: Thank you.

DR. PEARLSTEIN: Thank you.

CHAIRMAN SANDERS: Commissioner Horn?

COMMISSIONER HORN: So one of the things that I found a little surprising is that when you asked the federal government for statistics on who the perpetrators are in child maltreatment in particular for fatalities, they can tell you whether somebody's a biological parent, but they can't tell you whether the parents are married to each other at the time that the fatality occurred, that they don't even ask the question. Do you think that's important for the federal government to know, and if so, why?

DR. PEARLSTEIN: Yes, Commissioner, if for no other reason that the federal government may be the only entity collecting these data and they're inherently, intrinsically important to know.

CHAIRMAN SANDERS: Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: Well, I just want to say that I appreciate you highlighting that it's much more complex than whether parents are married or single, because, obviously, elements of domestic violence and substance abuse play a huge role in determining whether a relationship is healthy; and that oftentimes in the context of child welfare, to keep a child safe, we are actually asking a parent whether they are married or not married to exit a home. So I appreciate that it's not being oversimplified.

But in thinking about your presentation coupled with the last presentation, it also makes me think that we would probably do well as a system if we looked at cases where we do have single parents or teen parents who are very successful in actually raising their children, because I think we have multiple examples of parents who are able to raise their children on their own or who have children young who are exemplary parents, and that we analyze to see what is it that helps make them strong, good parents. Maybe we can direct our policy efforts in that way.

So I very much like the coupling of your two presentations, because it makes me think we could be doing a better job in the system at looking at our successes as well.

DR. PEARLSTEIN: Commissioner Rodriguez, I agree, at the risk of being propria. My wife, as I said before, who was a single parent for a long time, my stepsons who are now elderly at 43, 41, and 39 are all doing very well in every way, and we're very proud of them, but we also recognize how lucky we are.

COMMISSIONER RODRIGUEZ: And I tend to think that probably -- I'm also a member of the single-mother club -- that there's probably more factors other than luck that lead to our success that are institutional supports that we could be providing to families that in other ways are facing some isolation or not having a partner to share with, and that those are some of the ways that we could build our system.

So I think until we start looking with that lens of discovery and sort of careful analysis about what creates success and how we can build that actually into our child welfare framework, then we're not serving families well.

DR. PEARLSTEIN: Commissioner, again, I agree. And in this instance, I think all the time, especially at midnight last night or 1 a.m., about how isolated my daughter is and my granddaughter and the threats that they face. My daughter simply doesn't hang out -- I'm being real direct about it -- with healthy people, with law-abiding people.

We have to find ways of helping single parents be they mothers or fathers, be more connected with good institutions and good folks in the communities. I agree. Thank you.

CHAIRMAN SANDERS: Commissioner Martin?

COMMISSIONER MARTIN: First of all, Doctor, thank you so very much for coming in today.

DR. PEARLSTEIN: Thank you.

COMMISSIONER MARTIN: I appreciate your testimony today. Can you identify some of the elements within a marriage, a general marriage that you find so stabilizing for families? I mean, I certainly agree with your rendition of the statistics that minority children are falling at greater rates. But I'm trying to figure out what it is in a marriage that you see as so stabilizing in general for all children that make them safer.

DR. PEARLSTEIN: Commissioner Martin, thank you. One easy answer is to simply say that's what the research says and the researchers talk about. Well, there are two adults rather than just one looking after and supporting and loving a child. Very important. Research that -- well, let me do it this way.

There's something chemical about this. There's something spiritual. I don't want to get too carried away here. But if one views marriage as more than a contract but as a covenant, there is something it seems often, not all the time, that strengthens that relationship, that strengthens the ties to the kids. Then, again, in the most practical ways, a single parent perhaps not with very much education, when a child is sick, and going back to a question before, that the parent doesn't have sufficient healthcare or more likely the case now simply can't get off work to take the child to the doctor, that's a real problem.

I can tell you when Diane and I adopted Nicole, one of the things I learned very quickly was that if you adopt a special-needs child, as Nicole was, the amount of time it takes visiting psychologists, psychiatrists, lawyers, social workers, programs, is enormous. If I didn't have flexibility in my work life, it could not have been done. More specifically, in regards to your question, if Diane and I were not a team, it could not have been done.

So I would stretch the answer from very practical time constraints on the one hand and financial matters and then something very special in many, not all, relationships. And sorry for my spiritual moment.

CHAIRMAN SANDERS: Let me ask a question, and then Commissioner Dreyfus.

So you mentioned the lack of evidence of strategies or programs that increase marriage and talked about regaining our voice. Can you say, even in the absence of strong evidence, are there promising approaches or practices that have seemed to have some impact on increasing marriages?

DR. PEARLSTEIN: Chairman Sanders, I'm keenly alert to my left is Commissioner Horn, who is one of the nation's great authorities on that very question, and I purposely in my comments said large- scale ways. We haven't had success in large-scale ways. Are there specific programs tasked to various churches and other religiously animated as well as other organizations? Without question. But Dr. Horn led the way, and I'm very, very pleased that he did, seeking to put together programs that were well- evaluated across the country helping low-income men and women who were already married stay that way and who were not perhaps get that way, to become married, and as Dr. Horn is in a better position than I to talk about this. That was very, very difficult.

I suspect, and I know, if one were to do an inventory of religiously animated and other programs in various states and in communities, we would find nice programs. My concern is we've had nice programs and they're not accomplishing enough. How do we get to that next level? And I go back to questions such as having religious organizations become more involved in leading the way, in helping more boys become marriageable men and the like, and without forgetting about making it possible for a lot of guys, in particular who have records -- and my daughter has a record -- to have served their time, to get on with their lives, cleanse the names, protect public safety, so they can indeed get on with their lives. If there was some evasiveness in that answer, my apologies. There are programs out there. We just haven't found the way to take full advantage of them.

COMMISSIONER HORN: Can I just add some specificity to that? So what Mitch is referring to is when I was assistant secretary at the Administration of Children and Families at the U.S. Department of Health & Human Services, we initiated something called the healthy marriage initiative that had three major interventions.

Just the first had to do with dealing with when a lot of researchers, including Irv Garfinkel and Sara McLanahan -- no conservatives either, either of them -- took what's called the magic moment, when a child is born out of wedlock, where they're still in a romantic -- most of them are still in a romantic relationship with each other and are contemplating marriage. And the idea was could we do some intervention at that point to increase marriage rates?

The second one was to provide increased access to low-income couples; not because they are more -- because they're more trouble in any intrinsic way, but because higher-income couples can afford to pay for marriage education and low-income couples have to choose between food and childcare. They rightly choose food and childcare and not marriage education. So we provide free access to marriage education to already- married low-income couples.

And the third intervention was sort of community -- sort of public awareness strategy. Two of those three failed miserably.

There's no impact at all on intervening at the magic moment. In fact, on one side we actually saw an increases in domestic violence, which scared the begeebees out of us. Good news is that we knew about it and we were able to intervene. Other sides saw decreases in domestic violence, but across the sides there was no impact on marriage rates or family stability.

The community interventions showed no impact whatsoever and -- but they also -- we also did surveys and found that nobody in the community even knew there was a community marriage policy. So it's really hard to have impact when nobody even knows it. But the third actually shows some very promising effects, which is providing a skills-based approach to helping low-income couples develop better relationship skills, and all of us can benefit from that, as I said. When we're picking on low-income couples, it's just that, you know, I can afford to pay for marriage education, low- income couples can't.

And what we saw were significant across the board. In six or eight different sites around the country, about 5 or 4,000 couples participated with random assignment. I mean, this was serious evaluation work. This wasn't just, you know, typical ways the government works, which is do an intervention, ask people whether they liked it. This is random assignment, very structured, and we found significant impacts on relationship skills and some impacts on family stability.

So I -- I offer that just for two reasons. One is for those of us who work in this field, we should approach it with a great deal of humility because -- A, because we don't know what works; and the second we should approach it with great sensitivity; but the third lesson is we should not avoid it, and I think that's your message.

DR. PEARLSTEIN: Exactly, sir.

CHAIRMAN SANDERS: We have Commissioner Dreyfus, Commissioner Bevan, did you have -- and then Zimmerman, then Martin.

COMMISSIONER DREYFUS: Thank you very much. This is really a great conversation.

DR. PEARLSTEIN: Thank you.

COMMISSIONER DREYFUS: When I was the administrator here in Wisconsin, folks here from Wisconsin will -- I guess everybody is, sorry, that when we did our brighter futures work and we were looking at wanting to reduce teen pregnancies in the State of Wisconsin, and we studied the heck out of that issue, went all around the state, brought in people, really studied that. And I don't doubt as a person that's been married 37 years to the same wonderful man -- most days he's a wonderful man -- that my children having two loving parents who thought the sun rose and set on their tiny little faces and who was there with them for the good and the bad and who together were a team, it reduced stress in our household and were able to -- right, all the things you said.

But what we found was that what was -- made the difference was when a child had one stable, loving -- and we don't say enough in this country the word "love," right, one stable, loving, caring adult in their life that thought the sun rose and set on their tiny little faces,

was with them yesterday, today, and tomorrow, that that was a key resiliency factor in those youth that did not become pregnant as teens, right?

So I don't doubt that having two parents -- loving parents is critically important to any child. But I also believe those two parents do not have to be a man and a woman; that those can be two loving parents in a household, and that that indeed reduces stress, but I also think a single loving parent, adult, in any child's life is going to set them on a better trajectory than those without it.

And so I think as a nation, I don't want to get into the conversation of marriage between a man and a woman, because I believe marriage can be as beautiful between a woman and a woman and a man and a man, and I happen to love people who are, but I think the issue here is love.

DR. PEARLSTEIN: Commissioner, I have no major or even minor disagreements with anything you have said on the front end. And several months ago at Oxford College in Minneapolis, there was a debate between my counterpart at the progressive think-tank and me. And I did my 12 minutes. He did his 12 minutes. Time for questions from the floor. The very first question: "Pearlstein, what do you think about same-sex marriage?" I said, "Well, that took about 12 seconds." And I simply said, "Done deal." It is a done deal in this country.

I agree that having one absolutely loving adult, one parent, is better than having none. But I would also argue that having two, generally speaking, is better than having one. There are some people who believe that I am Don Quixote, that people who argue as I do, that we have to re-institutionalize marriage, that we're not realistic, that there's no chance, and they may be right, but I'm not willing to concede that.

And by the way, with teenage births, I have written about Milwaukee and the remarkable job Milwaukee has done led by or coordinated by a lot of people, but the United Way in Milwaukee. And I try to get my colleagues in The Twin Cities -- I was on the board of the United Way there -- to do something similar, but I failed.

COMMISSIONER DREYFUS: Thank you.

DR. PEARLSTEIN: Thank you.

CHAIRMAN SANDERS: Commissioner Bevan?

COMMISSIONER STATUTO BEVAN: Thank you for your testimony.

DR. PEARLSTEIN: Thank you.

COMMISSIONER STATUTO BEVAN: I'm very interested in what you're saying, because I think it does impact the topic at hand which is child fatalities, and this commission is about child fatalities and what the known factors are to be protective, to eliminate child fatalities. And to the extent that marriage is a known factor, protective factor, I think it's important that we explore as much as we can everything you know about what some of these other pieces are to this, because you're saying we need to, you know, re-find our voice, and I think we do. We need to find the words, which I don't think we really have. But I do know that we spent a year now and we don't have known -- very known protective factors. Not even money has been

found to be a known protective factor to eliminate child fatalities. Therefore, I am hoping that you can enlighten us with more about what it means to find your voice, how the religious community can help, how charter schools can help, because I think charter schools are power parents and they're more -- that you feel empowered and more likely that you will not feel that desperation that I think happens in terms of abuse. So I would hope that you would be able to talk a little bit more about that.

DR. PEARLSTEIN: Right now?

COMMISSIONER STATUTO BEVAN: Yes.

DR. PEARLSTEIN: Commissioner, when it comes to education, and my background is mostly education, and I am a great supporter of charter schools, they were born in Minnesota, but I'm talking more specifically here about private schools with a religious flavor, religious animation. And in this regard, I think about kids having holes in their hearts where one of their parents, or sometimes both of their parents, might be, and wonder what kind of education might work best for many; never all, but for many. And it just might be a school where teachers and other educators are comfortable in talking about how God loves you, that wants you to do well. Something that's really not possible in public schools. That might -- just might help some kids. I think it will help a fair number, and there's research to show that it does.

Well, how to make it possible for low-income kids to get that kind of education, by definition we're talking about vouchers or tax credits or education, savings accounts.

When it comes to religion, I'll be happy to share with the Commission we did a publication, 34 essays written by 36 people from around the country from Minnesota, about what religious leaders should do to strengthen marriage and reduce out-of-wedlock births, and the consensus view was that religious leaders are not doing nearly enough. I mean, if religious leaders are not doing it, something is amiss, it seems to me. And that is my next focus over the next six months, but I'll be happy to -- to share that piece of research. Again, it's a matter of, as with everybody else for the most part, talking about this, saying it is important, telling young people it is important, knowing something about the research but without turning people into social scientists, retrieving our voice, having the courage, the courage and grace to deal with what I recognize as an extraordinarily sensitive subject, a subject that my wife doesn't like me talking about. I recognize and respect that.

CHAIRMAN SANDERS: Commissioner Zimmerman?

COMMISSIONER ZIMMERMAN: I'm not sure who this is addressed to. You, Wade or to --

DR. PEARLSTEIN: It's addressed to Wade.

COMMISSIONER ZIMMERMAN: Okay. So I think it's asking again from what one of the commissioners has already asked to clarify a little bit more, in that particular study when you said the two failed, but the one that really seemed to -- so did -- did this increased relationship gratification or healthy -- increased healthy relationship, did that -- was there indicators about what made it healthy and were those indicators directly linked to child well-being or child safety or parenting? And if marriage is a protective factor, is it literally just

marriage? Is it a healthy marriage? Is it a -- you know, or is there a marriage -- do we know what the impact of domestic violence is on the well-being of children?

So what are those key indicators within the context of a parental romantic relationship that provides them the opportunity to grow as parents to increase the likelihood that the children will be adequately nurtured and cared for?

COMMISSIONER HORN: Those are fantastic questions and questions -- to get to the first set of questions were ones we were very interested in learning about.

So not only were the studies set up to be able to determine the impact about greater access to marriage education for already married parents on their relationship, but also does that translate into better child well-being? ACF has not yet published the data on the impact on child well-being. Part of that's because it's -- it's a later phase of the study. The idea was that the causal sort of pathway was increase the relationship skills, better relationship with parents, translates into better parenting, translates to better outcomes to kids. So it's an ongoing evaluation. Those results have not yet been released.

But very specifically they did look at, you know, listening skills, empathy skills, problem-solving skills, asked how much support that you felt from your spouse and things like that, and also looked at domestic violence; because we were very, very concerned that whatever we did, we didn't want to make domestic violence worse and we wanted to make it better. In fact, every single program in the initiative was required to work with the local domestic violence council and develop a domestic violence protocol to both identify and intervene in cases where they found that there was domestic violence. So we know the first part. We don't know the second part yet, because that's still an on -- as I understand it, ongoing point of anguish, which they haven't, to my knowledge, released at this point.

In terms of the -- so what is a healthy marriage, which is why we called it a healthy marriage initiative. We didn't call it a marriage initiative. There are people whose success is breaking up. Success is getting rid of somebody who's committing domestic violence. So we were very clear that we were not looking as a primary indicator of outcome marriage rates, because there are some couples that shouldn't be married and some couples that are that should get out of that marriage because it's so destructive. And so it is very clear it's about healthy marriage.

Here's the challenge, in my view, from the research, and it has to do with marriage versus cohabitation. So a lot of people say it's just all of the benefits of marriage are because there's two people in the home; and so, therefore, cohabitation should have the same impacts as marriage rates, if that's the case. The answer is research shows that's not true, and part of that's because cohabitation is so much more less stable than is marriage. There's something about the public declaration that I'm married to this person, committed to this person, that most people go through when they get married. Some people are advocating renewable contracts in marriages these days, but most people walk down the aisle and say this is forever. They don't go, "Hmm, this is for five years and then we'll reevaluate."

In cohabitation, it's a very different contract, you know. It is, "Well, we're in it until -- we'll evaluate as we go along." And so there's no great surprise that it's more unstable. And we

know that one of the things about child well-being is instability causes problems, so when adults go in and out of kids' lives, whether it's multiple foster homes, whether it's multiple adults, that that's usually, not always, but, you know, that's usually not something we recommend.

Now, the one -- just parenthetically the one -- you can tell I know a little bit about this -- the one exception to this is Sweden where cohabitation seems to be just as stable as marriage in Sweden, and the best answer I got to that when I asked that question was from Barbara Dafoe Whitehead. She said, "Well, that's because a lot of Swedes live there."

COMMISSIONER PETIT: I think there's another reason. I think there's another reason on that specific question, and that's the Swedes provide such a strong social safety net irrespective of the income levels of the families or whether they're married or not.

COMMISSIONER HORN: And that -- and you'll get no argument from me. This is not an argument about denying social safety to anybody. So that's not -- please don't misunderstand me in terms of my point.

But to your question, it is about the health of the relationship, and that's very clear. The question is -- you know, I founded a commission, the National Commission on Children, which was the first national commission that came out very clearly and saying that two-parent married households provided protective factors and all caveats that we've talked about. And at the same time, the Progressive Policy Institute and William Galston were also writing papers about the same thing, and there was sort of a breakthrough on the silence that had -- about marriage and the importance of marriage given that -- and, again, chaired by J. Rockefeller, National Commission on Children. You know, he's not -- I don't think he's a fellow scholar to your senator.

DR. PEARLSTEIN: I've always been interested in the Rockefellers.

COMMISSIONER HORN: So, you know, I just think it's something that, you know, if it -- if it is a protective factor or if it does raise the risk of child abuse and ultimately child fatalities, does this commission want to say anything about it? Is that an essential theme? It doesn't have to be the cover story. It doesn't have to be the lead. But should the Commission at least say something about it, and that's the only -- that's my question.

COMMISSIONER RUBIN: I'm just going to put on my own pediatrician's hat. You know, I still practice and I see patients across a wide -- you know, wide lens of socioeconomic status, but I have a large proportion of my patients for Medicaid from West Philadelphia. And, you know, over time it allows me in some ways a qualitative way to kind of observe relationships. And, to me, this is about sort of what you were saying, Commissioner Dreyfus.

Now when I have a family that comes in from West Philadelphia, it's the exception the family who has an involved father. It's just that's the way it works out in my practice every day. I always ask. But, nevertheless, although, you know, 80-plus percent of the women who are coming in as single parents, most of their kids do really well, right?

That said, what I find as unique is that even single parents find ways -- or in many cases there's no parent in the house. It's a grandparent, right, a lot of grandparents, and that's been

a growing demographic in recent years, right? So there's neither a mother nor a father in that home, right? It's very involved grandparents. It's about the strength of those relationships. I think when people are in those environments, they also go to great lengths to extend relationships, you know, whether to kin and families or to neighbors. And so the most resilient kids are kids who have a greater network, and I worry most about isolation and differentiating the single parent who's isolated versus single parent who's created a community.

Now, that said, I will say that even with my best single moms, we always have conversations about men and the influence of men in the lives of these children, and it is a problem. And I -- and I thank you for raising that issue, because there's certain types of mentorship that can be provided by men in the lives of children, and it's no disrespect to the single moms or the mothers who are out there. It's just the nature of the different ways people interact.

And for those who are interested in that dynamic, because you started to talk about this, Commissioner Petit, I just really -- you know, a couple months ago. I just would encourage everyone, you know, here to read about the systematic ways in which we've eroded the role of men and mentoring each other, et cetera. There was -- a lot of times it's hard to find signal from the noise in the press these days, right, and -- but there was a reporter from CNN after the violence in Baltimore, a guy by the name of John Blake who'd grown up in West Baltimore, and I just pulled it up because I was thinking about he wrote an article, Lord of the Flies Comes to Baltimore, and it was written on May 4th, 2015. And I almost feel like it's required reading about some of the systematic dynamics in which we've eroded a culture of mentorship in low- income communities around men, and so I would encourage folks to read it.

CHAIRMAN SANDERS: So I think we'll take two more comments that are out there right now and we'll move to our next presentation. Commissioner Petit and then Commissioner Martin.

COMMISSIONER PETIT: Yeah. I think the individual question of responsibility, marriage, are all important, and we know that single, never married, with children, very high poverty rates. We know that single, previously married, with children, much lower poverty rates. And we know that by far, like single digit, 3, 4 percent, married couples with children have much lower poverty rates.

Having said that, there are macro issues in addition to the individual issues, and one is half the adult prison population in this country is black. Black men are eight times overrepresented in that mix. We seem to be finally opening the door asking ourselves what is it we've done over the last 20, 30 years, because we went from 250,000 people in prison to two million people in prison, which I personally believe just wreaks havoc on African-American communities in particular.

So this question of jobs, I mean, when people get out of prison and they can't get a Class 3 truck driver's license or they can't drive or they can't cut hair, that doesn't seem to me to make somebody be an attractive, marriageable partner on this. So I think that that's an important issue.

The other -- the other piece is that it's always hard to prop up single families, and I know. I have two daughters who were in school for a while. They are having serious problems with employment, serious problems with housing, and because they had children, my grandchildren, I was in a position to say, "I'm going to buy an apartment house and they'll each have a floor until they get through this." But I think how many kids are in situations where that's impossible?

The thing I would note, and maybe it's not marriage, maybe it's complementary to marriage, but I think that what we do need to comment on is a strong background for that, and I don't mean necessarily just teens. I mean people that are not ready for marriage - - ready for children. If we look at what the child protective population looks like, it's often kids that are in households where the parents are just not ready for them. They're not -- they're not strong parents. And that may be something that we need to speak to.

COMMISSIONER MARTIN: So I'd like to just throw out a couple comments. One is Commissioner Horn talked about whether the study that he referred to, whether or not there's causation there, and whether or not they've done the work long enough to draw causation, so I would caution us to be careful about causation too. Is the reason that children in low- poverty households more unstable, is it because of a single-parent household or is it because they live in a low-income environment? So I think there are different issues that may relate to the causation.

If, in fact, we have literature, which I believe we do, to suggest that marriage, good marriages, strong marriages, healthy marriages, are protective factors, that's one protective factor in a series of factors that our families and our children need. So it's not the only factor, but it's one factor. That is not mutually exclusive in saying that single-family households cannot bring up well-developed and healthy children.

I also think we should caution ourselves when we talk about religion, because is it religion or is it spirituality? There are a lot of religions that don't believe in God, but the spirituality behind the religion offers stability, offers comfort, offers a higher being or a higher value to achieve and strive for. So I'm not saying religion is not or a belief in a religion is not a protective factor, but I think that we need to be careful. Is it a particular religion, is it a series of religions, or is it spirituality? And so I think we need to be cautious.

So I appreciate you bringing these to our attention. I think we have to be careful about causation, what is the causal factors, and that's why my first question to you, what are the factors about a healthy relationship that makes kids more stable? Because I think that's where we need to focus. I think that's the issue, you know. If it's X, Y, Z that causes safety for kids, that's where we need to focus. And it may be in all healthy relationships or all healthy marriages, but we have to draw the causal connection. Thank you.

DR. PEARLSTEIN: Mr. Chairman, may I respond briefly? Hardly anything has been said this morning that I disagree with. Sometimes in matters I've agreed.

But when it comes, for example, to factors perhaps other than marriage that leads to stability, it seems to me we talk a lot about these things. We write a lot about these things. What we don't write about enough and talk about enough is specifically what marriage brings.

And when we talk about causality, one of my favorite relevant points, there's a book called Class and School written by a wonderful, well-known education writer by the name of Richard Rothstein. And he writes from the left. I write from the right. And he wrote this book about how low-income kids, kids in poverty, do less well in school than other kids, generally speaking; and that's my argument. But never, with the exception of one or two oblique references in this entire book, does he talk about family breakdown and how family breakdown may have something to do with parents being impoverished. One of the best things I ever learned from a distinguished scholar back at the University of Minnesota, I try not to look at problems as layer cakes. They're marble cakes. Everything swirls into everything else.

And I would just note my final comment; that as we consider that complexity, we recognize marriage as a major factor or lack of marriage as a major factor in all of this.

CHAIRMAN SANDERS: Well, thank you very much, Dr. Pearlstein. You obviously generated quite a bit of conversation on that. And thank you, Dr. Horn, for the recommendation.

DR. PEARLSTEIN: Thank you very much. Great pleasure to be here and I appreciate everyone's candor.

CHAIRMAN SANDERS: And you will send the material that was referenced earlier to the director and we'll make sure we get it.

DR. PEARLSTEIN: Will do.

CHAIRMAN SANDERS: Thank you. So our next set of presenters are all from the Bureau of Indian Affairs. We're very fortunate to have them here to continue the conversation we began in Arizona. And I'm going to let Marilyn Zimmerman take over and do the introductions.

COMMISSIONER ZIMMERMAN: I'm very pleased to have representatives from the Midwest region of the Bureau of Indian Affairs with us this morning.

In Arizona, we focused specifically on tribal issues, and we had the privilege of touring a child advocacy center for the Salt River Pima-Maricopa and have conversations with the National Indian Health Service staff about issues around data, around counts, who knows how to -- how does child welfare sort of get practiced in Indian country. And what's critical to this conversation and what wasn't at Arizona was the Bureau of Indian Affairs.

So child welfare in Indian country is an amalgam of state systems for those 280 states. So a state system can be the child welfare providers -- child protective service providers in for a tribe. A local tribe can 638 contract or compact with the federal government to be funded to provide those services locally for that particular tribe. Or the Bureau of Indian Affairs Human Services Department can pass that funding and responsibility to provide those services. And so it's a very complicated issue.

The other issue is that early on in this conversation, we kept talking about state systems, state systems, state systems, and I kept saying tribes and tribes and tribes, because tribal systems are very, very different than state systems. A very discrete example of that is that state systems have a -- they follow the state regulations and the state laws.

For the Bureau of Indian Affairs, they involve the Code of Federal Regulations in their child welfare practice. It doesn't mean that they don't also do case management and all of those other sort of child protective service supports for families, but ultimately they have to follow the code and the code is the federal code and is very different than state codes. So I'm very delighted to have these folks here. I'm going to let them make their introductions.

Another key piece of the conversation for tribes is jurisdiction, particularly around, obviously, child fatalities. When an American Indian child dies, it depends on where he lives, so it will depend on who will investigate and who will prosecute the crime, if it's indeed a crime against them; they die by a homicide or a neglect.

So very often for American Indian kids living on Indian reservations and they are murdered, the investigation begins not necessarily with the tribal police, though it can; but it then very quickly goes on to the Federal Bureau of Investigation. FBI begins the investigation. From that investigation, the prosecution goes to the state U.S. attorney. And it can be many -- two to three years, and often the families are unaware of the progress of the case as it goes along.

So we're talking about that jurisdiction is an issue that I think is very complicated that I want - - I have wanted and others have wanted on the record for this Commission to be able to really think about how if we're going to talk about child fatalities, we have to think about what it looks like in Indian country, and that's jurisdiction.

And then data. We've had -- I've heard well- respected national advocacy centers say that Indian people don't kill their children, that many of the -- most of the deaths in Indian country are as the result of neglect for a whole host of issues which we've been talking about for the last year. We don't know that's true, and the reason that we don't know that that's true is because we don't have the research and we don't have the data to prove it. And that's a big chunk of what doesn't exist in Indian country, is this we don't know what we don't know because the data doesn't exist.

And so I'm very pleased that the Bureau is here to be able to address some of those issues, talk about it from their own perspectives, and give us insight into potentially recommendations that could very easily be addressed in a -- without a lot of funding, but just with a lack -- or just with a change of protocols and procedures. So welcome. Thank you for being here.

VALERIE VASQUEZ: Thank you. Good morning, Commissioners. My name is Valerie Vasquez. I'm the regional social worker for the Bureau of Indian Affairs. And we're honored today to be part of this very important undertaking as it relates to child protection and specifically how we can address it in Indian country.

I'm here to give a quick and brief overview of the BIA and the tribal relationship. Currently, there are 567 federally recognized tribes. With that there are varying degrees of involvement or relationships that the BIA has with any particular tribe. Tribes oftentimes exercise their sovereign rights as independent nations and are very autonomous of one another.

When I speak to the word "sovereignty," it is meant to define each tribe and having their own separate government independent of our own government and are also citizens of the United States and they also have the right to the same protections against abuse.

As all tribes are autonomous, they are also very different from one another in customs, culture, belief systems, and government, including governing their own communities. With that, some tribes have partnered with their respective states and have agreements, or MOUs, for child protection investigations. There are states where tribes are located that are public law 280 states which includes jurisdictional issues, which Jerin, to my left, will cover.

The Bureau of Indian Affairs ties its relationship to any specific tribe through a contract or compact. The contract for those tribes that are not self-governing tribes, meaning they are 638 tribes; and compacts are those tribes that are self-governance tribes. Self-governance means the funding flows directly to the tribe. 638 tribes the funding flows directly through the Bureau of Indian Affairs and is administered through a 638 contract. And there are also tribes that have no contract at all, meaning we have no relationship at all with that specific tribe.

The BIA and tribal relationship: With the BIA/tribal relationship, all responsibilities are outlined by regulation, as Commissioner Zimmerman had stated, and found in our 25 CFR and which encompasses all the reporting requirements. And some of the issues that she has addressed is the reporting requirements as they do not relate or correlate to the OJS data. It is merely pieces of data and is not comprehensive as it relates to child abuse and neglect fatalities.

Data currently collected does not paint a true picture of what really is going on with respect to Indian children. And then Jerin is --

JERIN FALCON: Good afternoon or good morning. My name is Jerin Falcon. I'm a special agent in charge for the Bureau of Indian Affairs for the Office of Justice Services for District 7. District 7 mirrors the Midwest region. It encompasses Minnesota, Michigan, Wisconsin, Iowa, and Illinois. We oversee about 25 tribal police departments. Some are self- governance, some are 638, and we have one that have BIA law enforcement that actually do the law enforcement on the reservation.

Just a little bit about the public law 280 versus nonpublic law 280, I don't know how familiar you are with that. Public law 280 was started back in the '50s and certain states could opt in; and in those states, the states assumed criminal jurisdiction on the reservation, and some states don't have that. And there's a myriad of them. Like Wisconsin has -- it's a PL 280 state, but the Menominee Nation is exclusive federal and tribal jurisdiction, so the state doesn't have it. So each individual tribe is, you know, kind of its own island. So everything is going to be specific just to that tribe as far as the relationship with the government, the relationship with the state.

So in those PL 280 states, the state assumes the jurisdiction and they also report the crime that's on those reservations. Unfortunately, I think, as far as child abuse, we're finding that in those states, the states don't recognize a differentiation between a child abuse case for Indian country or not. So we're not catching all those stats in all those PL 280 states.

So, for instance, if there's a homicide on a reservation in a PL 280 state, those stats were reported to the state, but it wouldn't be an Indian child in Indian country. So we really don't

have any clue within those states how many of those children that are being murdered are Indian children or not on the reservation. It's a huge gap that I think that we need to look at.

As far as jurisdiction in the non-PL 280 states, it's exclusive federal and tribal jurisdiction. So misdemeanors are handled by the tribes, and anything that starts going up and meets a felony level comes to the Feds, whether it be the Bureau of Indian Affairs or the FBI or, depending on what it is, the DEA could be involved, ATF.

Data collection for Indian country right now, the FBI has the uniform crime reports; and of those crime stats, we collect those and give them to the FBI. So the uniform crime reports that come out that are published -- or actually they go through us, so we report to them what they -- what they want. Right now it doesn't differentiate between a child or an adult homicide.

So the way the records are right now that we report to the FBI, you could have somebody -- a shaken baby that died. All that we would report under the Feds is the hierarchy or -- I guess what it's called is that is the highest crime is what's reported. So that shaken baby would just be considered a homicide and we would have no clue right now if that's a child or not. Same thing with child sex assault that would lead to that baby dying. We would report the homicide and right now miss the child sex assault and miss that it was child abuse. So that's under the UCR reporting.

There is another reporting system called NIBRS, the National Incident-Based Reporting System, that the FBI does have and they are recommending using, and I also would recommend that we try to move to that because it is individually based incidents that we can pull all that data from, but right now it's not being utilized as I think some tribes don't have the technology. And it's not just tribes. It's nationwide. The technology just -- it's out there, but the people don't have it yet. So that would be another big recommendation to try to get us, I think, involved in that; instead of reporting UCR reports to report NIBRS reports. N-I-B-R-S, I think it's what it's -- NIBRS, to report those to the FBI instead and that would really capture a lot more information and we'd be able to break those out.

As of right now, I think we're missing both those aspects, everything from the state, and most of it from the Feds. So that's about it, I guess, I have as far as an introduction. Any questions? We'll have Ms. Greene, I guess, go next.

KERMA GREENE: Oh, hi. I guess one of the things that we developed were some of the recommendations that we thought were pertinent for Indian tribes in our working relationship with them.

One of them is to develop reporting requirements, because like Jerin was saying, law enforcement has specific data that they capture from tribes under their contracts. It's their reporting requirements. And then human services under the Bureau of Indian Affairs has separate data, but there's no correlation between the data that we -- that we have nor have we looked at it in that sense, and I think that's something that is strongly -- we would strongly recommend that we -- with the Bureau's help that we work with tribes to develop data that is in relation to each other so that it gives a true picture of the fatalities that are happening on reservations. And we want it to be consistent and accurate.

In order to do so, we will then need to provide training and technical assistance to the tribes in order to help them understand why they're capturing that data and the importance of the data that they're going to capture for the Bureau, and in a sense for the United States, to see the disparity that happens on reservations for our Indian children. They're the one to provide the resources.

In Indian country, funding is -- has been decreased dearly; and so not only -- and we're talking comprehensively, so we're talking health services, domestic violence, child welfare programs, the law enforcement, judicial systems. It's a comprehensive problem that is going on in Indian country. And if there is an avenue that through this Commission that we can find a way to provide services or resources to the tribes to capture the information to show that there is a definite need to protect our Indian children, then I think that's something that all of us actually are wanting to do.

The other thing I think is important is to develop a longitudinal report, a longevity report, a research report documenting the impacts or the factors that are leading to youth fatalities, you know, from maybe 18 and younger. And we don't -- I have not seen, and I've worked in several different regions within the Bureau of Indian Affairs, where we have not captured longitudinal reports. We have youth prevention reports that are very strong under DHHS, but you don't see a correlation between those prevention programs and an intervention program under the child welfare social services programs, and there needs to be a better correlation between that information. Are the protective factors through our prevention programs actually impacting and safeguarding our children in Indian country? And I think if we can develop a more comprehensive research project, and possibly even link it to the Tiwahe initiative that is taking place under the Bureau of Indian Affairs. Right now there are four tribes that have been selected for Tiwahe, and if we can link that so that we can really capture true research data and follow a family for -- yes.

COMMISSIONER ZIMMERMAN: What is Tiwahe?

KERMA GREENE: Tiwahe, I believe, means family, and the Tiwahe came about because of the great concern in regards to child welfare issues going on on several reservations. I think the tribe that was highlighted the most is at Spirit Lake in North Dakota. Essentially what happened was the tribe was struggling to provide services for child welfare and child welfare protection. Therefore, the Bureau of Indian Affairs had to -- the tribe gave the program back to the Bureau, which meant that the Bureau had to go in and now operate child welfare services for -- for the tribe because they -- they could not function for many reasons; and because of that, there was -- the bureau was able to identify many factors from generational trauma to domestic violence to juvenile delinquency to lack of education, lack of housing. It was such a comprehensive dysfunctional system for a community that not one program, and especially not just the Bureau of Indian Affairs, could address that issue.

So with that there were, I think, three federal agencies that pulled together and said, "Okay, let's do something. Let's try to help at least resolve some of these barriers that are facing some of these families." And so I think it's DHHS, Department of Justice, and Department of Interior were provided resources to pilot three, four tribes that are now going to have the resources to look at the issues of child protection as a comprehensive issue rather than just saying, "Okay, BIA, fix it, you know, because that's -- that's your responsibility to your tribe

that you fix it." No. It's a comprehensive approach finally in Indian country that's going to take place.

And so with that, I think that's what we're talking about here, is if we can tie into what they're already going to be doing with four tribes, why can't we then also develop a research analysis of the progress and success that they're going to make and then also identify some of the barriers that come along with that so that we can improve lives for Indian people in Indian country?

And I agree with Jerin. One of the things that we need to do is to capture our data. We have to develop a better system to capture the data so it's very specific. For instance, under the Bureau of Indian Affairs Human Services, we capture data for Indian child welfare for child protection, but law enforcement has a different set of criteria on the type of information they capture, and we're not linking that information together nor have we trained the tribes to do so. And I think that's something that we need to build upon at least with the Bureau of Indian Affairs with our tribes so that under our contracts and our compacts with those tribes, that we ask them let's -- let's create better data because we need people in Washington, D.C., to see that this is -- this is a huge issue for Indian country. Oftentimes tribes are overlooked, but it really is a huge issue for Indian tribes.

CHAIRMAN SANDERS: Commissioner Rubin, did you want to ask your question now or did you want --

COMMISSIONER RUBIN: Yes. So, you know, I wasn't at the -- I apologize. I wasn't at the Phoenix meeting with you guys because of a conflict, but we've had -- we have had testimony on American Indian issues and just the uniqueness of the way child welfare runs in Indian country, right? And fundamentally I think one of the things I was grappling with in my limited knowledge was this fundamental tension of tribal independence, right, versus a lot of the folks we had testify are the folks who are doing actual child welfare work and they want to do more sort of protection for children and they were constant -- I'm not sure if you had tribal leaders speaking about that fundamental tension, but where is going too far? And so one of the things I think about is the problem we find in child fatalities, is often system fragmentation, and the risk for that is much higher in Indian country because you have two child welfare systems. You've got the state, and that also siphons resources away from Indian child welfare agencies because they're already funding the state. And so I think about, you know, with -- with -- you know, there's all -- there's a compelling case for resources, right, but with resources comes accountability.

And so are there newer models where people are starting to blur the line between Indian child welfare and state authorities and should we be re- envisioning a new model in which when state child welfare is involved in Indian country with the resources that they bring, that it's more about enforcing cultural standards and a new type of caseworker models, rather than like being in the old think about having two separate child welfare systems, you know. I don't -- I don't have an opinion on that, but I think it's the elephant on the table, if you will, like, you know, about that tension, right?

KERMA GREENE: I agree. I think one of the - - there's positive and negative. Because we need to keep in mind that tribes are sovereign nations within their states that they belong, but

they're also state citizens. And so there are tribes that have very proactive and progressive relationships with their states and the State of Washington is one of them.

COMMISSIONER DREYFUS: Oh, you bet they are.

KERMA GREENE: And so -- and I think even here in Wisconsin there -- luckily enough, Indian country is small and everybody knows everybody. And so if there are tribes within the state or tribes even across the nation that are working very well with their states, they share that information with the other tribes so that they can build upon that.

And Wisconsin here also has a very good working relationship with their tribes. In fact, we were lucky enough to reach out to their tribal liaison, Tania, over there because we -- we thought it was important for her to hear what was happening today. And so we -- we invited her to come and listen in.

So I think -- I think states that aren't working well with their tribes should be reaching out to the other states that have a good working relationship with their tribes so that they can -- they can see the -- and also review the evidence, because luckily state systems, child welfare programs, have excellent data systems that capture data because they're required to for ACF for their funding. And so for -- for tribes to either piggyback on state systems, because a lot of times states offer those access to state systems to tribal child welfare programs because they have to share information. So there are good working relationships out there, but I think we can do better.

CHAIRMAN SANDERS: So I have a follow-up question, I think, related to what Dr. Rubin just asked.

The BIA recently obviously issued guidelines around the Indian Child Welfare Act and the -- it seems that with those guidelines that, in part, the statement is that better compliance with Indian Child Welfare Act will improve safety of their children. Is that the Bureau's position and are there -- are there other things that we need to consider as it relates to the Indian Child Welfare Act and compliance that might connect directly to child fatalities and reducing fatalities?

VALERIE VASQUEZ: I think that form or that data collection system is only geared for the Indian children that are in state systems, not in tribal communities. So we're really -- we really need to capture all, not just the state, but tribal communities as well.

CHAIRMAN SANDERS: And, I guess, more specifically, is the belief that it is that compliance with Indian Child Welfare Act, which obviously includes the data, is one of the critical elements for improving safety, or is that an overstatement of the Bureau's position with the recent issuance of guidelines?

KERMA GREENE: I think we're talking about two different issues. The Indian Child Welfare Act is in place so that Indian children can be identified once they've been taken into custody under state jurisdiction for child welfare. That doesn't mean that the state then does not have to involve the tribe, because the tribe has the right then to either transfer jurisdiction or monitor that state case, and many of our tribes end up monitoring the case because, honestly, they don't have the resources under BIA funding or other resources that they've

been able to access to fully provide some of the -- some of the services that a state can provide. And so you're asking if ICWA improves child protection under state, I can't answer that. You need to ask the states whether they think that. I honestly I'm -- I just don't think I can answer that for a state.

COMMISSIONER ZIMMERMAN: I know I'm not supposed to provide testimony, but I'd like to make a comment. I think that critical to the safety and well- being of Indian children and the Indian Child Welfare Act in state and tribal relationships is the fact that there will be the establishment of a very good working relationship if the tribes have a belief and an experience where the state is acknowledging and working within the perimeters of the Indian Child Welfare Act respectfully with tribes. So in one way, yes, because child well-being in Indian country isn't just about safety and well -- that part of the well-being is about being culturally connected to their people.

So, yes, but mostly it's about developing that relationship between state and tribes that's respectful and honors tribal sovereignty by honoring the Indian Child Welfare Act and all the provisions of that act as they do their practice with American Indian children and families.

COMMISSIONER MARTIN: So I think it should be clear that ICWA applies to state courts, right? Tribes are not obligated to follow ICWA. And so asking the question does ICWA make kids safer, Indian kids safer in territories, I think those are apples and oranges, as I understand your question correctly.

CHAIRMAN SANDERS: No. I think Commissioner Zimmerman was getting at it; that it really is -- I mean, we have a specific action on the part of BIA that it seems we need to consider in our deliberation. If the belief is that the Indian Child Welfare Act improves safety, we probably need to think about what position we want to take on that. If that's not the case, then it would be something we'd reference, and that's what I was just trying to get a sense of.

KERMA GREENE: I would like to build upon that. I think that's one of the things, and I think Jerin and I were also speaking about that, sharing that tribal information that is collected by states and is important for Indian country. Because, like I said, once the family identifies as being native and the state sends notification to the tribe or to the Bureau to identify what tribe that family may belong to or may be eligible for enrollment in, it then becomes an ICWA case. But that information then is not reported to the Bureau of Indian Affairs nor is it reported to law enforcement about the factors of why this became a child welfare case, and that data under the states is critical to Indian people and to tribes because we're missing data. So our numbers don't necessarily -- are not a true reflection of child abuse and neglect.

CHAIRMAN SANDERS: Commissioner Petit?

COMMISSIONER PETIT: We've heard that loud and clear from the beginning and the states should provide that data. But what about the data that BIA is supposed to collect? Does it ask the states -- now, specifically, does it ask the tribes, whether on reservation or otherwise, do they ask each year for information on child abuse and neglect per se and fatalities per se? Is there something that we can see? We've been looking for something from the federal government side. Does BIA -- and then you mentioned -- which is buried within interior. They have HHS in which child welfare generally is buried there and then you have DOJ in which

child welfare is even less. It's all modest at those three levels. Somebody at the federal government is supposed to be collecting this information. Is it BIA? Is it HHS? And when you ask for this information, what does the tribe tell you? I mean, I've been to the reservation. I was at the Spirit Lake. I was at the -- what's the other one, rock?

COMMISSIONER ZIMMERMAN: Standing Rock.

COMMISSIONER PETIT: Standing Rock. And the tribes that as I talked to them kept saying, "BIA doesn't let us. BIA won't catch it. BIA won't help us." I mean, what I got was a lot of, you know, "BIA doesn't allow us." And I thought that was sort of a different response than I was expecting.

But, anyways, what is the formal process now in which you are supposed to be -- I think you're supposed to be collecting data on these things. You collect a lot of other stuff. Do you collect data on this and where is it?

JERIN FALCON: The data you're talking about right now we collect as a uniform crime report. So I get them monthly from the tribes and they're collected in our office and we send them to our crime analyst and they send those to the FBI. So those are the FBI uniform crime reports --

COMMISSIONER PETIT: But you said they wouldn't tell you if the cause was, let's say, sex abuse.

JERIN FALCON: Well, we get that from the tribe, but that's not what the FBI is wanting us to report right now.

COMMISSIONER PETIT: So when you get that from the tribe and they say -- from the FBI, the FBI has 20, 30, 40 of these a year, what are you guys doing? Do you have them in one place? Can you say to us there were 30 homicides last year referred to the FBI where a caregiver was responsible for the death of the child? Do you have that?

JERIN FALCON: I believe we can get that information for you, yes.

COMMISSIONER PETIT: I mean, I think one of the things that we've all been looking for is just how many children we're talking about, right? And I know that the states need to do their part, but the tribes, apparently BIA, need to do their part. And I'm just wondering if they've asked, and if they've not asked, why not ask for it?

JERIN FALCON: Right now the uniform crime reports are what we get. Those are what the FBI requires us to get from the tribes. They're sending us data every month on homicide, sex assault, child abuse. Unfortunately, they're not broken down in that uniform crime report to specifics of was this sex assault against a child. It's always, once again, that hierarchy, and that's a federal thing. Under this NIBRS system and what we're talking about, we can change that. That does collect everything that we need. We just need to start utilizing that system instead of this uniform crime reporting system. So we know that if -- if a child sex assault led to a homicide, we know all three of those factors, and with this NIBRS you can pull all three of those and know specifically in Indian country how many are.

COMMISSIONER PETIT: And if someone's been charged, do you know who that is? Do you know whether it's a stepfather or whether it's a mother or whether it's a family member or something? If there's a charge brought against somebody, you're going to know who that is.

JERIN FALCON: Sure. The tribe knows, and we have a really good working relationship with our tribes, our tribal police departments, our tribal courts. I don't believe we'd have any problem if we asked, specifically that information, we could get that.

COMMISSIONER PETIT: David, is that something that staff can in working with BIA, can we actually see what they do have on this thing and then decide whether it gets incorporated into a report or not or we just say, "Look, it's just not great data. Here would be a way to do it better in the future." Or can we say, "Well, this is as much as we do know. We know this much at least."

CHAIRMAN SANDERS: I think so. Commissioner Zimmerman, I know you had a comment. Do you have a comment to that?

COMMISSIONER ZIMMERMAN: I'm just wondering about permissions. So, you know, every federal bureaucracy are you allowed to? I mean --

JERIN FALCON: Well, that's what I'll have to go back and find out, is specifically can we get this and, you know, would it be a timeline. So I can definitely get back with the Commission.

COMMISSIONER PETIT: Yeah. Well, it will be good to know what they're saying, because that's part of what we can report on and make a recommendation on. So if they're not providing it, if they're providing haphazardly, they're providing it inadequately, or they're not providing it because they're invoking something, that would be helpful for us to know that, and then we can make a recommendation accordingly.

COMMISSIONER ZIMMERMAN: So I want --

CHAIRMAN SANDERS: So we will make the request.

COMMISSIONER ZIMMERMAN: Okay. Thank you. I've got sort of a question about the -- sharing the state data systems and what that would look like. Where I come from there is -- there's a tension between the tribes and the state when it comes to funding. So I know you've all heard this. I may -- I'll -- I've probably said it a few times.

The state gets ahold of tribal data and it jacks up the purpose area need for federal grant funding, and then they get funded by justice or SAMHSA or somebody and they don't share the resources with the tribes. So how do the states -- so, obviously, Wisconsin must be one of them.

How do the states and the tribes get over that hurdle where the state wasn't co-opting tribal data in order to get funded without sharing resources, and how do the tribes come to believe that that would actually occur, take the chance?

KERMA GREENE: I think one of the -- one of the best things that is happening for tribes is there - - a lot of them are starting to move towards IV-E programs. That way they can get the federal dollars directly for their child welfare programs. Most of them have difficulty with development of their infrastructure, and so there are -- because of the requirements under

IV-E, especially for our smaller tribes that may not have gaming or other resources to help build their programs, it makes -- going after IV-E funding could be very difficult. And I know like in Rocky Mountain Region, our Montana tribes have developed a very good working relationship so that they do receive some state funding. It's almost like pass-through dollars, it's federal pass-through dollars, that they work with the State of Montana and some of that funding then is funneled down to the tribes. But they still -- the state still provides jurisdiction over those tribal cases and the tribes then monitor what's going on.

I agree that the data that states capture for Indian children, tribes, needs to be more proactive on getting that information from their states so that they can utilize that to increase their numbers, or at least show the reflection from the state information to those tribes so that they can then show that there is a higher need on reservations for our Indian people and our children.

COMMISSIONER MARTIN: So are you suggesting that one of your recommendations is for us to advocate that the Feds make IV-E funding or eligibility more conducive to tribes, right?

KERMA GREENE: I -- I think that would be beneficial.

COMMISSIONER DREYFUS: I think we already have.

COMMISSIONER HORN: I'm not sure we have. What does that mean operationally? Because tribes are now eligible to apply for title IV-E funds.

VALERIE VASQUEZ: I think what that means is for tribes to define their own parameters for IV-E, not one-size-fits-all, and I think tribes need to exercise their autonomy when it comes to funding sources.

COMMISSIONER ZIMMERMAN: The hoops are too big for tribes often to be able to make -- match funds or do a jump-through that states are able to do that small rural tribes aren't able to do. And so, therefore, they're available, tribes can apply, but they actually can't really access them. They don't have the capacity to access them.

COMMISSIONER HORN: I'm not arguing. Please don't misunderstand. I was not arguing with her on things. I just need to know what those are. I think we as a commission can't just go, "Make it easier." We're going to have to say, "These things," because I don't think we want -- there's certain protections that are inherent to title IV-E that states have to adhere to. And I don't think we just want to say make it a -- maybe there are people that believe it, just make it a social services block grant. Then just raise your hand and we'll give you the money and we don't care what you do with it. So I don't think anybody's saying that.

What you're saying is there are maybe special circumstances on the part of tribes that have to be taken into account so that they can access them. All I'm asking for is maybe -- you don't have to do it now, is the more specificity that you can provide to us, what those things are, then we can incorporate that specifically into our recommendations.

COMMISSIONER MARTIN: You had mentioned earlier that you intend to talk with your tribes to bring more recommendations forward in written -- in the form of written testimony. If you don't mind, maybe you could respond to Commissioner Horn's question in that written testimony that you wanted to provide later.

CHAIRMAN SANDERS: Commissioner Bevan and then Commissioner Rubin.

COMMISSIONER STATUTO BEVAN: I did have a IV- E question. Is it what you're saying -- and maybe you can respond later, but is the issue -- two things. I have two things.

One is ICWA. ICWA, as far as I understand it, is an issue of defining an Indian child in the cases of custody with -- right?

VALERIE VASQUEZ: Yes.

COMMISSIONER STATUTO BEVAN: That's the issue. So it's not going to help us with -- I don't think it will help us much --

CHAIRMAN SANDERS: But active efforts is a component and so it -- and it seems like the question is does it contribute to safety. And if there's evidence of that, do we want to adhere to a policy much stronger than we have in the past or not? But active efforts is a major part of it.

COMMISSIONER STATUTO BEVAN: Active efforts in terms of determining Indian child and placement?

CHAIRMAN SANDERS: No, in terms of services.

COMMISSIONER STATUTO BEVAN: Well, back to services. But ICWA doesn't provide services, does it? There's no money.

CHAIRMAN SANDERS: Well, there's an elevated requirement for provision of services. At least one could argue that.

COMMISSIONER STATUTO BEVAN: Okay. Then where does it come from? That's what I don't understand. Where does it come from? Where are you getting your money from if you're having trouble with IV-E? Are you just depending on the states to share? I don't understand where the money's coming from right now.

KERMA GREENE: Okay. So if there is a family that is off reservation and becomes involved with the state child welfare program, the children are then removed and the state has jurisdiction now over those children.

COMMISSIONER STATUTO BEVAN: Right.

KERMA GREENE: If the family identifies that they are Indian child or Indian family, the state has to send notification to the tribe. The tribe says, "Yes. This is an Indian family. Because we are not able to provide services to that family, we will leave the jurisdiction under the state. But we will monitor what the state is providing." And that's where he's talking about -- Chairman Sanders is talking about active efforts. So the tribe then monitors that the state is providing active efforts to reunify that family and also keep them connected to their tribal culture and ways.

COMMISSIONER STATUTO BEVAN: Which is the requirement under ICWA.

KERMA GREENE: That's correct.

COMMISSIONER STATUTO BEVAN: Yeah.

COMMISSIONER HORN: But the payment --

COMMISSIONER STATUTO BEVAN: The payment is still --

COMMISSIONER HORN: -- is coming through IV-E through the state.

COMMISSIONER STATUTO BEVAN: Can we do the state -- what IV-E is -- IV-E's defined by the state Medicaid match, right? So is there a way for tribes -- given the fact that they are sovereign, is there a way for tribes even to develop a formula that would adequately ensure that you have in your own formula, not deal with the state formula, but you have your own formula in terms of what you need under IV-E? Is it possible to even develop it?

KERMA GREENE: The requirements for IV-E funding requires that tribes be able to -- I think what -- what everybody's talking about is how do we make IV- E funding easier access for tribes, because the requirements under the law, they have to meet certain criteria. For instance, because I work for our tribe and I also work for the Corley tribe for child welfare, and one of the things we were looking at was IV-E funding. But the requirements based on how the court orders are written -- because they have to be written in a certain manner and they also have to be done in a timely manner in order for that family even to be targeted for IV-E funding reimbursement.

And then under the time management, you have to track your time very diligently on how you're providing those services to that family in order to get reimbursement for -- from IV-E. So it's -- it's not just one thing under IV-E requirements. There are several factors that many tribes have very -- difficulty in meeting those requirements in order to even go after IV-E funding because their infrastructure does not -- is not in place.

COMMISSIONER ZIMMERMAN: So the tribal courts don't -- aren't able or that's not their general practice on how they write those orders in order for that IV-E funding, right?

KERMA GREENE: That's correct.

COMMISSIONER ZIMMERMAN: Okay.

KERMA GREENE: That's correct.

COMMISSIONER STATUTO BEVAN: Thank you very much.

VALERIE VASQUEZ: I think also another factor too is a lot of Indian families are not in the same home as their -- as their bio parents. Grandmas could be raising their children and there could be a child protection case on grandma. So when a child is removed from grandma -- grandma's home, that child is not eligible for IV-E. So, I mean, that's another huge factor that tribes face as well.

CHAIRMAN SANDERS: Commissioner Rubin and then Commissioner Dreyfus.

COMMISSIONER RUBIN: You know, it seems to me, as we start to deliberate on recommendations, one of the dichotomies I try to sort in my mind sort of saying where do we need to be prescriptive, meaning like this is such a fundamental, foundational problem that

we need -- that this is really federal and this is like -- this is, you know, because it -- because it's impractical for states to really handle this issue. Good example would be like, you know, enforcing military civilian data sharing. Like, you know, the military's made it very clear like we can't be doing that. We travel around the country. So like that's a prescriptive issue.

Now, it strikes me with Indian child welfare, the testimony I've heard over time, because of tribal sovereignty, diversity of tribes, they're going to be prescriptive for one-size-fits-all solution. But what I -- what I wonder and I'm sort of following up with this question, which is, there are certain values or processes that would get you closer to kind of the vision that you want, you know, more accurate data, the more flow of resources, and is there a way to incentivize states to enhance federal match or other ways around the outcomes you're trying to achieve? If they can demonstrate A, B, C, and D, the state would get enhanced -- and that could include some level of evidence of funds-flow, you know.

You know, is there a way of thinking about your recommendations for Indian child welfare that might be more around incentivating -- incentivizing through the way we pay states the kind of behaviors that you want to see so that you can assure that you get the vision for the outcome you're wanting.

COMMISSIONER ZIMMERMAN: How easy will that be?

COMMISSIONER RUBIN: I don't know. It's just a different way. Because that allows states then to really -- and individual tribes to then respond to that and say, "Well, how are we going to do this and what works for us?" And it avoids too much, you know, prescriptiveness, particularly because the unique relationships of that state. So is it integration? Is it availability of treatment resources? Is it data and how we capture data between tribes?

And so I -- I -- this feels to me like that should be the nature of how we think about how we get more resources aligned without outcomes in Indian country.

COMMISSIONER ZIMMERMAN: I think that what -- yes. I agree. That's one way. But I think what's -- what's probably going to be more -- be more likely to be accepted by Indian country by tribes is just straight to tribes, not going through states to tribes, so that the tribes have, you know, the self- determination to decide how they're going to do their child welfare practice without having to access state resources or access state policies to do the work that they know how to do.

COMMISSIONER DREYFUS: So Commissioner Zimmerman, how do you wrestle with the issue that they too -- like when I was in Washington State or here in Wisconsin, they were Washington residents too, that this state had responsibility as well. So how do you -- if it's going to be coming direct from the Feds to the tribes, right, how do you -- how do you wrestle with that -- that issue too, that they are also residents of that state and, therefore, responsibilities, you know, of the state? I always found that to be the difficult part. I just want to say in all my years of working with these 10 tribes in Wisconsin, 23 tribes in Washington State, and Washington State tribes taught me a ton. I wish I had known what I knew in Washington when I was in Wisconsin because I would have been better at it.

Is that -- first of all, this issue of sovereignty, as a -- as a United States of America, we don't know what that means. And the tribes had to teach me what sovereignty meant, right? But I

also had to learn and understand that these two were Washington residents. And what it meant for my relationship with the tribes was very different than my relationship with county governments in Wisconsin; not even close to being the same thing, yet sometimes I think well-intentioned bureaucrats treat them as if they're just, right, counties and that's not the case. They are sovereign.

What I always found was the problem you've got in the ability because -- we had several types in Washington become IV-E; Snohomish, I think, and it's about capacity-building. And the problem you've got is there's no up-front capacity dollars to help a tribe to develop the capacities to work with the state in understanding all the IV-E requirements, right, and how to build those capacities in their courts and whatever. That's a real gap; well-intentioned, but not the capacity.

The other issue though is that there are some tribes that either didn't want to build the capacity or were so small that that just wasn't something they were even interested in considering. Then I think it's beholden on the state to understand. I mean, that -- that you've got to then start delegating resources very differently into those areas, because when you look at your numbers, right, the data is right there in front of you, you've got higher percentages of kids. You've got -- you've got more issues going on there that you've got to start driving resources to. But I also found that we had to do more things like have a tribal unit.

So like in Seattle, right, in our King office we had -- we had units that all they did were the tribal cases. Had incredible relationships with those tribes, understood ICWA. That's the problem you've got. Child welfare systems in this country do not understand ICWA, and I think, Cassie, just as you are always talking about compliance with CAPTA, we've got a compliance-with-ICWA issue, right?

So I guess if I were to say one of the things to Dr. Rubin's point and to what you're talking earlier, is would there be the ability at a federal level where a tribe is interested in becoming IV-E, would there be the ability for access to some capacity- building dollars that I think are a real critical piece of this? I've watched tribes succeed and I've watched them fail, and that's been a critical piece. But is there also the ability for the Feds, sovereign nation to sovereign nation, to provide flexibility and IV-E requirements where tribes have some flexibility that states don't have? Is that feasible?

So, anyway, I just -- this is more complex than simple is all I'm saying. And part of this is do we really understand sovereignty? Are we really compliant with ICWA? Are we holding states accountable to being compliant with ICWA? And I just think that all swirls around this too.

VALERIE VASQUEZ: I really appreciate those comments, Commissioner. My wheels started spinning when you started talking about building -- capacity- building dollars and, you know, where can we find that pot of money. And then you talked about the states and noncompliance of ICWA.

Well, I think that that's your solution right there. States that are noncompliant with ICWA, there should be -- they should be fined as an accountability factor and that pot of money could go right into tribal liaisons to educate.

COMMISSIONER DREYFUS: Do you feel that's part of the CFSRs now? Is there adequate look at states' ICWA compliance?

VALERIE VASQUEZ: No. I don't think so.

COMMISSIONER ZIMMERMAN: The two cases that just --

VALERIE VASQUEZ: I can bet you any -- you know, any amount of money that states will start complying with ICWA if a dollar amount was attached to it.

CHAIRMAN SANDERS: Commissioner Horn?

COMMISSIONER HORN: So I'm just going to, I mean, reinforce that this is complicated and I need much more specificity. Because, for example, when you talk about the court orders, and if we're just going to say we don't have to do the court orders anymore, we're throwing out reasonable efforts not to do removal and we're throwing out contrary to the -- you know, removal -- maintenance over contracts.

COMMISSIONER DREYFUS: You don't throw them out. You cross-walk them.

COMMISSIONER HORN: No. No. So all I'm saying is this demands a level of specificity which I think we have not achieved. If you're talking about capacity-building grants or something like that, that's -- that's something totally different than title IV-E requirements, so -- and because I don't -- I don't think we want to throw the baby out with the bath water.

COMMISSIONER DREYFUS: Absolutely not.

COMMISSIONER HORN: And we don't want to get rid of concepts, which I think are legitimate in Indian country as they are, you know, in the rest of the United States, which is that kids should only be removed when it's contrary to their well-being to stay in the home because they're in imminent danger of being harmed. We don't want to throw out some pressure in Indian country towards dispositional hearings which -- I mean, you know, they're called privacy hearings now, which used to be 18 months and now it's shorter than 12 months, which I still think is at least 6 months too long because the idea that the kids in foster care for 10 months or 12 months without anybody saying what the plan is for that child is -- has always been ridiculous to me and we should force people to do their planning much quicker than that.

So I don't want to -- I just want to make sure that we don't lose sight of -- title IV-E is not this terrible program that was set up by terrible people to do terrible things. It was meant to prevent or to cure some abuses that were going on and it embodied in it a lot of really good things that I think we -- we still -- particularly when we're talking about protecting kids, that we want to make sure doesn't get thrown out.

COMMISSIONER ZIMMERMAN: We just want to make sure the tribe has access.

COMMISSIONER HORN: I need to know what that means. What does it mean when you say the court orders are onerous in Indian country? Which other things are we throwing out or we want? That's all I'm saying.

CHAIRMAN SANDERS: Just a couple of things. I think that to the -- that we should make sure that we have the sufficient background on pieces of this. Because if I'm not mistaken, fostering connections was intended to offer the technical assistance to tribes around IV-E access, and so -- and I know that's received mixed reviews, but the structure was in place there. And tribes have had direct access to waivers now, and Port Gamble in Washington has one. So some of the flexibility then that can be exercised under a waiver for IV-E are now being exercised by at least one tribe.

So I just think that we want to make sure that we're as informed about what some of those elements are right now. Commissioner Zimmerman?

COMMISSIONER ZIMMERMAN: I'd like to change the direction. We've heard a lot from state. So it's not that I'm trying to out anybody in Indian country, whether it's BIA or tribal programs, but -- so I want to preface it we heard a lot from state systems in the last year, year and a half, about those front-line workers and the capacity of those front-line workers to do an effective job, and the kinds of training that those workers actually have and the professional development that states have acknowledged that they need to provide in order to do really, at least, adequate child safety assessments, right?

So could you guys describe the -- describe the diverse levels of education, experience of tribal child welfare workers, child protective service workers, and BIA service workers across the many regions? And, again, not to out anybody, but I just think it's important that we have this conversation for tribes too.

KERMA GREENE: There's a big disparity between social workers, and I use that term as for a bureau employee. In order for me to even be -- take a position as a social worker, I had to receive my MSW. At a tribal level, unfortunately, they don't have the means to attract a qualified MSW worker because they don't have the resources to pay them an adequate wage in order to provide for them, themselves or their families, in a tribal setting. And so we have workers that either don't have the education or they don't even have the child welfare experience but are placed in those positions because they're the only people that were willing to take on that responsibility.

The Bureau does provide training and technical assistance to the tribes that are contracted through the Bureau of Indian Affairs, which means we will then go out and provide them the training or we will find resources that can provide them the training and technical assistance to implement their programs. Unfortunately, because of the budget cuts, it makes it very difficult for tribes to seek out training outside of the Bureau, Bureau's funding, because they just don't have the resources to do so and there aren't very many programs for them. Additionally, education may be difficult for many of their social workers to seek out because they don't have the resources to do so.

The other one is then the state workers, most of the state workers either are BSWs by requirement or they're MSWs by requirement. And so the disparity between the level of education and experience for state and BIA is dramatic between a tribal child welfare program.

COMMISSIONER ZIMMERMAN: So I just want to make a comment -- this is from personal experience and observation -- that very often somebody that -- so BIA Human Services encompasses courts and the management of individualized Indian monies accounts, housing, sometimes juvenile detention, initiative and child welfare has all of those encompassing, and sometimes somebody who is helping families who has a GED who has helped families for, you know, a couple of years manage their individualized Indian monies accounts gets pulled in because they need someone because of the -- you know, there's one social worker to cover two million acres and they need someone to do an investigation. They get pulled in to do that investigation with no background and no training. So do you find that that statement or that description I just gave is true?

VALERIE VASQUEZ: That's a reality. It really is. You know, as far as even Bureau of Indian Affairs social workers, out of all the social workers within the Bureau system, I believe less than half have child welfare experience, and I believe that's a true statement.

CHAIRMAN SANDERS: Well, thank you very much. Any final words that you have, Commissioner Zimmerman, or Commissioner Martin?

COMMISSIONER ZIMMERMAN: I guess my final just to top off this conversation is I would love to see some recommendations around building that local capacity for tribes and for BIA. I know that many -- the Rocky Mountain Region, their FTE, they're at 47 percent. Only -- you know, only 47 percent of the positions are filled. They can't seem to fill them because they're serving tribes that are in isolated, rural, difficult, harsh conditions, harsh weather. You know, a movie theater is 350 miles away and you don't want to go there. People don't want to stay there once they go there because the work is hard and it's isolating.

So if you guys can come up with any wonderful recommendations about capacity-building, about professional development, about what kinds of resources that the Bureau could -- would like to see provided, I would love to have that a part of our recommendations.

COMMISSIONER MARTIN: I just want to personally thank you for coming in again. We are delighted that you were able to come and provide the testimony that I believe was very helpful to the commissioners. And, again, I would encourage you to follow up with the written testimony that you had talked about earlier, including any recommendations you may have for IV-E eligibility, as well as information about the counting and what the FBI can do to request information about designating kids and demographics about the deaths and the other issues we talked about. So thank you again.

COMMISSIONER DREYFUS: Thank you very much.

CHAIRMAN SANDERS: Thank you very much. So we're at a time for a break. We will break for lunch until 1:15. We'll reconvene with the discussion on accountability.

(Recess)

CHAIRMAN SANDERS: So we will go ahead and get started. We've had a lot of discussion over the last number of months about issues related to accountability both at the federal level as well as how the federal government holds states accountable. And so we've put together a panel to talk further about that and look to have as much conversation as possible.

And so we'll start with Dr. Mark Testa. We will follow with Amy Harfeld and then Kathleen Noonan, who's on the telephone.

DR. TESTA: Thank you very much. And I appreciate the invitation to address you today and also to listen to the conversation this morning, because I think it really provides a nice context for the themes that we're going to be discussing in this panel.

So we know that eliminating fatalities resulting from abuse and neglect is a grand challenge, and it is a challenge that is complicated by the fact that child welfare authorities are accountable for safety outcomes over which they are incompletely responsible for the conditions necessary for safe and healthful parenting.

I like to use this distinction, which I've used in my book, between accountability and responsibility to talk about some of the tensions that we've heard about this morning. And even though the two concepts are intertwined, they are separable to some extent, which makes child protection a wicked problem. Thinking about family permanence there. Whereas birth parents are responsible for the safety, care, and well-being of their children, they are not publicly accountable to anyone else for their parenting practices, except in the narrow sense that they should not violate child abuse laws and they should not evade compulsory school attendance or vaccination requirements, but we see even there there are wicked problems; for example, in California about the vaccination law.

And then, conversely, child welfare authorities are accountable for maltreatment prevention outcomes for which they have a weak responsibility for the conditions that contribute to success.

And so I think this incomplete overlap between accountability and responsibility for a child creates tensions that can be resolved when the public authorities take full responsibility for a child; for example, when an investigator takes protective custody of a child deemed at risk of harm or even when a physician takes custody of a medically fragile child.

Alternatively, the tensions may be reduced -- this is the fourth box, weak responsibility, weak accountability -- by narrowing the scope of public accountability to only those conditions which authorities exercise direct control. And as the Judge knows, this occurred in 2004 when court organizations declined to hold juvenile judges accountable for child well-being outcomes when they said consensus did not exist on those outcomes which they were already accountable, like permanency planning timetables and safety in foster care. I think that's changed a little bit, Commissioner Martin, I think.

But as we heard this morning, neither taking full custody of children deemed at risk of harm nor narrowing the scope of accountability to those processes over which authorities have direct control is responsible to the grand challenge that you have, the challenge of eliminating fatalities resulting from child abuse and neglect.

What I'd like to argue is that what is needed is a new system of results-oriented accountability. This system operates on the premise that public authorities are accountable for outcomes that are only incompletely their responsibilities. This requires working with other systems that have weak accountability, weak responsibility. We've heard, for example, hospitals, schools, but also include the military, prisons, Homeland Security. And what

results-oriented accountability requires is building evidence for both the validity of the effectiveness of interventions as well as ensuring the integrity with which interventions are implemented. And that requires working with other systems on a collective impact agenda even though they may only have a weak accountability and weak responsibility. So I think that's the challenge that child protection faces. How do we stay within that maltreatment prevention circle, that square, without necessarily always taking protective custody, which, I think, is one of the knee- jerk reactions when we have child fatalities; and, two, how do we work more effectively with these other systems?

Now, I'd like to argue, and I think this is going to echo some of the work that Kathleen Noonan has done, that accountability for both intervention validity and implementation integrity constitutes a new phase in the evolution of public accountability. I call this results-oriented accountability. Kathleen in her work has called it experimentalist at times. But I think they're very much related. And let me just say that in this context, intervention refers broadly to policies, programs, and practices as long as they're clearly defined and can be distinguished from one or more alternatives. The specified activities is what I mean then by intervention.

And results-oriented accountability evolved because of dissatisfaction with compliance-oriented systems. This was the 427 review process that fellow government have. Often we see in these consent decrees that are highly prescriptive in terms of the staffing ratios; and while they're strong integrity -- implementation integrity, they tend to be weak on validity, which sort of creates this efficacy gap that is even though many courts and many departments have come up with rules that agencies should follow, that they follow those rules. We discovered that compliance in and of itself was not enough to improve outcomes, which then led to, I think, a change in focus to what's known as outcomes-oriented accountability where, again, we're strong in knowing whether or not something improved or not, but we're very weak in knowing why something improved or did not improve. So that creates special challenges in how to scale up successful interventions.

Now, results-oriented accountability is intended to address both these gaps, the efficacy gap and the reproducibility gap, by recognizing sometimes that otherwise valid interventions will not succeed because they weren't properly implemented. Poor fidelity to the proven design or failure to reach enough of a target population. This was a lesson, I think, learned from the Nurse-Family Partnerships and the Head Start experiments that effective interventions can be undermined if they're not implemented with fidelity to the proven design.

At the same time, we may be confident that the intervention we're implementing is being done faithfully, but then they don't have the impact that we had anticipated because they were weak on intervention validity. And I think this is a lesson learned from a lot of the compliance-oriented consent decrees that came early on across the country, and also in the replication of the differential response program in Illinois, which I'll mention at the very end.

Results-oriented accountability builds on these three principles, and I think they're principles that I also heard very much underlie the direction that this panel commission is taking.

One is you don't understand a wicked problem until you've found an evidence-based solution that works. I mean, wicked problem is a term of art talking about interventions that are trying to accomplish multiple and thoughtful conflicting goals.

And, secondly, collective impact, the interconnection, interconnected nature of wicked problems necessitates an interconnected response, and I think I've heard that several times, that this is a system-wide responsibility that we have to do.

And then, lastly, preventing child maltreatment and reversing its adverse effects on future health and well-being, what we learned from the ACEs work, are best addressed within the context of safe and permanent family relationships.

And so I think these are three principles that really we can point to as underlying a lot of the major investments that the federal government has made in evidence-based solutions. They all deal with the interrelated nature. They all deal with success in family settings, subsidized guardianship, post- permanency support, and all of them have a strong evidence base for arguing for why they should be scaled up.

Now, this framework is what social scientists call a phase model of increasingly generalizable studies. And this is how I illustrated it in -- let's see, in the book that I did. And what is striking is how quickly a bipartisan consensus on results-oriented accountability has emerged. I've included my own book in the lineup, but I think better books have come since that time, and all of them are calling for the building of evidence by testing interventions and subjecting their implementation to controlled experimentation. They're using some type of random assignments. We had Commissioner Horn talk about the strengths to the marriage studies that used RCPs or some other comparison design. And I think within extremely broad limits states should be permitted to change almost any aspect of federally mandated laws and policies on a trial basis, and I think I heard repeatedly the call for the use of federal waivers. And so I would hope that one of the recommendations from the commission is that we recognize the continued need for federal waivers and that that be a permanent part of the IV-E program.

Just quickly, this cycle of results-oriented accountability, this was the framework that I used in my book, 2010. It's become the blueprint for a framework to design, test, spread, and sustain effective practices in child welfare, which the Children's Bureau has published and now is guiding many of their federal demonstrations. It's also the blueprint that's being used for their quality improvement centers.

And rather than go through that framework, I just wanted to illustrate it very quickly with Cuyahoga County's pay-for-success initiative, because I do think it illustrates the sorts of demonstrations that we need to begin doing on a regular basis across the country. This was dealing with a problem that often emerges, is that sometimes when we're successful, we create other problems that need to be resolved. Here the case of foster care reduction which resulted in more children staying in foster care for a long period of time, so reducing the front end, the children who come into the system, tend to be the most difficult cases. Therefore, they have challenges for returning home.

They went through this identify-and-explore phase, they looked at the interrelated nature of child welfare problems, and discovered that 30 percent of the parents were involved in the homeless system, so they had to work with homeless authorities in developing their work. They identified two problems and practices, and then began developing a randomized cost-comparison design which will allow them to see exactly whether and how effectively they accomplished their goal of reducing long-term foster care. They set a goal of 25 percent

reduction based on their knowledge that children with parents not involved in the homeless system spend 520 days in care. Where they had a homeless engagement, they spent 678 days. So they're going to try and reduce it.

The important thing for results-oriented accountability is developing what we call a PICO question, P-I-C-O, population, intervention, comparison, outcome. And so any demonstration should be able to create a question like this; and we've also translated this into social science jargon for our evaluation colleagues.

I won't go over this, but I wanted to say in concluding that even though there is often strong evidence base for things working elsewhere, we also have to be careful in not assuming that they're going to work in our particular context or setting.

And here are the findings from the low-cost RCT that raised safety concerns about differential response in Illinois. In this case, the investigation response proved to be safer over 18 months than the differential response, which is the intervention group, which is quite different than what people were expecting. But the important thing is that it has caused the state to re-examine, explore, actually using quality service reviews to figure out how we can understand this unexpected finding better. So thank you very much.

CHAIRMAN SANDERS: Thank you, Dr. Testa. Ms. Harfeld?

AMY HARFELD: Good afternoon, Chairman Sanders, Commissioners, and staff and attendees. After working alongside many dedicated advocates to help get the Protect Our Kids Act passed years ago, it is deeply gratifying and a great honor to have the opportunity to present our testimony here today. You may have gotten used to seeing me, as I've closely followed your work around the country. I am already preparing myself for the day my now-toddler-aged children may ask me if I was ever a groupie of any cool rock bands or anything, and I'll have to confess that the only semi-groupie status I can claim is having followed Eliminate Child Abuse and Neglect Fatalities Commission around this great nation. Don't worry. I'll try to make it sound very cool.

On a more serious note, I want you to know that I and many of my colleagues in the field deeply appreciate your commitment to this work and the sacrifices that it's taken for you to serve on the commission. Like you, I'm here today primarily because the safety of children is a driving force in my career. My commitment to this work goes back to 1995 during my first year as a Teach For America corps member in Los Angeles. There I met Leonard, a 12-year-old scrawny boy who wouldn't look anyone in the eye, couldn't read, never carried a backpack, and came to school every day in his L.A. Raiders jacket no matter how warm the weather or how bad it smelled. After failing to reach his parents on the phone and developing increasing concern about him, I showed up at his house early one evening. He answered the door in a white tank top, and I immediately saw that one of his arms was covered from wrist to elbow in cigarette burns. He was a human ashtray. Even more heart-wrenching though was the look of humiliation, shame, and fear on his face knowing that I had seen. That moment transformed me and ignited an enduring spark to help protect children like Leonard. I began my work in this field of child welfare litigating child abuse and neglect cases for the City of New York. In spite of what you might hear during this testimony, let me assure you of my

deep understanding and empathy for the heavy burdens placed on local and state agencies. I'm proud to serve -- whoops. My slide show.

I am proud to serve now as the national policy director and senior staff attorney at the Children's Advocacy Institute, a nonprofit based at the University of San Diego School of Law. We conduct advocacy on a variety of issues on behalf of vulnerable children with a focus on child welfare and foster care.

Our primary area of concentration for us since 2007 has been the issue of child abuse and neglect fatalities. As you may know, we published two editions of a report entitled "State Secrecy and Child Deaths," first in 2008 and again in 2012. The third edition of this report is under way. This report came about when we learned that many states were grossly out of compliance with their requirements under the Child Abuse Prevention and Treatment Act-mandated public disclosure requirements. With an understanding that we can't fix what we don't know about and that systems can't make well-informed changes without good data, we analyzed and graded each state on whether they were complying with the law in hopes that the grades would serve to commend those who were doing a great job, expose states that were grossly out of compliance, and bring the larger issue to the attention of the public and the federal agency responsible for monitoring compliance. I'd like to acknowledge from the get-go that we know that data is not sexy and not fun. Frankly, I would like -- sometimes I think we place too much emphasis on data. But as we know, resources in the child welfare arena are scarce and precious. As such, it is imperative that within this subset of cases, which obviously represent the worst and most tragic outcomes for children, that we meticulously collect and analyze the data that can show us where the biggest fault lines are and use that information to direct reforms most likely to save children's lives. Greater accountability, transparency, and full disclosure are essentially a protective measure for children. You have all read about too many examples of knee-jerk firings and haphazard reforms that result from individual fatalities that take over the headlines for a day or two. These sorts of reactions may appease the public, but they really just highlight an infective game of whack-a-mole that leaves broken systems intact and more children dead.

The aftermath of our reports has been mixed. Some states such as Utah, Georgia, and Tennessee improved their grades dramatically between the two editions of our report. Many other states made more positive changes. We had expected that this research would be of great interest to the Children's Bureau as well. We provided copies of our reports and met on numerous occasions with relevant top officials at ACF.

Unfortunately, we got nowhere with them. Actually, we got worse than nowhere. After meeting regarding the rather disturbing findings of our reports, we were politely told that ACF does not have an appetite to enforce any punitive measures on states that are not -- that are out of compliance. No sanctions, no penalties, no public censure.

It would be bad enough for them to simply ignore the exposure of states running amok with federal CAPTA dollars, but they also seemed inclined to ignore unambiguous directions from U.S. Congress on the matter. As your briefing book today outlines, Congress instructed ACF with a 2010 reauthorization of CAPTA to develop clear guidelines in the form of regulations instructing states of their responsibilities under CAPTA to release public information in these case was child fatalities and near fatalities. We provided them with suggested language to

accomplish this. But they steadfastly refused to implement regulations. They said it was too time-consuming. They said it was too complicated. They said they needed further input from the states before doing so. Well, that's not what they were instructed to do, and the last time I checked, ACF does not have the authority to determine which Congressional directives to follow and which to flout. It is now 2015, and we still have no regulations to make it clear to states that they must release this information. Furthermore, the acting -- the current acting commissioner of the Children's Bureau has made it abundantly clear that no regulations will be forthcoming. How can the case be made for greater investments to improve the system without the data that can make the case -- I'm sorry, without the data that quantifies the need for such investments?

Why, you may ask, are these restrictions -- are these regulations so important? Well, they're important because they're enforceable. Short of amending the statute, that's the only mechanism that we have to compel state compliance.

Since 2012, ACF has made half-hearted motions to amend the nonbinding Child Welfare Policy Manual to address some of these concerns. I wish I could tell you that at least the policy manual was consistent with legislative intent of CAPTA and with the directive of the Health Committee, but it is not. In fact, the current guidance pertaining to the disclosure provision is so permissive that it allows states to withhold disclosure of information about any case simply on the basis that it could cause harm or even just embarrassment to any person in the family, including the perpetrator of the abuse. That's right; not the child victim or the surviving siblings by the perpetrator. The question of who does have a legitimate expectation of privacy in these cases is a very important one for you to consider. Is it the victim, the survivors, the siblings, other family members, caseworkers, casework supervisors? We agree with several commissioners that meaningful disclosure that leads to data-driven reform can be accomplished without interference and ongoing criminal prosecutions and without embarrassment to survivors or their siblings. But certainly confidentiality provisions were not intended to be so broad as to protect the feelings of the person who killed or nearly killed the child over the safety of surviving children or siblings.

Last month, ACF solicited feedback on the manual's guidance around this again. We duly submitted ours and provided them to you. But let's not be fooled. ACF is still on the hook to enact binding regulations on this, not optional guidance in the policy manual that we know states will ignore.

Our frustration with this pattern of apathy and inaction by ACF spurred further research through a wider lens. Earlier this year, we published another report entitled "Shame on U.S.-Failings by All Three Branches of Our Federal Government Leave Abused and Neglected Children Vulnerable to Further Harm." The report has been brought up several times by this commission, and it's no coincidence that its name harkens back to the original report on fatalities 20 years ago entitled "A Nation's Shame." In "Shame on U.S.," we outline how the array of federal child welfare laws on the books are weak and inadequately funded, detail the nearly invisible role that ACF has played in oversight and enforcement, and discuss the disturbing trend within the judiciary to decline standing to petitioners seeking to enforce their rights under these statutes. There isn't time today to review our findings in this report in detail, but we encourage you to review them as relevant provisions. Although the report does

reflect a grim state of affairs, it concludes with a list of concrete recommendations for each branch of government to remedy some of the worst problems and get us on the right track.

Which brings me to our requests of you today. At the end of your work on this commission, you will submit a report with recommendations that you deem most critical to your mission to eliminate child abuse and neglect fatalities and near fatalities. As you know, the opportunity an independent, nonpartisan, high- profile commission like this comes along but once in a generation. So your task is awesome.

We would like to distill our findings and concerns into three recommendations for you to consider including in your report, several of which I was happy to actually see in the materials I was given this morning.

Number one, amend CAPTA. Frankly, all this debate around regulations and the Child Welfare Policy Manual is irrelevant if CAPTA itself were simply amended. During the next reauthorization of CAPTA, the language related to public disclosure of child abuse fatalities and near fatalities needs to be clarified and strengthened significantly, and adequate funding provided to states so that they can meaningfully execute those changes.

Then we need to specify more a robust oversight, evaluation, and enforcement across the board. The various players responsible for public disclosure need to do their jobs and we need to make sure that we have mechanisms in place to see that happen.

We have to have closer Congressional oversight at ACF. The relevant Congressional committees with jurisdiction over CAPTA should get public -- should get publicly available quarterly status updates through the interagency workgroup or another body. If it is found that ACF is not fulfilling their role in oversight and enforcement, they themselves should face consequences, including sanctions, or perhaps be subject to Congressional oversight hearings, which some of you have already suggested.

ACF must actually enforce CAPTA and Title IV- E. Amendments to CAPTA and IV-B and IV-E must include clear provisions regarding consequences such as sanctions and penalties on states who fail to comply.

CFSR reviews must be amped up. The Child and Family Service Reviews in place must be conducted more frequently, evaluate a more comprehensive scope of measures related to fatal and near-fatal child abuse with meaningful consequences applied to states, and program-improvement plans required of failing states must require actual compliance with the law and not a relaxed set of benchmarks.

NCANDS must be utilized. As already proposed by this Commission, NCANDS must be made mandatory, for it to be meaningful, with expanded measures, standardized definitions, and penalties for nonreporting.

Private rights of action, CAPTA and IV-B and IV-E must explicitly recognize a private right of action which would ensure that courts can continue to serve as a critical avenue to pursue justice for aggrieved parties when states fail to comply with the law.

Finally, we need to align funding with the Commission's recommendations. Listen, eliminating child abuse and neglect fatalities in America is not a revenue-neutral proposition. I am all too

aware that we live in an era of scant resources, continuing divestment from foster care, and decreased spending on children generally. But what is the status quo costing us? Well, we know that it accounts to a massively underreported account of about 1,600 dead children a year. Research from the CDC has shown us that the total lifetime economic burden of one year of new cases of maltreatment is estimated to be as much as $585 billion. And we know that in 2013, we spent $25 million on CAPTA. Yeah. I know the proportional amount in this slide doesn't show up very well, but you might have to zoom in to see it more clearly. It really is there, just barely. You don't have to be a financing guru to see that this doesn't add up.

Although waivers have produced some exciting innovations and results, they're not a cure-all. Most often they involve reshuffling of funds rather than much needed deeper investments in the system. And it is critical to remember that often waivers absolve states of some of their basic obligations to children under the law. So flexible funding and waivers are exciting and promising as long as they don't concede budget neutrality and as long as they ensure continued statutory protections for children in the system.

Although this Commission's charge is not to weigh in on the larger child welfare finance reform debates that are occurring now, we believe it is imperative to recognize that implementing the recommendations that you make will cost money. It is your difficult task to let it be known what, after all these months of testimony and debate and materials that you've sifted through, what needs to happen to eliminate child abuse fatalities and near fatalities and how much does it cost to get that done? If Congress or others balk and choose to implement only selected provisions or scale back recommendations, that's their prerogative and it will sit on their conscience.

A system with greater accountability and transparency will better serve the interests of public, the child welfare community, and most importantly, the children at stake. Once evaluation tools are better, our data more accurate and consistent, and the respective federal and state agencies are performing their jobs conscientiously, it will inevitably lead to safer children and fewer fatalities.

Once again, thank you for hearing this testimony, and for your hard work and commitment on this commission. Make no doubt that with a strong set of recommendations in your report, children's lives will be saved. As an advocate deeply committed to -- deeply engaged and committed to this work for the long haul, I know that I look forward to helping advance some of your recommendations in the coming years. Thank you.

CHAIRMAN SANDERS: Thank you, Ms. Harfeld. And so we have Kathleen Noonan on the phone, and so I'll turn it over to you, Ms. Noonan.

KATHLEEN NOONAN: Right. Thank you very much. Hi. This is Kathleen Noonan and I am very glad to participate today. Because I'm on the phone and I don't have a PowerPoint, I'm going to keep my comments pretty brief and then just see how the issue of consent decrees, which is the one that I was asked to talk about, comes up in Q and A.

So let me just start by telling everyone that I'm a lawyer and I have done mediation in a number of child welfare cases that resulted in a settlement or a consent decree, and I've also done mediation in cases involving Medicaid. In fact, that's where I first met Commissioner

Dreyfus in Washington State. So I think that everyone in the room on the Commission understands that consent decrees are seen by many advocates as an accountability tool. I think that might be -- I think that some commissioners or some folks on the agency side might sometimes question that, but I think that they -- they certainly are in this panel today sort of under the -- you know, the rubric of an accountability tool.

Most -- so consent decrees are -- I'm going to call them class action cases. Most class action cases are actually focused on kids in care and not on the front end of the system, meaning hotlines or CPS; and that is because the children who have rights, and Amy was just talking about causes of action, the right to sort of bring the suit attaches to the child who is already in custody. Although some cases involve children who have been -- where there has been a fatality or a near fatality, because the class action cases -- what happens is you might have a set of named plaintiffs, so six or seven kids are going to represent who are put out as representing sort of, you know, typical injuries you might see in a system. Class action cases usually end up involving all of the kids in the system. And an example is I am the monitor right now in a class action case against Oklahoma and the class action covers about 11,000 kids. So they typically focus on permanency, I just want to say, so it's an accountability tool. If you're thinking about them and thinking about the front end of the system, there probably needs to be more, you know, ideas about that.

So the class action cases that I've seen also tend to be very singular in the system that they focus on. So they're generally just against the child welfare agency. That sometimes the child welfare agency sits in an umbrella and so other agency partners might be involved or sometimes there's Medicaid funding at stake, but mostly it's just the child welfare agency.

So I know that this Commission has talked a lot about child welfare and child abuse and neglect as a public health issue, but it's really not ever viewed -- at least to my knowledge, there isn't a consent decree or class action that has sort of taken that approach.

So Mark Testa spoke earlier about decrees, and I have written about their highly prescriptive nature and compliance-oriented nature of decrees, and I think that my reaction to them was that if they had resulted in better systems, we might have said that was the right way to go. But they -- a lot of them did not result in better systems. In fact, they just resulted in systems being in litigation for a lot longer and sort of -- that sort of continual contempt fight.

I think that everybody has gotten sort of smarter. I think states and cities and plaintiff's counsel has gotten a lot smarter about the decrees, and so the decrees now sometimes afford a lot more flexibility. I think most people again, probably on the Commission, know that there are dozens of these lawsuits underway right now. I actually tried to count and I couldn't. I don't know if any of them -- anyone in the room has a count of them. But probably upwards of half the states have either just gotten out of a consent decree or there's a case against them or they are under settlement agreement. And so there are -- I'm sorry. Did someone just say something? Okay. Sorry. I just got feedback. Anyway, so they are -- they are used regularly by plaintiffs as a way to sort of get the systems to perform better.

So when I wrote about decrees, I found one system that I thought had been able to sort of get up - - you know, to basically reform their system more quickly and in a way that actually focused on practice; and although they used compliance measures, they weren't so focused on

compliance that they sort of missed the kids and the families that were right in front of them, and that was Utah, which, Amy, I know you lauded in your remarks, and they had a model in their consent decree that I thought actually allowed for system change. They had very good data. There was a lot of transparency. They used the QSR as a way to both measure progress, but also be a training tool on the ground with caseworkers. And, importantly, they were able to sort of modify what they were doing without returning to court. In earlier decrees, I don't know if people know this, but literally if you wanted to change a provision, you would have to go back to court and do that, and so they were very rigid.

So I have to say that in my work closely in the systems, I've seen child welfare systems that are very -- that can be very, very defensive. I think that child welfare needs something more like what hospitals have, in that they do mortality, morbidity conferences, and have a lot more protection.

I was just involved in something that involved a very, very egregious near fatality of a child, and I believe that the child welfare agency did not do right by the child simply because the workers were terrified about what was going to happen to them. And so I think we see this a lot in child welfare. I think that sometimes I feel like there's such a chasm between the agency directors that are -- you know, are sort of -- feel like they don't want to be sued, and when they're sued, they don't want to deal with it. And then the plaintiff's lawyers, you know, who are rightfully sort of agitated about what they've read about these kids that sometimes we don't have the forums to sit down and really talk about what would a good reform process look like? How could we use this mechanism to really change these systems?

I actually think that the -- and I've been doing some study in this area, that the process of bankruptcy that we let companies go into is much more generous in terms of actually giving companies an opportunity to be able to reform themselves, but without the sanctions that seem to come on the child welfare side. But a bankruptcy process also includes a lot more stakeholders. I have to say that most consent decree processes don't include stakeholders outside of the agency and the plaintiff's lawyer. But in the bankruptcy process, you know, creditors, including employees and other people that might have an interest, actually get involved and have representation; and I think that that would be a really interesting evolution in child welfare, to actually figure out how to bring those kinds of voices into the planning process around consent decrees and settlement.

So, anyway, I think I'm going to stop there, because I'm on the phone and it's hard to do this without seeing folks and you seeing me, and just see what kind of questions now come from the Commission based on this and what else you've heard from Amy and Mark.

CHAIRMAN SANDERS: Thank you, Kathleen. Listening to some music trying to leave. Commissioner Petit?

COMMISSIONER PETIT: I have a question for each of the panelists, and I thought the information was excellent and thank you for presenting it.

The first question that I have is for Ms. Noonan. Kathleen, I think that you mentioned that litigation's brought against and on behalf of kids that are in care?

KATHLEEN NOONAN: Yes.

COMMISSIONER PETIT: And that is, I imagine, at some point related back to title IV-E, which is an entitlement program that these kids participate in. And you're saying that the states or whoever's bringing the action saying the states are not in compliance with the requirements under IV-E, right?

KATHLEEN NOONAN: That's actually -- I'm sorry. I'm hearing feedback. But that's not the basis of the decrees. The decrees are usually based on Constitutional -- the actions are usually based on Constitutional deprivation and then -- yes.

COMMISSIONER PETIT: What is the legal basis for intervening on a child-protection side? Which I rarely ever see litigation brought specifically around a failure to protect children in CPS.

KATHLEEN NOONAN: Well, I think you could probably -- and, Amy, I'd be interested in your thoughts about this as well, but you could -- you know, you'd make a case around -- if it was a false negative, meaning that the child wasn't protected, is that what you're thinking about, like a child who wasn't brought into care and should have been?

COMMISSIONER PETIT: Yeah. Yes.

KATHLEEN NOONAN: Well, I mean, there's a -- there's a famous Supreme Court case that comes out of Wisconsin called DeShaney, which basically says that the state's failure to act was -- actually didn't rise to the level of state action. Now, that -- you know, you'd have to somehow distinguish it and show that the state's activities were so reckless or so shocking that it was Constitutionally a violation of the child's rights to be protected. So, you know, we don't have it. I don't know -- Amy, I'm trying to think of another case that's like DeShaney.

But, you know, DeShaney was a child that was in care and then actually was reunified and then the father did kill the little boy; and the Supreme Court found that that -- that there was no state action there, is what it's called in legal terms. So I don't know. We have to think about it. But I don't think it's out of the question.

AMY HARFELD: This is Amy. I think this brings up some other interesting questions. I bring us back to one of our recommendations, which is we need to actually explicitly recognize the right of action for children whose rights have been violated by state inaction on CAPTA or IV-E.

But it also points to another interesting issue, that I know Commissioners Rodriguez and Martin are well aware of, in that many children in a dozen or more states across the country don't have attorneys while they're in foster care or while they're under the supervision of the system; and as such, that would be - - the attorney is the person who would be most likely to recognize a violation of their rights and be best positioned to actually intervene and file a case or organize a class of plaintiffs to file a case to pursue that course of -- that course of action.

So I want to underscore this is also located in CAPTA, which we know is sort of the kitchen sink of a lot of child welfare provisions, but CAPTA is the source that recognizes representation for children in child welfare cases, and right now it only guarantees that the child be represented by somebody with training. It does not require the child be represented

by an attorney. And I would say, Commissioner Petit, that we would be better situated for these children to actually recognize when their rights have been violated and in a better position to file cases if all children were guaranteed attorneys.

COMMISSIONER PETIT: So to answer the second question, which is related to that, you said that you believe that ACF was flouting Congressional intent. That's a pretty serious charge. What is your experience with Congress holding hearings or oversight sessions with respect to ACF's compliance and timetables and activities regarding the laws that were adopted by the Congress and directed to the executive branch to implement? What has been the nature? Are there hearings? Are there -- what happens now when you work the Hill?

AMY HARFELD: So what I have found is that the members of Congress involved in the subcommittees and the Senate, it's the finance -- the Senate Finance Committee, they're upset -- I'm sorry. The Health Committee oversees CAPTA. They're upset when they hear that ACF has not acted on their direction. There have been letters sent to ACF by members of the relevant subcommittees with no followthrough. It's not -- to my knowledge, there have not been oversight hearings on this; and, you know, we've debated about whether that's something we really want this commission to pursue. And I -- I don't know what the right answer is, because in my experience, having seen a lot of oversight hearings, they don't always result in the changes that you want to see, and I'm hoping that this commission's report and recommendations will result in really meaningful outcomes that effectuate your charge.

And so I -- I do think that there needs to be some answering for ACF's role in not really seeming to understand their full responsibility in implementing oversight and enforcement of the law, and it's very upsetting to advocates in the community and to many others that, in fact, they're not -- they're not playing a very strong role in this.

So I don't know if oversight hearings are the answer to that, but certainly a number of different mechanisms can be put into play to make sure that there is better communication between Congress and ACF. And, I mean, we'd recommend penalties against ACF if they're not doing their job.

COMMISSIONER PETIT: My last question is to Dr. Testa. Mark, the country's spending 25 to 30 billion a year right now directly in child protection, foster care, and so forth. What research exists that estimates or calculates or otherwise comments on what would happen if we didn't have the system we have in place now? We know a lot -- we all have a lot of criticism about it, but what is it they're doing at this point that if they stop doing it would create a real problem with respect to child fatalities? Is there any relationship in what they're spending on caseload ratios, on supervising ratios, on treatment services? And even though there's two or 3,000 kids killed a year now, if you said tomorrow CPS doesn't exist, would there be more children that would be killed? Has there been any research on the efficacy of any aspect of this system? I mean, you provided a lot of numbers, but they went by so fast.

DR. TESTA: Right. No. And it's a very important question. And let me just refer back to the point you made earlier, that even where states are responsible as well as accountable for child welfare, that's when they have public custody, and the challenge that you face is that you're often dealing with prevention programs in which you do not have legal responsibility

for what happens. And I think that tension has to be alleviated by being able to answer the very questions you're raising.

That is, I think we've learned from the 30- some-odd years of consent decrees that we've evolved a new system of accountability that's less compliance- oriented and more results-oriented. And so we need to be able to test out whether interventions are having the effect that we think they are.

So, for example, Nurse-Family Partnerships; very strong evidence base that we can actually reduce levels of repeat maltreatment. Of course, the numbers around fidelity prevention are so much lower that I think it's really hard to then generalize. But we also have other studies with respect to Triple P Prevention, another well study which says you can reduce child abuse and neglect rates.

So I would imagine that if we abolished CPS as it exists, although we can't approximate that counterfactual in any really solid way, but I think we can concede that the number of fatalities would rise if it was completely abolished simply because we would remove from state authority the ability to intervene with families in the right way around the right occasions.

But I think we have to begin to start thinking about how we make a dent in reducing near fatalities and fatalities, and the only way we can do that is if we give states greater flexibility to experiment and then hold them accountable for the outcomes so that they can show a connection between what they do and what results.

COMMISSIONER PETIT: Thank you.

CHAIRMAN SANDERS: Commissioner Rodriguez?

COMMISSIONER RODRIGUEZ: I have a question for Kathleen. I was actually really intrigued by what you were saying about the opportunity given to companies during the bankruptcy process to reform themselves.

KATHLEEN NOONAN: Yes.

COMMISSIONER RODRIGUEZ: I was wondering if you could talk a little bit about the conditions that are necessary for an agency that has not been running itself effectively to be able to sort of identify and create a plan that actually results in a -- not just looking at, like you said, tinkering with various parts of the system, but of thinking of the work that they're doing in an entirely different way. And I think there's also sort of some similar constraints about there are federal laws that place, you know, obviously some restrictions on how creative folks can be in reform, but I'm very interested in that.

And then I'm also really interested in hearing a little bit more about what type of evolution happened to allow stakeholders to be part of that process; because even though I'm a lawyer and believe that there's a place for litigation, I'm often frustrated that litigation proceeds and settlements do not have any consultation with folks like foster parents and youth and birth parents who are most directly affected by the changes, but that are often sort of done by experts who are advocates who are very distanced from what actually happens in the lives of folks who are affected.

KATHLEEN NOONAN: Yeah. Is my mic still on? I think it is.

COMMISSIONER RODRIGUEZ: Yes. We can hear you.

KATHLEEN NOONAN: You can still hear me, right?

COMMISSIONER RODRIGUEZ: Yes.

KATHLEEN NOONAN: Okay. All right. So as far as the condition, I would say that, you know, if a system is going to reform itself sort of in a system reform that is like a settlement or something, I mean, you sort of have to have two tracks. You have to have the track that is focused on how are you going to sort of turn practice around and then the track that is all about our data and accountability and so when are people going to trust us and our numbers.

And I know that in Oklahoma it's taken us about two and a half years to get the data, and that took, you know, the monitoring team having our own data expert that works for the state. But now we can really say that like their caseload -- you know, where only 20 percent of the caseload staff was at -- you know, at the capacity they were supposed to be at, you know, we now know that 50 percent of the case -- of the staff is now at caseload -- at the caseload ratio that they're supposed to be at, and we really trust the data. And so you need that. You have -- you absolutely need that.

But then you also need a process that allows for there to be the -- you know, you have to have caseloads ready and you have to have enough foster families so then you can start doing the good work that workers need to do. And in a place like Utah where they did -- you know, they did get their caseloads down and they did, you know, then have a sufficient number of foster families, they really went in and focused on their practice with families while they really also tracked what they were doing with data.

So I'd say the conditions are really that you have to sort of go -- you have to do both things and you -- it's really important for these systems to be working with outside people on the data part because, you know, sometimes you just get stuck in their own bubbles.

On the stakeholder part -- I'll just say quickly because other people may have comments -- in bankruptcy, and I am sort of looking into this now and, you know, likely be writing something about it. The -- you know, the difference between a bankruptcy and a consent decree process in public-impact litigation is that in bankruptcy, although the lawyers work out the sort of details of the reorganization documents that the court has, the lawyers don't work out the plan for the company. The people who run the company do with outside folks who are representatives of the stakeholders, and that's very different.

Because, I mean, in -- in public-law litigation, you know, it's the plaintiff's lawyers who are often sort of doing the negotiating around the business plan. And you don't have foster parents' point of view and you don't have, you know, youth-who- have-recently-exited point of view, and you don't have provider -- you know, a provider's point of view. And I think that, you know, we have to do a little bit of experimentation and see if that might help and -- and so -- anyway, so that's what I'm thinking about, but I haven't seen it and it usually doesn't happen in public law litigation, you know, whether it's child welfare or police litigation or education. We tend to not do it that way.

CHAIRMAN SANDERS: Commissioner Horn?

COMMISSIONER HORN: Thanks to everyone for your testimony. Amy, I have a question for you.

So as you've probably seen on our agenda, we will be having a conversation later today on public disclosure. I go into that discussion with no preconceived conclusion, because I don't know enough about this, which is why I wanted to have it as a discussion and not as a presentation by any particular subcommittees. But I'm interested in your thoughts.

So you said that one of your recommendations was to clarify and strengthen CAPTA's public disclosure mandate. I assume that also means requirements, okay, what has to be released? What -- what -- you mentioned one -- one issue, which was that some states -- and I've got Wisconsin's law here in front of me -- including Wisconsin does allow the withholding of information about the perpetrator if the perpetrator's a family member.

What other recommendations do you have as to what kinds of information should states be compelled to share and under what circumstances do you believe it's -- there should be exemptions from public disclosure? For example, do you believe there should be exemptions based upon a belief that it might jeopardize an ongoing criminal investigation?

AMY HARFELD: Great question. So let me just start by saying that when we made proposals to amend CAPTA in 2010, we submitted a list of what we thought those amendments should include to address specifically how this part of the disclosure provision in CAPTA should be strengthened.

So I think that your question -- to answer it, part of it involved what information is needed to actually get what you need to find the fault lines and fix the problems, part of it is what are the exceptions, and part of it -- well, part of it is what happened.

But let me say that I -- when I spoke most recently with ACF, while they were telling me they refused to issue regulations, they said, "Well, if you have a model statute that you would like for us to provide as a model to states of how it should look, we would be happy to provide that as a resource for states to look at." So we actually have put together elements of a model CAPTA policy of public disclosure policy that I will provide to the staff so that you can see it. There are 12 elements in it.

I think, most importantly, let me just highlight. Number one, there -- every state's policy has to be codified in statute, because if it's not statutory, then it's subject to political whims of whatever governor's in office or whoever is controlling the state legislature or whatever new commissioner comes in to control the agency or the county. So it needs to be codified in the statute.

It needs to be very specific about the information that needs to be disclosed. And, really, we're not talking about names. You know, what we want to know is if in this county 80 percent of the fatalities occurred to children within six months of returning home from care and that, you know, 70 percent of those children were under the age of six, and there were at least five instances of prior contacts with CPS prior to that removal and that there was a particular agency that had jurisdiction of most of those cases. That's what we're looking for.

We're looking for the information that can help point to, "Whoa, this, this, and this are broken and this is how we can fix it."

In terms of the exceptions, I think that's the biggest problem here, because an awful lot of states, including Wisconsin, actually have great provisions on the books, but the exceptions allow for - - allow for states to withhold the information for a variety of circumstances.

So what we have proposed is actually that CAPTA require a pretty specific list of information that needs to be provided, and that states be required to go to court for exemptions. So there needs to be a presumption of transparency in disclosure, and if there is a valid reason that the information needs to be kept secret or withheld or whatever you want to call it, the state needs to go to court to request that that -- an exemption to release information on that case. We think it should rise to that level.

COMMISSIONER HORN: David, would it be possible -- I assume you have that model legislation in front of you. Would it be possible to -- for the staff to get a copy of that circulated in advance of our discussion this afternoon just so that we can reference that?

CHAIRMAN SANDERS: Good idea. We can do that.

AMY HARFELD: You know, and I'd also like to point out, the third edition of the report that we do that evaluates all the state statutes is about to come out. We were going to provide a few state statutes that are actually doing it and operationalizing it, and I can certainly provide examples of a few of the best states who we think are doing a really great job of this and have figured out a way to pay for it. I don't know if we have a perfect one. But if you want examples of states who really seem to be doing the best job under CAPTA, we're happy to help with that as well.

CHAIRMAN SANDERS: Thank you. We have a couple more comments and then we're going to have to move to our next panel. Dr. Bevan and Dr. Rubin and --

COMMISSIONER STATUTO BEVAN: Dr. Testa, you asked for increased -- continued IV-E waivers and you also talked about flexibility. What do you think we'll gain from flexibility? You know, in terms of child protection, where do you think we'd go? Number one.

Number two is how accountable, how useful do you think the CFSRs are, OIG reports, GPRA, you know, all these systems that we have that don't seem to be at this point particularly strong in terms of holding states accountable?

DR. TESTA: So, you know, let me say that I think IV-E waivers have been one of the best investments we've been able to make. We've seen the ability to change federal law once you had strong evidence around the efficacy of subsidized guardianship. There's additional evidence out there about what works. And, in particular, I think it addresses some of the questions we heard about Native American nations, the need for flexibility, and if they were IV-E tribes, they could then apply for a waiver, except that authority has expired.

So right now no new waiver can be provided, which I think is a great problem and that I think even if we were to have a comprehensive welfare reform in child welfare, we would still need waiver authority. And, in particular, at the front end when children are candidates for foster care, you can use IV-E waivers to figure out better ways of keeping them safe in their own

home because they're candidates. So even though IV-E, the bulk of the money is focused on kids in public custody, the candidacy rules allow for some of those dollars to be spent in preventing negative outcomes.

With respect to the CFSR and others, I think, again, they haven't fully made the transition to this results-oriented accountability framework, because I think it's really important to have good data and to compel states to provide that data. But we should not mistake that our analysis of that data and our generation of promising explanations is all that's needed. That's just the first step, because from that information, you should be able to put together some policy, program, or intervention, subject it to some rigorous testing to see if it has an impact, and that should be the way in which we think about the PIP, particularly around program improvement plans. I was in Washington last week talking about this framework to improve practice, and it was clear the consensus was that most PIPs simply involve a group of people around the table saying, "Oh, wouldn't that be a good idea?" And no real systematic thinking about, "Okay. How do we take that good idea, implement it in a way that we can answer the question, did it work or not?" And only after you can answer the question -- and let me just say we know that 80 percent of our good ideas don't work. But once we find those 20 percent that do, then we should think about scaling up.

So I would say that while we have a, you know, promising start with CFSR and PIPs, they haven't yet made that second leap into results-oriented accountability to say that, you know, we did something well, but we did it well and it worked and we can make the causal connection that Commissioner Martin was looking for; because without that information, I think, you know, it's just a good idea.

CHAIRMAN SANDERS: Commissioner Rubin?

COMMISSIONER RUBIN: So I'm thinking about your testimony and, Mark, I'm thinking in the context of what you just said as well too, and a couple things. And you can react to some of these statements, because I want you to react to these statements.

But, number one, I think the outcome on the table of CAPTA, we can spend a lot of time investing more resources into the enforcement of CAPTA, and once we saw we were truly going to create teeth in terms of that accountability, there's just not enough money. And so it doesn't mean you don't to it. It means that it's broken because there isn't enough of a hook there for states to really comply with whatever you do on a federal level. So I worry about the fact that you can't do one without the other, all right?

Number two, is the sense -- you know, and I do believe we need -- there is -- there is -- we need resources and more resources for kids -- very aware of the data in terms of our divestment in children's funding in general and our lack of ability to do child welfare finance reform. We want the lookback every year.

But that said, I have come to the belief that, you know, we're that -- that this issue in terms of the community response, we're not -- we're not taking advantage of other existing money streams at the state level and federal level, including Medicaid and MCHB, the MCH Block Grant et cetera, particularly Medicaid, maybe to some degree IV-E flexibility, et cetera. Before I would -- you know, outside of some key specific resources we'd need right now to

fund fatality teams, et cetera, stuff that clearly has no other financing mechanism, I think there is this sort of uneasiness in me about we're not just going to open up the spigot for resources until states can prove to us that they can coordinate, they can integrate, and actually elaborate some of these CQI models that Mark's talking about. And so there's a pathway of how you create incentive to get you to increase resources. But I think, you know, this idea that we're just going to provide resources and suddenly we're going to reduce fatalities, I just -- it bothers me because this is such a complicated issue, right?

AMY HARFELD: So I'd like to respond to a couple of things that you said.

One of the experts who testified this morning on a different panel said, you know, sometimes people don't listen until you actually take away money to the point that it hurts; and if you take away money, then you can reinvest it in something that matters, and that's how we feel about some of this.

So, you know, ACF's primary reaction, when it really came down on the part about issuing sanctions against states, was CAPTA represents such a tiny amount of money that states don't care enough to do everything that's in it, and they know that we're not going to take away the money, and, furthermore, it's not worth our time and money to enforce the provisions because it's such a tiny chunk of money.

So what we have proposed again and again is to actually make a small, simple legislative tie-in between IV-E and IV-B and CAPTA for the purposes of enforcement so states actually think that their IV-E and IV-B money is on the table if they don't fulfill certain provisions in CAPTA that have to do with fatalities and near fatalities.

COMMISSIONER RUBIN: Add Medicaid.

AMY HARFELD: Huh?

COMMISSIONER RUBIN: Add Medicaid.

AMY HARFELD: Well, we can add whatever we want to it, but that's our limited recommendation. Now, the reaction we've gotten on the Hill to that is, "Oh, but Finance doesn't like to collaborate with the Health Committee. It's too politically complicated to accomplish cooperation between committees in Congress." And to that I say, "You know, you're a bunch of really smart people and you all care about kids. You can figure it out. We can learn how to share jurisdiction if it means saving kids' lives."

Another point I would make to respond to what you just said is it's true. I mean, I'm not going to sit here and say that there's enough money in CAPTA to do everything that's in it. It really is the kitchen sink of child welfare legislation. And as Chairman Sanders has mentioned on numerous occasions, you know, the whole scheme of how much money gets put into which pots of child welfare financing, it's skewed and it doesn't work together. And so maybe we really do need a much larger discussion about what's expected of states under the various statutes and how to coordinate that better. I'm not sure that you have the opportunity to do that.

And I agree that CAPTA doesn't have enough money in it, but I will say that when states go to the table and ask for more funding for CAPTA, they're coming in it from one side. And if

advocates like me go in and request more money from CAPTA, they're coming at it from another point of view. But when you make recommendations as a commission that's nonpartisan and independent that CAPTA actually doesn't have enough resources to fulfill its obligations in this regard to protect kids from fatalities, that has -- that has more weight to it and might be taken more seriously than recommendations that come from one or the other community or side of the table. So don't be shy.

CHAIRMAN SANDERS: So we're at a late point, but I know there's at least two other comments. So we'll go ahead with those, but if we can be as brief as possible. Commissioner Dreyfus?

COMMISSIONER DREYFUS: So kind of a shock when you hear a former child welfare administrator say this. But I've got to tell you, I have a real hard time with states saying, "We won't be compliant with CAPTA because it's not fully funded." It's the law. And I sit here, right, as a former child welfare director that used to say those very words. I used to say it in Wisconsin. I used to say it in Washington. "They can take their CAPTA. We're getting tired of adding one more thing to it." But then when you really read CAPTA, you realize, man, what is in here that is not good for kids?

For the federal government to make a very strong statement about an expectation of the safety of America's kids, an expectation of a minimal standard upon which all states must meet, should have nothing to do with funding. So I don't buy into Feds can only have a law like that if they fully fund it. When was the last time Wisconsin fully funded the mandates it puts on its counties?

You know, so I know I just have a really hard time with us thinking that we can't put teeth in CAPTA without funding. I just have a hard time with it. I'm not saying I wouldn't love the funding and I wouldn't love to see the federal government do more to invest in CPS, but I'd rather see them do more between IV-B and IV-E and let me try to keep more kids out of the system and let me be responsible as a state for my CPS system from a funding standpoint. But I don't have a problem with the Feds saying, "There's a minimal standard of safety, an expectation with accountability of states, that isn't dependent on whether or not they fund me or not," so that's my own personal.

COMMISSIONER RUBIN: I think the middle ground here -- because I agree with you. I agree with you there. I think it's about enforcement. I think that -- to me, the funding to CAPTA already exists in some of these other funding streams, right? It's a matter of states putting the dot -- having the flexibility to be able to use those funds, and for those systems like Medicaid, for example, to have accountability for participating in the plan around CAPTA, right?

And so the way you're thinking about it, you can separate the level of funding for a particular act from the enforcement of the provisions in that act and the accountability could be much greater across multiple systems than the actual funding level for that particular program.

CHAIRMAN SANDERS: Commissioner Petit.

AMY HARFELD: Hold on. I'd just like to add one more thing.

CHAIRMAN SANDERS: No. Commissioner Petit.

COMMISSIONER PETIT: This is directed, David, back to you in terms of a comment about finances, and, Mark, this is something you may be able to help us with.

But very early on I put numbers on the table that showed -- use almost any indicator that you want in child welfare, removal of children from families, substantiation, anything that you want, and that the difference between the lowest state rate and the highest state rate was always in six, seven, eight, nine, tenfold, on that magnitude, not 10, 20, 30, 40 percent, but 100, 200, 300, 400 percent. We have asked as part of our process for staff to assemble the numbers on the safe-child welfare budgets, and I think what we need to be able to do at some point is do a cross-tab on what the states are spending on a per- capita basis and what that translates into in terms of the caseload ratios, in terms of their supervisory ratios, in terms of the treatment services that they have. It is literally true that some states spend ten times more per capita. Are they getting ten times more than the lowest state? Are they getting six times more? Are they getting two times more? This is going to prove to be a critical question in terms of how do we go forward on this with new money or not new money, how much new money, how much old money.

So, David, I know that that information's been collected. I think Tom's been working on it with some other staff. But I don't think that we've actually sat down and seen an analysis of it. Maybe it's there, but even if it -- if it's not, I think it can be done in fairly short order, and I think it's critical in terms of informing us whether it makes a difference or not to see what the capita -- per-capita spending is. I know it's not directly comparable. It's not all apples and apples, and that's because of the lack of standards and all this other stuff, but it's close enough to, I think, provide some guidance.

CHAIRMAN SANDERS: Let me make a last comment then, actually, since both -- well, all three, Noonan, Testa, and Harfeld, have been so great and offering their time, we'll offer you a last comment, particularly given what part of what I want to say, because I am struck -- and thank you, Commissioner Dreyfus, for your comment.

But I'm not sure that we have evidence that accountability related to fines has improved -- has reduced child fatalities. And so I just think we need to think about the -- all of the things that we put in place. Are they related to actually impacting child fatalities? Do we have some evidence of that? States have been fined in the past, counties have been fined in the past, and I don't know that it drives improvements in the performance. And I think when we talk about accountability, we may need to think a little differently about that.

And, you know, I think similarly with -- with Kathleen's testimony, I'm -- there -- I believe it's -- and you said over 30. I think it's -- certainly between 25 and 30 states are -- the mid-20s are under consent decrees and I think other counties and so forth have lawsuits against them. I'm not sure that the performance improvements that we've seen are enough to compel us to say that those accountability measures have been effective.

So I just think this is a great start to the conversation. I'm not sure that we should look at the first reaction being fines against states.

So Kathleen, any last comments, and then Mark and Amy?

KATHLEEN NOONAN: Yeah. No. I don't -- I haven't seen any evidence about fines and, in fact, that has certainly come up in some of the cases that I've been in and I've always been reticent because I -- just based on my interaction with both sides, I just -- I -- that never is the same, that it looks like it's going to make the change happen.

COMMISSIONER RUBIN: You can define it as fines versus incentives, right, and so it doesn't have to be penalties per se. It could be a roadmap to -- to -- like a funding roadmap that says if you -- if you can demonstrate the following, then we will -- we will reach out on an investment of X, whether it's an enhanced rate or et cetera. So it depends on how you frame it. And I do think states do respond to incentives when they see an opportunity to bring in more funding from the state.

COMMISSIONER RODRIGUEZ: I'm sorry. I can't control myself on this. I mean, the thing that I think also about the fines and the compliance is I think the last thing that anybody wants who runs a system is a death. I mean, there might be a lot of other things that I personally believe that they probably don't really care about that I think are horrible, but I don't think child welfare directors or state human services directors ever want a child to die under their watch, because it has career implications for them, for their agency. I mean, there's -- they have a personal stake in that as well.

And so it seems to me -- it's why I asked Kathleen the question earlier about how do systems reform themselves -- I suspect that people don't know what to do to actually make the safety-related changes. And I think a lot of it is related to what Dr. Testa said. We don't have an evidence base that tells us do the following things. And so, to me, the accountability is also about somebody saying all of the things that we've learned over the course of this commission about what may be promising, what needs further research in order to determine if it's promising, what we know doesn't work, that when we see that states aren't complying, that's what we need to go in and provide. I think that's the kind of accountability. I mean, I -- I just can't see it, sort of a fine driving, this sort of mass reform. It seems to me that people would do it if they knew how to do it.

COMMISSIONER HORN: And this is me knocking on the table showing how much in support of that statement I am. Thank you.

DR. TESTA: So, Commissioner Rodriguez, I just want to enforce that last point, because I've worked with states for many years. Having another stick to hit them in the head with is really not going to give them a sense of how you go about improving what you want to improve. I think most people do have the desire to do well by kids to make them safe. They lack the knowledge as to how to accomplish that and they also lack the means for going about knowing what they did actually worked.

I heard from Commissioner Petit this morning a suggestion about how we could use data around recurrence and who's at greatest risk for -- or something on fatality, and it reminded me of very much the work that the Children's Bureau was supporting on the post-permanency side where they're identifying those children and selected an indicated risk and having some procedure where we go out and visit with adoptive parents or guardians on a regular basis who are at high risk of disruption of that placement. Give us a model in thinking about how we might do something on the front end as well where you can look at the high-risk groups,

children under the age of four, those who have had a previous experience with the foster care system. Why aren't we going out and contacting them, seeing how they're doing? I think that's a demonstration that the federal government should be encouraging. They should have a quality improvement center to try and improve the success based on that information.

So I -- I agree. I don't think the stick approach is the solution. I just think we have to help the profession know how to do the work better.

CHAIRMAN SANDERS: Amy?

AMY HARFELD: I also appreciate that comment, Commissioner Rodriguez. I think that we have to consider a variety of approaches. You know, ACF for the last years has been saying, "We'd like to help improve disclosure which can -- which can inspire reform and reduce fatalities. We want to work with states. We want to provide them with technical assistance. We want to help them. We want to take it a little easy on them because we know they have a lot on their plates."

Well, how's that been working out for us? We have to look at what they've been doing so far and how that's working. What they have not done yet is actually imposed any penalties or sanctions. So we are totally open to other -- whatever means work to actually get the information needed that we can learn from what's broken and fix it.

But I'd like to end just with saying that, you know, the report that we released, "Shame on U.S.," there was a young woman who introduced the report for us. Her name is Shalita O'Neale. She's a former foster youth and she's the founder and director of the Maryland Foster Youth Resource Center. And she stood up and said, "You know, when I grew up in faster care and all the group homes I was in, within an hour of being there I knew exactly what the rules were, what was expected of me, and what was going to happen to me if I broke the rules." And she said, "I'm standing here today in front of -- in Congress in front of, you know, staffers and legislative directors testifying before you that although that was expected of me, apparently states don't have the same expectations of them to follow the rules and apparently they don't face consequences when they break the rules."

So what this report is saying, and what I would like to emphasize to you, is that we all have rules that we have to abide by and there are consequences to not following the rules, so if we need to amend the law to make sure that states know what's expected of them and if we need to provide models of legislation and better technical assistance to make that happen and whatever incentives we need to provide to help states get the job done, that's great. But we need to be serious about letting states know that if they break the law, there are consequences.

CHAIRMAN SANDERS: Thank you. Great discussion again. Thank you for the suggestion. We'll move to our next presentation. Thank you very much for taking the time. Thank you, Kathleen.

KATHLEEN NOONAN: Absolutely. Bye.

CHAIRMAN SANDERS: So our next pair of presenters are Mark Lyday and Cynthia Johnson, and this was recommended from the Public Health Subcommittee, really focused on the interplay

between health and child protection and improving child safety. And we'll have a couple of examples from here.

Thank you very much for coming. Mr. Lyday, I think you're starting?

MARK LYDAY: Good afternoon. I'm very happy to have the opportunity to meet with you today to talk about some of the things that we are doing at Children's Hospital of Wisconsin around the issues of child safety and fatalities.

Particularly, it is nice for us to be meeting with Commissioner Dreyfus. She's an old friend and colleague. We know each other well and we very much respect her and the work of this Commission.

So I'm going to talk a little bit about some of our programs, but the first thing that I want to make sure that you all understand is the context that these programs exist in.

I work for Children's Hospital of Wisconsin, which is a large tertiary, quaternary-care hospital in Milwaukee, 196 beds, 24,000 admissions, well-known teaching affiliate with the Medical College of Wisconsin, nationally ranked in ten pediatric specialties. I put those slides up, because I want you guys to think that we're a big deal, right? And that from a medical standpoint, we really do know what we're doing. I mean, we're doing like really high-tech stuff, right? I mean, we're doing heart transplants and, you know, all kinds of really complicated sub- subspecialty sorts of things. Our neonatal ICU was featured in TIME magazine which we brag about every chance that we get.

But in the middle of that very medically technical organization, we are very aware of and very focused on the social determinants of health. And so we have a community services division that really spans prevention to intervention. And so I could really talk about all of those programs and what they may or may not have to do and how they are pertinent to your work. But I'm going to talk specifically about the program that I direct, and that in the Community Services Division we call the CAPS program, which is Child Advocacy and Protection Services. And these are the ten programs that report to me.

We have seven child advocacy centers that we operate across the State of Wisconsin. We have two medical satellites where we provide onsite medical work for other people's child advocacy centers, and we have a large inpatient-based child abuse pediatrics consultation program. We have an ACGME-accredited fellowship program. We're just graduating our first fellow right now. We have our second fellow starting actually this month. So altogether those ten programs will evaluate somewhere in the neighborhood of about 7,000 kids annually across the State of Wisconsin.

So I'm going to talk about some of the statewide partnerships, one particular statewide partnership that we have, and then talk a little bit about some of our local multidisciplinary team projects.

First, the statewide project. We've been very well -- we've been very aware for a long time that there were many times that we would be offering medical opinions in child abuse cases to child welfare workers, to police officers, to others, and they would either not understand the information that we were giving them or simply disregard it. And so we became very

curious in why that was, and started to realize that in many ways there was very much an educational deficit; that when I say that they didn't understand what we were telling them, I mean just that. That they really didn't understand what we were saying. And that also that there were -- tended to be cultures in some of these agencies, law enforcement and human services particularly, that would kind of override some of the medical opinion, and they would go about and just form whatever opinions and draw whatever conclusions they wanted to.

So we set about forming a statewide network that has as its goal to increase medical expertise in child abuse investigations and improve the accuracy of the investigations and the overall safety of the kids and families. And the target population were, first of all, medical providers, because we found that most local medical providers didn't really understand child welfare or even law enforcement systems that were involved in the cases that they were also involved in. But we really also wanted to focus on those investigators, particularly law enforcement and protective services workers, who had the primary role of determining if maltreatment had occurred.

So what we really developed was a public/private partnership that involved state agencies, nonprofit community-based organizations, statewide professional associations, and a number of the state's medical universities and Children's Hospitals, and you can see the list.

I can say that this was really for many years a labor of love on our part and on the part of our partners. There was really very little funding for this. We operated this for many years on shoestring funding, some of which came from Children's Hospital, some of which came from University Hospital in Madison. But we are just now kind of getting to the point that we have our legs.

This is kind of a schematic to show you what the model looks like. There were advisory boards. There were focus groups that all fed down to educational, capacity building, partnership, development, and evaluation outcomes were needed. There's been -- a lot of our focus has been on educational -- multidisciplinary educational kinds of opportunities. So we can help because it allows better understanding of really what -- all of the partners, what's important to them, and what -- how -- how they interact with each other and how their cultures are inside of their organizations. It really aided in partnership between all of these groups and it enhanced education. It provided a network where professionals can actually get realtime consultation and also allowed us to do some data collecting and evaluation.

So with the focus being on education, I can tell you that we did 22 Webinars in 2014, we had 676 attendees from across the state, and those attendees came from 106 different agencies. So we have a very diverse group that kind of meets in this kind of virtual world of the Webinar on a monthly basis and discusses and gets educated on different aspects mainly of the medical identification of child abuse.

So just to give you an example of one of these situations, we'll talk a little bit about sentinel bruises and how they may or may not precede serious abuse injuries in infants. We did some work out of our center in 2008 and 2009 looking at sentinel injuries in kids that had ultimately had major head traumas, shaken-baby syndrome. And what we found was in 25 percent of those infants, there was a sentinel injury that had occurred before that major trauma had

occurred. So sentinel injury would be some small injury on an infant that really doesn't have any business to be there, but which oftentimes would get overlooked. So, for instance, a child may have a small bruise on the arm or a small bruise on the abdomen, a scrape on the face someplace that we wouldn't expect it, and we would find that a lot of those sorts of injuries really preceded more serious injuries that ended up happening days and weeks and months down the road.

So we presented this study and really needed to have a way to let on a practice level people in the field kind of know to not miss these things and to pay more attention to them than they had been paying to them in the past. And so we used the Webinar system that we'd developed through the WeCan Project. And now it is not unusual, I can say, for us to get consultations on infants that have these small sentinel injuries. CPS agencies and police departments will do a deeper dive into the family situation, and there are many, many examples that we have where underlying dysfunction and really safety threats were uncovered that would not have been uncovered if those small, apparently insignificant, injuries would have been overlooked.

So this has really been kind of a way for us in a multidisciplinary way to really learn about the culture of CPS agencies, police agencies, and medical, all kind of learning about the cultures of each other's agencies. None of this is mandated. Nobody needs to appear. Everybody is at the table purely because they want to be at the table. They want to learn. And I think that when you have that kind of environment, it's a much -- it's a much more positive situation than, you know, somebody mandating a certain kind of education. So this is an example of a statewide kind of partnership that we've developed and that we maintain around this issue of culture inside of agencies and education.

CHAIRMAN SANDERS: Can I just ask a question in clarification? Are the sentinel injuries fairly uncommon or are they -- do they happen all the time in the general population or are they uncommon?

MARK LYDAY: Well, most of the sentinel injuries that were as a part of our study were kids that were brought into the emergency room for one reason or another, and so they were significant enough for that. And I would say that while, in general, they are not unusual, when you have an infant that has one of these injuries, that really is an indication that more attention needs to be paid to that case. May be nothing, but it certainly would call for a deeper dive. So that's the state partnership that we're presenting.

And now we want to talk a little bit about some of the local partnerships. And so, as I said, we run seven child advocacy centers, and when you run child advocacy centers, multidisciplinary teams are your stock-in-trade. I know that you all have had presentations about child advocacy centers, so I won't go into a lot of detail about that; only to say that when you run a child advocacy center, what you do all day every day is you form relationships with partners and you maintain those relationships. That is your stock-in-trade. We don't do anything by ourselves. We always work only in relation to other people that are on our team.

I'm going to talk a little bit about the multidisciplinary team that we have in Milwaukee, although understand that we've got teams like this all over the state. All of them are pretty much similar. All of them are also very different depending on different things about local communities that they're in. All of them will have a joint protocol that they voluntarily sign

off on that describes how -- the protocol that they will use to develop a collective response to the investigation of child maltreatment.

In Milwaukee, we call our multidisciplinary team CART, the Child Abuse Review Team. Why do we call it that? Because that's what we've called it for 20 years, and if we changed it, nobody would know what we were talking about.

So the purpose of the multidisciplinary team is to really maximize child safety. We want medical exams by competent experts. We want to figure out ways in the protocol for kids to get transported to our child advocacy centers. We want really good collaboration, information sharing among agencies. We want really timely collection of evidence. He want to minimize revictimization by overinterviewing kids. We want really good forensic interviews. And we want really good advocates and mental health providers and we want them as early in the case as we can possibly get them.

Really, in a way what we're doing in these multidisciplinary teams is we're saying that, you know, health is not just a purview of the medical providers. Really, we all on the team are interested in healthy kids. Justice is not just the role of the police department. We all have a stake in seeing that justice is served in individual cases. Safety is not only the concern. Child safety is not only the concern of the child welfare agency. We are all invested in safe kids, and so we all need to work together to get what we need, but to also meet some of these higher goals.

These are the cooperating agencies that we have in Milwaukee. We have some nontraditional partners here. The public schools are very strong partners on these teams. The public health departments in the area are very strong partners. Wraparound Milwaukee is a mental health agency in Milwaukee County. And we also have the domestic violence agency in the community that has been a strong partner on our multidisciplinary team for years, and I'll actually talk about them more in a little while.

We have case reviews that we do on a weekly and monthly basis, and what we've done in our protocols is establish criteria for these reviews. We worked a long time to get out of the business of finger-pointing about what cases were going to get reviewed. When it was just a, "Gotcha, that I just didn't like what you did," it was a very negative attitude. By establishing criteria in our protocols so that we know we're going to talk about head-injury cases, we're going to talk about multivictim cases, we're going to talk about some of these sorts of cases, then we could come together more as a team and work together rather than being defensive about what we were finding. We need for there to be accountability for recommendations. So if somebody says they're going to do something, they come back to the team and they report back. Like I said, they occur weekly and monthly. Teams may also meet on an emergency basis, and we have many examples of where there was an immediate problem, we met that day, resolved that problem.

Really, in a way I think about our CART executive team, our weekly and our monthly case review, as kind of a continuous quality improvement process, that really what we're trying to accomplish is the best collaborative process that we can get. So we have weekly and monthly case reviews that feed information up to our executive team. Our executive team can suggest

to our weekly and monthly case review teams kinds of cases or issues that we would like to have evaluated.

So that really is our Milwaukee local multidisciplinary team process. It's probably not that different than many other that you've heard about when you heard about child advocacy centers. But it really is the stock-in-trade for what we do; and it leads us - - when we have these trusted relationships with other partners, it can lead us into other kinds of projects that we would never have access to if these were mandated programs or if we were trying to somehow cajole some of these agencies to be involved with us.

So one of those programs that we've developed is our screen-out program. We became very interested in screen-outs after the noncaregiver law was passed in Wisconsin and put into effect in 2006, and all of a sudden there were a lot of cases in child welfare agencies that had been getting screened in for investigations, but now were noncaregiver cases that were getting screened out, and so we were very concerned that there were kids falling through the cracks. Police departments didn't really necessarily understand what their role was in some of these cases.

And so in a couple of our child advocacy centers in Walworth and in Eau Claire, we started a project where we started looking at the screen-outs from the child welfare agency. Now, you can imagine that if you're a local child welfare agency, if you didn't have a good, trusting relationship with your child advocacy center, you're not going to give them access to your screen-out cases. So, again, all of this goes back to that relationship building that we do as child advocacy centers.

So we have two of these screen-out programs. They're both pretty similar. They review cases that have been screened out by CPS with the goal to reach out to the families to provide resources and to really kind of initiate a multidisciplinary kind of response.

So there's additional review of CPS reports. That's kind of an extended safety net. At times we go back to the agency and say, "We really think that you need to review this more closely and maybe you want to screen this case in." We do outreach to families as a preventative measure, and we really work with police departments and advocacy agencies so that we have a multidisciplinary response even though the CPS agency may not be involved in the case.

So this is some data from our Eau Claire program that reviewed 400 screen-out cases that they had reviewed; and not on this slide, but I would say what everybody was concerned about when we started this, was that we were just going to be going back to the child welfare agency and saying, "You shouldn't have screened this case out." And then we're going to be doing that constantly. Actually, in the 400 cases from Eau Claire County that were reviewed, less than two percent, about eight kids, we made recommendations that they review those cases and they ended up getting screened back in. So the majority of the time what we were talking about had nothing to do with cases with inappropriate screen-out decisions or encouraging the agencies to screen those cases back in.

What's important to me about this slide was that when we reached out to families that had screened- out cases, almost 60 percent of those families were either receptive or very receptive to ongoing contact with the child advocacy center and advocates and

multidisciplinary teams that we put them in touch with. So, you know, in the majority of cases, we were interacting with families, again, that wanted us to be involved and that were interested in getting the help that we needed. So this is one of the local examples of how our multidisciplinary team relationships have led to new programming.

The second one I want to talk about is the domestic violence program that we have going on in Milwaukee right now. As I said, the domestic violence agency has been part of our multidisciplinary team for years and years and years. This is a very nontraditional partnership. In a lot of areas in this country, there's animosity between domestic violence agencies and child abuse agencies. We never really experienced that in Milwaukee because of the relationships that we formed with this group in our multidisciplinary team.

We became aware a number of years ago that we were really a lot of times working on the same cases. We were just working on them separately. Studies show that somewhere between 40 and 70 percent of the time there's a co-occurrence of child abuse and domestic violence, so that the same families that were walking in their door, were walking in our door. The problem was that we were siloed in a way that we were dealing with those families. We were kind of pretending that the other side didn't exist or we were just giving lip service, so, well, that needs to be a CPS report or that needs to be a DV report. They're typically -- these two issues are not typically addressed together. Although I can tell you in the lives of our kids and families, they certainly are lived together. So if you want to look at how kids and families live their lives, to them, it's just all violence. It's just all family violence.

We started to become aware that it may be more economical to have partner agencies co-located in a single space that dealt with both of these issues. We were also, pertinent to this group, aware that there are many child deaths that are either directly or indirectly related to domestic violence. I don't think -- I've not seen that statistic quartered. I don't know if that statistic exists. But certainly, in our experience, kids are being very badly harmed, and at times killed, that in situations that are somehow related to domestic violence that's occurring in the family.

So there was an effort on the part of the local DV agency to start a family justice center in Milwaukee. The family justice center model and the child advocacy model are extremely similar. I mean, they are one-stop shops, safe places for victims to come to get a variety of services.

So in Milwaukee, what we have done is we're in the process of building a building, which we broke ground on last October that we will be completing construction on in October of this year, where we will completely co-locate and integrate services of a family justice center, the local domestic violence shelter, and a long-operating and well-established child advocacy center, the child protection center in Milwaukee. We will co-locate law enforcement, child welfare, and the district attorney's office. I'll say that the entire sensitive crimes division of the Milwaukee Police Department is going to be in this building with us. We are really looking forward to those relationships. We will have mental health agencies onsite. We will have community partners on site. 72,000-square-foot building, $20 million. State of Wisconsin paid for 50 percent of this building. So we're really looking forward to this being a laboratory for us to be able to ask questions of how can we work more closely together in kind of an unsiloed

approach to issues of family violence that really starts to identify and address issues earlier so that kids and families don't need to be getting quite so much downstream.

We're asking you make recommendations, and here's some of the recommendations that we would make. The first is to really engage healthcare systems in the effort to reduce or eliminate child abuse deaths. This is not just about public agencies. The health community has a large stake in this issue, particularly the pediatric health community.

Second is to use multidisciplinary trainings as an opportunity to change cultures. When people get to know each other and get used to each other, it's much easier to break down some of the barriers.

Third would be to strongly mandate a coordinated multidisciplinary response that is informed by medical science. So the idea that started in Huntsville, Alabama, in the mid-'80s of multidisciplinary investigations is now, frankly, just best practice, and we need to really find ways nationally to really make sure that this kind of a multidisciplinary response is available everywhere.

Fourth would be to eliminate -- to work to eliminate a siloed approach in responding to family violence. Again, these kids and families are not siloed in the way they experience these problems. We need to get over some of our problems in working with other nontraditional partners and really look at this as one problem.

And then the last recommendation we would make would be really that we need to do a better job of studying near misses. I think that we can learn, you know, an awful lot by some of the things that have been discussed in this group today about a more transparent way to really look at cases, particularly cases where there were near-missed fatalities, to really see systematically what we can learn from those cases. So thank you very much.

CHAIRMAN SANDERS: Thank you. Before our next testimony, I'm going to turn it over to Commissioner Bevan to introduce her.

COMMISSIONER STATUTO BEVAN: I want to extend a warm welcome to Ms. Johnson. I'm very excited that you're here. I think many of you know Chairman Paul Ryan has Ways and Means Committee and also IV-B and IV- E programs run through that committee, and he had nominated Ms. Johnson to come and testify before the Commission today. And I think it's so amazing when a representative knows a constituent's name and what they do. And so I'm very delighted to have you come and I thank the Commission for allowing the invitation.

CYNTHIA JOHNSON: Thank you very much. Thank you for that warm introduction, and I'm very pleased to be here.

And my presentation is really going to be on a roadmap of hope and looking at cutting-edge ideas, prevention, so heading off on the beginning, on a forefront, rather than on the back end, but also talking about long-term commitment. This is for the long haul. This is not short-term flash-in-a-pan. This is -- it takes time to see the outcomes on the impact of maltreatment or the progress towards prevention.

So when a child dies, something has happened and it also means that something didn't happen, and you've heard this throughout -- the speakers that I've heard so far have been

talking about this. What hasn't happened? And that's that whole prevention piece that I want to speak to.

So we can't continue to do the same thing and expect different results. And so I'm going to offer you another opportunity to look at how to spend money, federal dollars, to impact the lives of families, and I have a recipe for you to sort of think about. I'm going to be explaining about data, really death data, and then how do we diagnose a problem is number two, and then implementing the program, and this is the program I'll be talking about, and then, of course, evaluation. You've got to reflect the outcomes. So that's that recipe that I'll be referring to.

Our mission statement, of course, but I think for Kenosha County our mission statement is a little bit more impactful. Health is our business and we're committed to a healthy Kenosha; and really, all of my colleagues, this is what we strive for and we do have a business plan. So I want to assure you that fiscally this is highly important in local public health. We're only 23 percent local levy dollars, so very small. The rest is what we bring to the table.

So Kenosha, really, I'll offer you a snapshot. We sit geographically in the southeastern corner of the state, border Lake Michigan and the State of Illinois, so where we have I94 that goes between Milwaukee and Chicago. Our residents, we have about 168,000 of them, and our poverty rate is 14 percent. Our child poverty rate though is 21 percent. And to give you some context with that, in the zip codes of Milwaukee County, the Wisconsin poverty report just described about 39 percent poverty rate. We're not far behind that and that's the zip codes in the inner city off Milwaukee city.

A little bit more information. We have 88 percent white, 7 percent African-American, 12 percent Hispanic, but in our community we have multiple mixed races, and so it's determined really by mom on what they decide at birth. Graduation rate is 88 percent.

And then also this particular slide is describing the community health status indicator through CDC and for Kenosha County. We're in the worst quartile for children in single-parent households, high housing costs, and housing stress. So it's those other variables that impact.

So I'll get to the data and, really, this death data. This is the first part of our recipe. And that, again, something's happened and what has happened and want to better understand why that happened.

So we first -- to understand life and the improvement of life, you have to understand death. My colleague here to the left was talking about death review teams. We have three death review teams in Kenosha County. Not only do we have a child death review team, but we also have a fetal infant mortality review team, but we also now have an adult death review team. We're one of the first in the state and nationally that we took it that it was important for us to understand why our adults were dying also.

So some of the specifics as we further analyzed some of these deaths, you can see that toxicity and, of course, opioids -- you hear a great deal about that -- people self-medicating, and whether it's intentional or unintentional deaths.

But to the types of child deaths, really, are from first breath to up to their 21st birthday, and so you can see through the years the numbers might be small -- some are larger than others, but they might be small, but yet they're all impactful.

An example, in 2014, we had three homicides, children. One was by the hands of -- a one-year-old by the hands of her father who flung her to the ground, and you may have heard about that, and the other two were teens that had died from toxicity, drug-related, whether it was intentional or unintentional. So, again, through these, understanding death, we're trying to further understand the means, diagnose the problems of death.

And so this, again, tells you -- gives you an idea of the trends. I did bring hard copies of these slides, so we'll leave those in case you're interested in having this information to take with you. So you can see the trends and, of course, the toxicity is just increasing and has been remaining steady for a long period of time as people are self-medicating, whether they're children or adults.

And so now I'm going to talk to you about ACEs, adverse childhood experiences. This is really a concept of understanding. It's really a tool, a methodology, of understanding about death and trying to quantify the number of stressors that are in an individual's life, and those would be called the number of ACEs, and so the number of ACEs in an individual's life and how they apply then towards outcomes or poor determinants of health.

And so you can see from this pyramid that these number of ACEs and as it can potentially lead up to early death, and sandwiched in between are all of these other areas of impairment, maladaptive behaviors that occur, and cause, rationale, cause and effect for people, whether they're using drugs or causing harm or self-harm.

So these ACEs in an individual's life, whether they're a child or adult, and this is what we've been discovering through our death review teams is -- whether it's abuse, neglect, or household dysfunction, these number of ACEs really yield up to that maladaptive behavior. Some have been learned in their childhood and some either they've self-inflicted or as a result of the infliction upon themself.

So here I'll describe a little bit about this connection with the dysfunction that occurs and the ACEs in an individual's life and relate to the ecological model. And, again, we're talking about this cause and effect and trying to get to -- you know, so we're diagnosing the problem, which ACEs help us to do, and then how do we -- how do we put in place a program to -- which would be the third part of the recipe. But here again, here I'm quantifying that cost burden that affects our society, and there's a lot of detail there.

So the third part of my recipe is implementation, and it's a program, and the program that we've selected to reach out and provide that roadmap of hope for our families are home visitation programs. These are evidence-based programs, evidence- based practices. First one, the Nurse-Family Partnership, has been in existence. Dr. Olds developed this back in the '80s. It's been in existence for over 30 years. We're starting to see outcomes from the first cohort group of adults, and I'll describe those outcomes later on.

But the Nurse-Family Partnership program, if you're not aware of this, it's, yes, evidence-based, outcome-related. It's first-time moms. So it's -- it's reaching them at that very young

age. They have nothing to compare. You know, it's a blank slate, new baby, and, of course, there's no manual with that new baby. And when they're trying to parent, they're using those skills that they learned throughout their life. And so they might be maladaptive or also that child or that woman, the mom, may also have a high number of ACEs in her life and so she's using how she's coped in the past.

This is a program that we have received for home visitation program which is evidence-based. We're receiving MIECHV dollars to support this program. But, also, we receive a return on the investment made through the federal dollars and that we're able to recoup money through Medicaid or prenatal care coordination.

But this program also achieves improvement in people's lives. It's very process-driven. We just had our first graduates in November of this past year, so this is a new program for us. So the outcome data that I'll be relaying is very -- it's only a couple of years of what we have available at this point.

But currently we have 115 families in this program. That's a lot of families. We have six R.N.s and one nurse supervisor, R.N. supervisor, so these are nursing-based. That's where the cost comes in. These are nurses who are implementing this -- these programs.

Besides NFP, the second program is Parents as Teachers, and that's also a program that if a mom is having her second child, we need a program for moms that hadn't been in our first program that we could then place them into so that we can, again, be providing those skills, those positive skills, parenting skills.

So we were going through some of the activities; and, again, these are evidence-based activities. It's prenatal/perinatal. It's preparing for the baby. Those safety mechanisms, we provide car seats, cribs. They're ready to go when that baby is brought home. We also provide reproductive life plan. So before they have that baby, they -- they don't even go to that hospital until they've already developed their own personal reproductive life plan ahead of time. So we're talking about birth spacing, giving those moms the tools and the skills in order to be prepared that when they come home with that baby, they already have thought about some of those own personal skill sets.

We discuss about education and employment. High school drawings is key. Mental health, we -- this is also a very new piece that we brought into this mix. We have an advocator for mental health. Twenty five percent of our 115 that are rotated through, about 25 percent we're able to get them into mental health counseling. They can really start talking to someone about some of those ACEs that I talked about, some of those maladaptive behaviors, or it could be anxiety, something as -- and I don't want to say minimal, but on a spectrum of mental health, anxiety disorders are -- are truly a part of how we -- how we cope with our anxieties, how we then lead to a healthier life.

We talk about relationships, positive parenting, and, of course, self-efficacy and school readiness for the child, you know, starting to get that kids are ready for school and how the mom can start reading at birth to their children, all those little skills that really make a difference.

These are the evidence-based tools that we use within this program. So there's depression screening, there's stress scales, check again the ACEs, we do a survey of the moms, we use the Ages & Stages Questionnaires; and then the social and emotional aspect of the ASQ also.

Our community partners are key. We really pride ourselves in Kenosha County of having a large number of community partners that support -- are supportive means of these programs. They're an integral part. Silos was mentioned. That is -- that is not operational to function in silos. And so working within the public health system, which is a very broad system of community partners, they are all part of the Nurse-Family Partnership, the PAT, these home visitation program. And so we integrate with them whether they're through a referral piece or some other mechanism.

I have to say that our referrals -- I mean, I'll just step back once. We have about 2,000 births per year in Kenosha County and our referrals, we receive about 1,000, 900, 1,000 of our referrals from our WIC program, Women, Infants & Children. So this is a strong key connection with another federal program who refer the moms. They discuss about our home visitation. The moms agree. They send the referral. We then do the call and schedule the appointment and bring the mom into the program. So it just kind of gives you an idea of the numbers that we're working with.

And now here's some of the impacts. I think that what I haven't really touched on, and this is a long -- these are two-year visitation programs. That's why I said this is not a flash-in-the-pan. This is a long-term commitment. And it's a commitment with money also. And so we take it very seriously about the results that are achieved so that this is part of our business plan in order to have health improvement in our community.

But the key here, this long-term visitation, is developing trust with families. When I was a public health nurse back in the '80s, traditionally public health nurses went to see moms -- all first-time moms when they left the hospital. You know, after I did that year after year, I asked myself why? What for? What are the outcomes? How can I prove this made a difference? You know, I had some really nice visits, hour and a half. They had -- you know, they showed me their -- the bassinet and the beautiful room and, you know, grandma was there. These weren't the families I was supposed to be spending an hour and a half of time with as a public health nurse. We need to be with the high-risk families, and that's why that WIC connection is so important to identify moms that truly need our services, the ones that can receive the support and also then be referred and connected, navigated in a system that is just so vast, but the resources are there, and often there's reimbursement through Medicaid for those services that are provided to families. So we're offsetting living dollars. So here's some of the outcomes.

And so, again, of this recipe that I've been describing, so we talked about the data. We talked about the diagnosing through using ACEs. We talked about the program home visitation. And now here is the evaluation piece, the outcome, which is critical to speak to people like yourselves.

As I go home, my county board supervisors, my board of health, how do I show them that this is working? It's only two years old, but we're already seeing a decrease in our African-American infant mortality rate, which we were appalled at 24 percent in 2012. We were down

to 12. Now, mind you, one death in Kenosha raises our percent, and so it -- it doesn't take much to raise that rate and it depends on our population, because it's only seven percent.

But here's the second piece that I really want you to pay attention to: Low no-show rate. How many times have you heard medical providers say, "I don't want Medicaid clients because they don't show"?

CHAIRMAN SANDERS: Ms. Johnson, just -- I want to make sure. We have a break that we have to take in just a minute that we need to give our court reporter.

CYNTHIA JOHNSON: Absolutely. I'm wrapping up.

CHAIRMAN SANDERS: Great. Thanks.

CYNTHIA JOHNSON: Thank you for keeping me on target here. Appreciate it. So a low no-show rate; critical, because providers often say 50 percent no show of Medicaid clients. Those are our clients. We build these partnerships with our community, as I said, assisting families with the mental health.

But long-term impact, this is what we're going to be looking at in the long haul and we're starting to see with the first cohort group of adults, on-time graduation, decreasing poverty which is breaking that cycle of poverty, and also decreasing the number of single parents. Birth spacing I already described with having that personal reproductive health plan. The household stress that occurs, I've heard colleagues mention about that stress and the dysfunction and the domestic violence. Decreasing our governmental cost, that's high on our radar, and the study has shown that for every dollar spent on a home visitation program, there's $7 in savings of healthcare costs.

So in closing, this is the recipe I described repeatedly. And then closing, our opportunities for change, and so, of course, to maintain, but also to expand, MIECHV not only in our community, but in our state and potentially nationally; looking at tax incentives for impoverished citizens, so those are people in poverty. Those tax incentives might be supporting marriage, work skills, graduation, teen parents that remain in their parents' home, childcare and transportation, welfare reform, decreased tax rates for those in poverty, and returning to work so we can cultivate a culture of work and earn tax credit.

And looking at monthly disbursements as opposed to annually. Through our VITA program we're showing that 24 percent of our families have to pay back their debt that they've occurred throughout the year because they had to use a credit card or some other means rather than being able to have payoff on their monthly bills.

So I want to thank you very much for your time, and I look forward to any questions that you might have.

CHAIRMAN SANDERS: So we're going to take a break, but I'm going to ask the two of you if you -- right after the break if you'd still be available for questions.

CYNTHIA JOHNSON: Absolutely.

CHAIRMAN SANDERS: And then we'll go to our final panel. And so we're going to take a break for ten minutes, and I would ask commissioners to try and stick to that so that we have

enough time for our deliberations around disclosure at the end. So we'll come back in ten minutes with questions for our panelists. Thank you.

(Recess)

CHAIRMAN SANDERS: So thank you very much for sticking with us through the break. I know that Commissioner Rubin has questions, so we'll get started with that.

COMMISSIONER RUBIN: Yeah. You know, thank you for -- both of you and, you know, each time when I go into local public health environments, right, across the state, there's always something unique going on in that state that sort of gives me a little bit of an "a- ha" moment.

I just went up to Mark beforehand, and we hadn't really made that connection yet, but the idea of these kids that are being screened out or going to differential response throughout the country, the idea of aligning a referred -- because you have the kids because they just -- they've just been noticed as high risk and then referring them to a community-based sort of referral and prevention strategy. Then you have the opportunity particularly because of what looked like tremendous satisfaction in the fact that folks were interested to actually task what you can re-use for your report if you make that connection in a much more integrated way.

So I encourage Mark, and we can think about this as from the context of research that needs to be done, to evaluate whether you make those connections, can you actually change outcomes and reduce the reliance on the system? Because that's the kind of data that's going to actually strengthen these all and enhance findings in the future.

The second issue with respect to home visiting services, I do think there is some new data coming out that is starting to suggest a reduction in infant mortality. And so I'm not surprised to hear what you saw in Kenosha County. I'm not so sure it's for violent homicides, but there are a lot of neglect deaths in there too. And I think in particular on those neglect deaths, because of all those parent resources and parent training. There's also evidence of increased use of health services, appropriate health services in terms of, you know, coming to the primary care doctor, adequate prenatal care, and subsequent pregnancies, those types of responses by families.

But I also know that, you know, when I look in Philadelphia and I see our 15- to 24-year-olds are having their first baby, half of them have a history of CPS involvement at some point in their life, right, and it's pretty similar in a lot of large cities elsewhere. And so when you look at intergenerational maltreatment and the risks to someone who grew up in care, for example, I potentially kind of noticed an opportunity, particularly because MIECHV is not funded at a level that really fills the need of where we need to go, you could create a carveout for MIECHV as part of child welfare, at the very least for women who are having a baby while they're in custody or either JJ or child welfare, that a city or state has access to funds to actually augment the MIECHV allocation to actually -- because those are the moms that we find need the -- at most need those resources from that infant home visiting program, and if you can identify them early, they could be eligible for an NFP model, right? And so that's the key there.

So those are my two comments, but thank you both for kind of giving me those "a-ha" moments as I thought about it.

CHAIRMAN SANDERS: For Ms. Johnson, I have a question about the reduction in the infant mortality rate that you've seen so far. And I believe there's been a reduction nationally. Has the reduction exceeded that or exceeds what you would have expected in Kenosha County without the interventions that you put in place?

CYNTHIA JOHNSON: We really had quite an awareness and focus in our community. We've been through a process of a focus on infant mortality when we developed Black Healthcare Coalition in 2006. Then we started a delegation of infant mortality especially for African-American children in our community in 2010. We saw providers not taking Medicaid clients, and so they were really kind of passing them around. And one provider had like 85 percent of the cases and he left our community; big gap. And so we have seen through the initiation in 2012 of the home visiting -- home visitation program the two-year -- two-and-a-half length of time with moms caring for them, being there, helping them navigate, building that trusting relationship with one person that is caring about them that they can know as a backup person, as a knowledgeable resource, as a nurse, has made a huge difference in the reduction in these rates. I hope I answered your question. I know yours was a little bit more global and national.

CHAIRMAN SANDERS: No. It sounds like you could point to when the efforts started and the impact that it's had. That's what I was trying to get at.

CYNTHIA JOHNSON: Yes. Yes.

COMMISSIONER DREYFUS: Mark, when I met with you before I started on the Commission, I had a meeting with you, I had a meeting with Bureau of Health & Child Welfare staff, which was fabulous. And you shared with me CART, that the -- the Commission has been interested in this whole issue of analytics and using data. And so in Hillsboro County, they've identified a number of factors that when present in cases and when present in a cumulative way, risks rise, right, and they use that as a way to prevent kids from child death.

I believe the CART does something similar where there's a set of factors that you have seen, so it's not just dependent on somebody's anecdotal submission of a case to be reviewed.

MARK LYDAY: Correct.

COMMISSIONER DREYFUS: I just thought you could share that.

MARK LYDAY: Right. We can do either. We have a set list of risk factors that, if they're present, we will routinely review that case. We also have the availability anecdotally to just bring cases in when somebody, you know, feels like that would be --

COMMISSIONER DREYFUS: Or on topics that you're interested in.

MARK LYDAY: Or we were talking at the break. One of the topics we're interested in right now is human trafficking. So we're reviewing human trafficking cases partially because they're complicated and partially because none of us have a clue about what to do about them. And

so we're using that as a way to learn about the population and to learn about what kinds of interventions might be effective.

CHAIRMAN SANDERS: Can I also raise a question with you that -- I don't want to oversimplify this, but I was really struck by the slide on the sentinel injuries.

MARK LYDAY: Yes.

CHAIRMAN SANDERS: And so I was thinking about the work that you're doing on screen-outs. So to not oversimplify this -- but if I am, please let me know -- but it seems like a call to the child protection agency where there's been a sentinel injury within the last six weeks should be handled differently than those where there's a call in. That's information that should be considered. That we were talking earlier about the several million calls that come into child protection hotlines and how do you reduce that number. But it sounds like this is one of the ways, by using data from other sources that the child protection system would normally have that could save this group of infants is at a greater risk than another one.

MARK LYDAY: And as we were talking before, I think the big -- the biggest issue there is to get people educated to the point that they're actually making those referrals. Because many of those injuries that we call sentinel injuries really look pretty benign.

CHAIRMAN SANDERS: That's fascinating. Thanks. Other questions or comments? Well, thank you very much. Really wonderful. Thank you.

So we now have a panel and really appreciate their patience in waiting so long, and their time has been shortened some, but we still have plenty of time with the front-line practitioners here in Wisconsin. And we've heard about some of the safety decision- making changes that have been made here and really get a chance now to hear what's happening in the actual decision-making with families.

So I will turn it over to the four of you and let each of you introduce yourselves and spend a few minutes talking and then we'll finish and we -- finish with questions, and we will finish at around 4:30 just to give you a sense of the time. We'll switch to our discussion topic at 4:30. And you can -- whoever wants to go first, go ahead and introduce yourself. And then if you just do it sequentially after each of the presentations, I think you'll be fine.

KIRK MAYER: So my name's Kirk Mayer. I'm an initial assessment specialist with the Bureau of Milwaukee Child Welfare in Milwaukee County.

First off, I'd like to thank you guys for allowing me to be a part of this process. I really appreciate what you guys are doing.

My current role is initial assessment specialist. I work firsthand with children and families on a day-to-day basis in Milwaukee County gathering information to make determinations about child safety.

When I'm assigned a case as a worker, I follow the state standards that have been presented to me. This consists of first contacting the reporter of the allegations to gather additional information. The next step is to meet with the alleged victim. After meeting with the alleged victim, I meet with any other children that reside in the home. After that we then meet with

a nonmaltreating parent, if there is one, followed by the maltreating parent. Throughout this process, I also speak with collateral sources to gather additional information. Following this outline allows me to gather as much information as possible about families to make safety decisions. When it is possible to meet privately with a child first, I'm able to gather information without the child being influenced by others. During this process, I believe that one of the most important skills to have is for the ability to engage with others. Being able to effectively engage with others allows me to gather additional information which is pertinent to determining child safety.

At each step of contact, information relating to the family is gathered in order to get a better understanding of the family to identify any safety concerns. As I gather information, I always keep in mind present and impending danger to ensure child safety. Information regarding parenting strengths and weaknesses is gathered to assess caregiver's general functioning and their ability to parent. However, the incident of maltreatment is something that is addressed while gather -- the sorry. The incident of maltreatment is something that is addressed while meeting with families; however, this is not the main focus of the assessment process. The information that is gathered is used to complete a comprehensive assessment in seven areas. These areas are maltreatment, surrounding circumstances, child functioning, adult functioning, parenting practices, disciplinary approaches, and family function. Completing the assessment gives me the ability to identify any diminished protective -- parental protective parent -- diminished parental protective capacities and to address them to ensure child safety going forward.

Part of my responsibilities as a worker is not only gather pertinent information, but be able to convey that information to a supervisor. Initial staffings typically take place while still in the field to rule out any present or impending danger. It is imperative that sufficient information is gathered to make sound decisions relating to child safety. Additionally, that information must be related to supervisors during staffing so they can address -- assess also for child safety. Communicating effectively with supervisors allows me to address any additional concerns they may have relating to child safety.

Once a negative family condition has been identified, it is put through our danger threshold analysis. This threshold has four parts: An observable family condition which is out of control, not managed, which must be present for a negative -- I'm sorry, which will remain active now or in the near future, and have a severe impact on the child. All four parts must be present for a negative family condition to move from risk to danger. Also taken into account is the vulnerability of each child in the home to the condition. Once a danger threat has been identified, it must be addressed immediately. In circumstances of present danger, a protective plan is put in place while allowing time to gather additional information to better assess the family. When impending danger has been identified, a safety plan must be implemented to control any danger threats. This can consist of a family-managed plan -- an in-home family-managed plan with agency oversight, and agency- managed in-home plan, or an out-of-home plan.

One of the challenges with this model is when a negative family condition has been identified, but it does not cross that danger threshold. At times it can be difficult to gather enough information to meet all the criteria of the danger threshold. These types of risk cases

can be frustrating, because although a negative family condition has been identified, the agency cannot take action. These risk cases are often offered community resources; however, it's up to the family to utilize them.

A strength of this model is that it provides structure and guidance in decision-making. The model provides a strong foundation of knowledge to complete comprehensive assessments of families. The threshold criteria consists of a guideline to determine if any danger threat exists. Using this model provides myself with confidence in the decisions that I make relating to child safety.

TARA MUENDER: Hello. My name is Tara Muender and I'm an initial assessment training supervisor for the Bureau of Milwaukee Child Welfare. I would also like to thank the Commission for allowing me to testify here today. I'd also like to express my gratitude for your dedication to this topic and your diligent efforts to formulate solutions to protect America's children.

Child safety and the prevention of serious injury and child fatalities is the key focus of child protective services practice. It is a topic that I take very seriously and one that can keep CPS workers and supervisors up at night. I have worked in the role of initial assessment worker, initial assessment supervisor, and in the areas of policy and quality improvement exclusively in Wisconsin over the past 12 years. I am now in the role of a training supervisor where I am able to share my experience and knowledge to prepare new initial assessment workers for conducting thoughtful assessments of families to determine child safety.

As you may be aware, the State of Wisconsin conducts safety assessments using a modified version of the Safety Intervention model created by ACTION for Child Protection. The safety decision-making model consists not only of assessing for present-danger threats, which are threats that are occurring now or in the process of occurring, but also identifying impending danger threats, which are family conditions that will negatively impact children in the near future and whether the caregiver has the capacity to shield the children from that danger. As Kirk stated, this model outside of -- or in addition to child vulnerability has four characteristics that we must consider: The family condition is specific and observable; it is out of control; it is certain to happen now or in the near future, which means in the next several days to weeks; and it is likely to have severe effects on the child.

This model is dependent on the worker's ability to gather sufficient information about families. Having sufficient information about a family results in an objective and descriptive picture of how the family functions on a routine basis. A thorough assessment reveals important information about family functioning, child functioning, and caregiver functioning, which identifies both strengths and concerns within families. Understanding the strengths and concerns within a family will ultimately help form a picture of whether a child is safe or unsafe within that home. Information collection must remain neutral and objective to prevent worker bias and premature decision-making, which may impact how and/or what information is collected. When interviewing family members and collateral sources of information during the assessment process, the worker must seek to gather a thorough amount of information about any conditions present in a family that are routinely typical. Family conditions occur on a range from positive to negative to dangerous.

The greatest challenge workers and supervisors face in safety assessment and safety management is in making the determination of foreseeable or impending danger. Identifying impending danger requires conscious, deliberate, and extensive efforts to understand the complete family dynamic. Information-collection efforts that are isolated to the maltreatment alleged in the report, or incident-focused assessments, or passive-information collection that gathers general facts and information or lacks a guiding purpose can result in missing impending danger.

As a trainer, I emphasize the importance of thorough information collection. I believe the biggest challenge to supervising safety decision-making is a reliance on workers' ability to gather all the necessary information. It can be a struggle when workers do not use their critical thinking skills when they are working independently in the field during the assessment process.

As a supervisor, it is my job to ask workers questions around all areas of functioning to ensure they are not only remaining open to all possible family conditions, but also to ensure that they are digging deeper to fully understand each condition. A supervisor must learn about each worker's strengths, struggles, and biases in order to effectively manage how information is collected, ensure the worker is not missing key information, and to help them enhance their professional knowledge and skills. For example, the agency may receive a report with one type of maltreatment allegation. However, as the worker begins to learn about the family, other conditions which negatively impact a child may be uncovered. It is imperative for the worker to recognize this condition as one that may negatively impact the child and be able to focus their information collection around that condition to gain the understanding needed to determine whether impending danger exists. The supervisor supports the worker in ensuring this occurs. I have found that if the concern involves a topic that the worker is not confident or comfortable with, it may hinder information collection. The information collected and analyzed at the conclusion of the initial assessment provides the basis for the initial direction for ongoing intervention services when a child has been determined to be unsafe and services have been determined necessary. The initial assessment identifies what caregiver protective capacities need to be enhanced through ongoing intervention.

The State of Wisconsin worked with ACTION for Child Protection to implement an intensive training program called Supervising Safety Decision-Making, or SSDM, to improve supervisor competence and confidence. The training focuses on both present and impending danger in two separate sessions. I participated in both sessions, which were approximately three months in length, and found it to be very helpful in my development as a supervisor. The training program not only breaks down the safety decision-making model to ensure the supervisor's understanding of the material, but it gives the participant language and methods of explaining the model to workers. By helping workers to develop their capacity to use the model effectively, they are helping to improve outcomes for families. Most of the supervisors at the Bureau of Milwaukee Child Welfare have participated in the training to date. The culture has started to shift at the agency in that we are able to be consistent in our conversations with the workers and agency staff at all levels and to hold each other accountable to the fidelity of the safety decision-making model.

Safety assessment continues during ongoing CPS in association with case plans, service participation, and case management. Safety assessment during ongoing CPS focuses on managing existing safety plants and then shifts to consider what kind of progress is being made to enhance caregiver protective capacities and if or how conditions are beginning to change within the home. Safety assessment at case closure is judging whether impending danger threats still exist and the sufficiency of caregiver protective capacities to shield the child from danger.

In summary, Wisconsin safety decision-making model provides a systematic approach that is applied consistently for all of the families that come in contact with CPS agencies. The decision-making model guides decisions made around which families warrant an initial assessment and subsequently may need ongoing intervention services. Following the model results in a higher degree of accuracy for decision-making.

KELLY OLESON: Hello, Commissioners. My name is Kelly Oleson. I'm the children and family services manager for Adams County Health & Human Services. Thanks for this opportunity today.

I want to tell you a little bit about the training program that I went through to enhance safety decision-making. First, I'm going to tell you all about the program.

After Wisconsin joined three other states and the organization ACTION for Child Protection to develop supervisors and safety decision-makers curriculum, the state faced the challenge of statewide implementation. So the Department of Children & Families and the Wisconsin Child Welfare Professional Development System partnered to address the implementation challenges in Wisconsin. The local modification included a focus on the complex analytic process of safety decision-making and developing the habit of thought that supports consistent rigorous practice. The curriculum integrates Wisconsin practice standards, the eWiSACWIS case management system, and job tools to provide a practical integrated support to practice a learn-it- today, use-it-tomorrow philosophy. It builds an engaging environment that invites participants to examine their own understanding of complex safety concepts, past decision-making, and practice across their agencies to support organizational change. Lastly, it breaks the program into modules so that the schedule is responsive to the reality of demands on supervisors' time and allows for the implementation of agency change in one area of practice before moving on to the next area of concentration.

Given the modifications and structure and content, this program was renamed Supervising Safety. A group of 24 supervisors piloted the program in its entirety last year. By the end of this year, 117 participants from 48 counties, one tribe, and DCF will have completed the first module, which is present danger threats. The plan is to focus next year on the second module related to impending danger threats. The structure of the curriculum, in my opinion, was very successful. The curriculum is multifaceted through face-to-face seminars, coaching, homework assignments, and peer-to-peer coaching.

Now, before telling you about what happened in Adams County, I'm going to tell you a little bit about our county just so you have a good picture of it. We are an extremely rural community, very different than Milwaukee and very different than Dane County. In our experiences, however, some of our same concerns are very similar to urban communities.

We've seen an increase in heroin use, child poverty, and a lack of affordable housing. Additional concerns that are unique to our community is a lack of a transportation, a lack of mental health resources, and a lack of skilled childcare. Our county currently has one grocery store for a population of 21,000. Adams County does not have a dentist that accepts Medicaid nor are there any pediatricians or obstetricians in our county. 75 percent of our children qualify for free or reduced lunch. And we rank just behind Milwaukee County in the areas of child poverty and teen birth rate. We consistently rank in the bottom three counties for our health factors as measured by the county health rankings. Child maltreatment is often entrenched in our families through multiple generations.

Now that you have that in mind, I'm going to share my experiences with you. I completed the entire curriculum of supervising safety, both modules, present and impending dangers, over an 11-month period of time. I was able to incorporate this analysis of safety into our practice at Adams County nearly immediately. Because of this, we believe that we are better able to identify present danger at the point of access in receiving child abuse reports. We've seen an increase of 50 percent reports being responded to since implementation. I feel more confident in my decision- making when supervising the work being done with families around safety. In turn, my workers feel more confident in deciding a plan for children when there's an unsafe finding. For example, if safety concerns are properly identified, removal to out-of-home care may not be necessary, but a less intrusive plan can be constructed thus reducing the trauma experienced by families who come into contact with child welfare.

Some of the outcomes that we've experienced in Adams County as a result of both structural and cultural changes, in addition to supervising safety, are the social workers are completing better assessments of families, gathering sufficient information to inform their decision-making. This results in a better understanding of the families that we work with and more creative and self-reliant planning.

Social workers are more consistent in their evaluation and analysis of safety. We conduct a weekly staffing which cases are brought to the group and impending danger threats are identified as part of case consultation. The social workers present safety analysis to the staff and this has supported consistency in the application of safety standards.

Social workers are more confident in their decision-making, which has resulted in more thorough protective planning with families, which means more families stay intact and there have been fewer removals into out-of-home care.

Our safety plans are better structured, easier to understand, and safety services are more focused resulting in more positive outcomes without being referred back to our county. Communications with families is improved and social workers understand safety concepts and are confident in their decisions.

Here are some of the cultural and structural changes that we've gone through the past couple of years. Through an increased support from our director and county board, Adams County increased staffing by adding three full-time social workers and added a supervisor position in 2014. These changes were much needed. They reduced caseloads, significantly reduced caseloads, and the addition of this supervisor position is providing an opportunity for

individual supervision. Now social workers are afforded more opportunity to adhere to the standards with the guidance of their supervisor.

An initial analysis of supervising safety along with the staffing and cultural shift in Adams County shows that by creating an environment of supervision, we are beginning to see a reduction in time children are spending in out-of-home care, a reduction in those children being removed from the home without implementing a protective plan first, a shift from placement costs to preventative costs, and an increase in the number of families that can be served for the same amount of dollars. Tentatively we are anticipating a reduction in our out-of-home care costs by nearly $200,000 this year compared to last. We are better identifying at-risk families at access. We are less focused on substantiation. And we are creating an environment to provide families with services before a tragedy occurs.

A real-life example of supervising safety, a report came into our agency regarding a family with numerous children with a response time of same day. It was determined initially that without proper supervision for the children, it required a removal. Informal supports of the family were located immediately to provide supervision to the children. Informal supports -- I'm sorry. Informal supports were located immediately to provide supervision only during the times that were needed, which was when the father was at work and the children were not at school. Over the next few weeks, the worker was able to assess parental capacities and continued to gather information which led to better understanding of safety within the home. There was an eventual reduction in the outside supervision in the home. Both parents had a role and cooperated with the development and implementation of the plan. This family continued to receive supportive services and the case was safely closed with no new referrals. Even two years ago our agency's response would have been removal of all the children as we couldn't adequately determine the critical times.

In conclusion, my participation in supervising safety has impacted the overall practice in Adams County around child welfare. There's been a paradigm shift from constant crisis in our work with families to having a clarified focus with our families on safety. Supervising safety has also stressed the importance of providing direct supervision to social workers and creating a culture of using supervision. The outcomes of this program to both me and my staff are beyond measure. Adams County is already seeing an increase in quality of safety decision-making and its impact on our children and families. I believe it is imperative to have highly skilled, technical, and adaptive training available to supervisor and managers. Social work staff also must have a manageable caseload in order to adequately assess safety concerns in the families they work with. Thank you.

JULIE AHNEN: Good afternoon. Commissioners. Thank you very much for this opportunity and for the work that you're doing.

My name is Julie Ahnen and I'm the manager of the child protective services for Dane County, which is the county that you're in right now. Dane County is the second largest county in Wisconsin and it's the largest county-administered human services organization in Wisconsin. I've been the manager of CPS in Dane County for over five years, and I oversee a staff of about 80 including seven supervisors.

Four of the Dane County supervisors completed the first part of supervising safety training dealing with the present danger threats earlier this year and the rest of us will complete the first part of the training in early August.

My two biggest takeaways from the training at this point are the solidification of the central role that safety decision-making plays in CPS involvement in families' lives. The second takeaway is related but different. I feel I have a better understanding of the fact that safety decisions, substantiation decisions, and decisions around petitioning the court for jurisdiction are separate and distinct decisions from one another.

When I think about challenges around safety decision-making, I believe that these three distinct areas of decision-making for social workers and supervisors can be a significant barrier. From the point of first contact, we can spend too much time anticipating whether or not we have enough evidence to substantiate or whether or not our legal counsel will accept a petition which can take the focus off of safety decision-making. A significant challenge for supervisors is that they are supporting decisions based on verbal descriptions provided of injuries, conditions, or circumstances provided by workers over the phone. One way that we have partially addressed this issue is by providing all CPS staff with iPads that allow workers to take pictures of injuries or living conditions and email them directly to the supervisor as part of the infield consultation.

I've been mostly pleased with the Wisconsin model of safety assessment, and I've been in Dane County for 20 years, and our initial assessment standards. Back in about 2003, a number of workers and supervisors in Dane County became familiar with ACTION for Child Protection and their website and we kind of became ACTION for Child Protection groupies. We would routinely look forward to their monthly articles and share them with other staff. And while this was done on an informal basis, I can see that these concepts have become embedded in our language and decision- making over the years. We've come to understand that safety decision-making does not end at initial assessment, but continues throughout the time frame of the family's involvement with CPS. One example of this is our frequent conversations around the fact that safety concerns can be very different around family interaction than they are when looking at reunification. For our ongoing staff, there's an ongoing challenge around determining when a home environment is safe enough for a child to return.

From the vantage point of a manager, who oversees the work of the supervisors, a number of practices have been put in place to assist me in determining whether or not staff are managing safety sufficiently. Back in 2008, in response to an infant fatality in 2007, we instituted a practice in which any report involving a child under the age of two needs to be reviewed by two supervisors for a final screening decision. The initial screening supervisor will provide their recommended response, and if there's a disagreement, the response with the highest level of urgency is adopted. In addition, I review emergency response cases on an almost daily basis. And with some of my new learning in supervising safety, I've shifted my focus to include an assessment of the quality of the information gathered at access and the justification of safety decisions that are documented. For the past several years, I've also been reviewing a number of the screened-out reports every month.

Several years ago when the ongoing standards were revised, we made a decision to fully implement the expectations around case transitions between initial assessment and ongoing.

We established internal policy around the need for ongoing social workers to review the initial assessment and safety assessment before the case-transition meeting so that the meeting could be a more meaningful conversation around safety decision- making and the next steps needed in regards to further information-gathering or planning for the family by the ongoing worker.

In Dane County, we've had an internal case review process for all out-of-home cases for over 20 years. The focus of these reviews has changed over the years; and about a year ago we decided that rather than having workers come to the review and provide panel members with an update, we would require the panel members to review documentation in WiSACWIS so that the review could be focused on the current status of safety evaluation, discussion about the parents' status in regards to stages of change, and progress toward permanency. This has allowed me to ensure that workers and supervisors are regularly discussing and updating documentation around safety, family interaction, and child and adult functioning.

For more than 20 years, Dane County's had a commitment to having community social workers embedded in key neighborhoods throughout the county. Our Joining Forces for Families workers have an open-door policy and are skilled at helping people meet basic needs for housing, food, transportation, and other crisis-related issues. Over the years, these community social workers have been torn regarding working directly with child protective services. They find that being too closely associated with CPS can greatly diminish the trust that community members have in them. We have continuous conversations about this challenge because we're aware that we're very often serving the same families.

Dane County has recognized the importance of early childhood intervention and programming, and I routinely encourage my staff to promote family involvement in early childhood programming. One challenge recognized in our community is that there are many different early childhood initiatives under way currently. So it can be hard for providers and families to know which program would be the most appropriate. Our early childhood providers have recognized this challenge and have begun to meet regularly together to discuss referrals, waiting lists, and the idea of a centralized intake process.

For the past five years, I've been a member of Dane County's fetal infant mortality review team. I provide information for the reviews in regards to department involvement with families experiencing a fetal or infant death, which allows for a more robust discussion regarding social issues involved with these losses. In Dane County, we're currently focusing attention on infant deaths related to unsafe sleep conditions, and I've been directly involved in those efforts sharing information with our staff as well as staff who oversee our out-of-home caregivers.

Finally, I review every child fatality case and every case that is reported to the state as a serious or egregious incident. I then review findings with the supervisor and staff involved as needed. Over the years, a number of patterns have emerged in regards to these cases which mirror state and federal findings. Most of these cases involved young children under the age of four. In addition, we've seen that there are elements of domestic violence in many of these cases as well as isolation of these families from natural and community supports. We're fortunate that we have a good working relationship with our local domestic violence advocates and we routinely provide cross- training opportunities.

In addition, we continue to look for ways to enhance our ability to reach out to families who may be isolated and unwilling or unable to take the initiative to seek support. These isolated families are sometimes known to CPS, but the conditions or circumstances that are reported to us are often not enough to warrant formal agency involvement. I believe that funding for a community-response approach to these families should be prioritized and would demonstrate positive outcomes in strengthening families and preventing maltreatment, including child fatalities. Thank you.

CHAIRMAN SANDERS: Thank you. Thanks to all four of you. That was really very informative. I know I have a couple of questions. But are there questions? You have about five minutes. Commissioner Rubin, Commissioner Petit, Commissioner Dreyfus.

COMMISSIONER RUBIN: That was great. You know, I was sort of interested -- I don't know to the degree -- since you've implemented this training, I imagine you've had near misses, maybe a couple fatalities, and I guess the question is have you guys done a qualitative review on sort of did the -- in terms of the process that was followed by folks in your groups, was the training sufficient? Were people not implementing the model? Were -- was there a hole? Like have you -- is there -- is there a continuous quality improvement aspect to this which is -- when you have those near misses? So can you speak to that a little bit? Have you had any of those issues come up since you've done the training?

JULIE AHNEN: We haven't yet. We're just in the middle of the training. So I don't know if you all have.

TARA MUENDER: In Milwaukee we have had a few and we do review all of those cases both internally as well as the state comes in and reviews them as well. So we have looked at that to see where it kind of -- where the model was not followed and what changes we could make. So we look at each case individually when those happen.

COMMISSIONER RUBIN: Are there general themes at all that you see?

TARA MUENDER: I think the biggest general theme that we have is thorough information collection was not done. And so maybe there were things that were present that workers didn't dig down or supervisors didn't explore further that had we explored that further, we would have determined that impending danger was there. So I think, for me, the biggest thing is making sure that we are really gathering sufficient information so that we have a full understanding of the families so that we can support our decisions.

KELLY OLESON: I can answer that also. I just finished -- I'm one of the supervisors who highlighted the program that completed it last year. We fortunately, knock on wood, have not had any near misses or fatalities at this point. We're also a very small community. So we don't have the same volume of those counties, but if we have a re-referral with the same family, then we do -- we analyze what was missed.

COMMISSIONER RUBIN: Are re-referrals down?

KELLY OLESON: Yes.

COMMISSIONER RUBIN: They are?

KELLY OLESON: I'm knocking on wood. I'm very superstitious. Yes, they are.

COMMISSIONER PETIT: You said thorough collection of data is important. But preceding that needs to be training as to what constitutes collecting data, and companion to that is having sufficient time to be able to do it. So you -- all of you talked to a degree about adding social workers. Just what happened to your caseloads per worker? They went from what to what? And from a supervisor perspective, what is the supervisor-to-caseload ratio? And, finally, how did you get out-of-home services cutbacks like you've got in a small county like yours, realizing savings of $200,000? If you're bringing kids home or back into the community, it means you feel like they're safe. You feel pretty confident about their safety.

But can you speak that, caseload ratios, the training, and, you know, the piece that you also projected as needing would be to have a stronger community response for cases that aren't as urgent. And so I agree. That's the whole tripod upon which this rests, resources staff training. But what happened to your staff?

KELLY OLESON: I can speak for Adams County. We have undergone significant change over the past two to three years. We were not specialized in work, so social workers could be in excess one day. They could be carrying juvenile justice cases, working on a termination of parental rights, ongoing cases, and getting assigned a same-day report. So we looked at that and said, "We're not doing good work. We need to evaluate this." We restructured. We looked at our restructuring and social workers had 30-plus cases. That varied in degrees of work and they weren't doing good work. We weren't able to get the work done that needed to get done, and meeting standards was very difficult.

So we took analysis of what was going on and had to go to the county board and say, "We're not doing a good job. We need to increase staffing and we're putting this on you. If you as a community agree that we need to reduce abuse and neglect, then you're going to give us these positions." And they did.

Then I ended up being the -- I am the only supervisor at that time managing all the programs, and I had 11 staff, which I couldn't do all of that. So we went back to county board and said, "We need another supervisor," because there is not space to do supervision when staff are constantly going out on site visits and they don't have anybody to talk to because I wasn't available.

COMMISSIONER PETIT: So what's the staffing caseload now?

KELLY OLESON: Now we have one to five per staffing.

COMMISSIONER PETIT: What?

KELLY OLESON: One to five or one-five. One of my -- for my supervisor and then I have seven staff that I supervise.

COMMISSIONER PETIT: But the workers have how many cases?

KELLY OLESON: They have -- ongoing has about 12 to 15 cases.

COMMISSIONER DREYFUS: Families or children?

KELLY OLESON: Families. And we have multiple children in each of those families. I wish they were single-children cases.

COMMISSIONER PETIT: Do you think 12 to 15 is right or do you wish it was even lower?

KELLY OLESON: I wish it was lower.

COMMISSIONER PETIT: How much lower?

KELLY OLESON: I think eight to ten. If you really want a worker to gather adequate, sufficient information to build that relationship for change, they need the time and space to do that.

JULIE AHNEN: I'll just add that I feel that this training is shining a huge spotlight on the central role that supervisors play. And in Dane County, in initial assessment we have a ratio of one supervisor to seven or eight workers, and that's really pushing the limits, and in ongoing it's one to ten, which is unacceptable. So we're -- I'm in the process of advocating for another supervisor position, but we're in a fiscal and political era right now where that's really difficult to even get people to buy into the idea that you need more workers and we -- in Dane County, we've seen continuous increases over the last five years in reports coming in, cases that we're screening in for assessment, and we've been able to stabilize our ongoing caseloads. We have probably about 12 per worker also, but that -- that's 12 families, and I think that's too high. And our initial- assessment workers are getting 8 to 10, sometimes 12 cases per month, which I think 8 should be the maximum in order to be able to gather that sufficient information.

But, you know, the nature of CPS is so unpredictable as far as knowing is this a sustained increase or is it, you know, a peak? Is it going to go down? And it's -- but we're constantly looking at those numbers and talking about how it's affecting our staff.

COMMISSIONER PETIT: So if a supervisor has ten workers and ten workers have 12 cases, that's 120 cases that fall under the review of that one supervisor.

JULIE AHNEN: Correct.

COMMISSIONER PETIT: Yeah.

JULIE AHNEN: And that includes multiple kids in out-of-home care.

CHAIRMAN SANDERS: Commissioner Dreyfus, this will be our last question.

COMMISSIONER DREYFUS: First of all, as a Wisconsin resident, thank you for your professionalism. Thank you for choosing this to be your profession and the excellence within which you guys are striving to do your work every day. Thank you. It's just fabulous. So I'm going to pick on Mr. Mayer, his turn.

So when I was administrator here, every quarter I'd go out in the field with staff in Milwaukee, and I would tell you where I learned the most was going out with your positions, when I would go out in the field with someone that was doing initial assessment. And what you are -- what you are being asked to do is Herculean in terms of trying to capture all things in a period of time to make decisions about, "Is this child safe?"

One of the things that we've heard around the country that some states are starting to do is when you're doing these screen-ins you know to be higher- risk cases, same day, we've got to get out there, they're sending multiple people out. Maybe an R.N. goes out with the initial assessment person or they contact law enforcement and law enforcement goes out. But it's more of this teaming that goes on, not after a case escalates and becomes a problem; but to team early on so that we really are gathering all the data, right, all the information that we can from a multidisciplinary perspective. How would you like that?

KIRK MAYER: I think -- I mean, if we could have enough staff to coordinate all of that, I think it would be great. But especially in Milwaukee, we get such a high volume of emergent cases, that I don't know if it would be feasible to have a nurse or a police officer on every -- you know, go out on every case. But to have someone there; like, for instance, the medical field, I -- obviously I don't know a whole lot about, and it's nice to have someone to lean on to have that expertise, and I think it would really be beneficial. I mean, when we get kids that are medically seen, I lean heavily on that information that's provided to me to make my safety decisions because, you know, they're the experts. And rather than sitting at a hospital for four hours, if I had, you know, a nurse go out with me or something like that or it could be a lot faster, we could be able to get them a lot more information, a lot shorter time, I think it would help the overall process.

COMMISSIONER DREYFUS: Thank you.

CHAIRMAN SANDERS: So I want to echo the thanks from Commissioner Dreyfus for your dedication to this work and the excellence with which you accomplish your task, and thank you very much. Thanks for taking the time to come speak to us.

So we're going to move into our last part of our agenda, and it is an opportunity for us to deliberate on an issue of significance, and that is disclosure, and Dr. Horn is going to lead us through that conversation.

COMMISSIONER HORN: So thank you, Mr. Chairman. So as part of the public policy subcommittees, one of the things we're charged with is taking a look at the existing federal statutes to see what kinds of recommendations we might recommend to the full Commission in order to further our mission which is to, if not wholly eliminate, at least significantly reduce child abuse and neglect fatalities.

One of the issues which has come before this Commission in various forms has been how -- what's the proper amount of public disclosure to be provided after the case of a fatality or near fatality due to child maltreatment. We particularly had sort of a truncated, in my view, debate about this in Tampa where we heard from some agency personnel, and we also heard from several journalists. And as you all may recall, the primary ordinance against full disclosure would be the right to privacy of the family members involved in the case as well as trying not to do harm to any ongoing criminal investigation. And the arguments for it, we heard, I think, compellingly from Amy today, that the best disinfectant is the sunlight and the way we're going to learn from errors that may have occurred is for there to be transparency as you look back on these tragic cases.

So I -- I sort of telegraphed my feeling about this. I have no firm conviction as to what our conclusion should be. So I have no idea what to develop in terms of a set of recommendations for you to consider.

So, in that case, I thought what I would do instead is come back to you as a Commission in the whole and ask for a conversation about this. And there are four questions that are in this short paper that Tom Morton developed for us. Thanks, Tom, for that. And that would be useful to help us frame our conversation.

So the first one I think is -- is sort of philosophical in some ways, which is, you know, what is the appropriate balance between family privacy rights and the public's need to know particularly regarding system accountability? I don't think anybody here would argue that the right -- the public has a right to know because of pure interest, that they're just curious, or they're interested in salacious stories in the newspaper. But, rather, it's really about, you know, improving the system.

So I -- we have judges -- we have a judge on here. We have lawyers. We have long-time child advocates. So I'd just be interested in hearing -- is there consensus on the Commission as to what the appropriate balance is when it comes to public disclosure after a child fatality or near fatality? So I'll open that up.

COMMISSIONER RUBIN: I think there was also testimony kind of around confidentiality law in terms of the culture of safety, which is that in order to really do continuous quality improvement, you can't get a situation where people working in child welfare are constantly being tried in the press, and -- and so they actually passed a state statute around confidentiality. So I think that's actually -- because I feel like we -- this is a very divisive issue. We've gotten testimony from both sides and it's ramming up right against each other, right?

COMMISSIONER HORN: Right.

CHAIRMAN SANDERS: Commissioner Martin?

COMMISSIONER MARTIN: So one of my questions when we come to issues like this is: So putting information about the case in the paper, how does that translate into accountability for the system? And the reason I ask the question is typically when we talk about the system in this framework, we're talking about the agency. When I think of system, I think about the court, the lawyers, the service providers, and everyone. And oftentimes when the newspaper goes after the agency, they go after the agency. They don't go after worker Pat. They don't say, "Worker Pat failed to do X, Y, Z," and whatever. It's "the agency didn't follow through." The agency doesn't lose any money. The agency doesn't -- nothing happens to the agency. Sometimes, very few times, a worker will get disciplined, but even if the worker gets disciplined, I look up in my courtroom and they're with a different agency the next day. They're with a private agency the next day.

So I don't understand what accountability means, the term "accountability" in this framework. I don't get that. And, more importantly, I would prefer looking at what failed, if something failed, and talking amongst the system stakeholders so that we can patch that hole in the system. That's where I would rather spend our time.

So I would rather spend my time with the heads -- so in Cook County we have a Table-of-Five meeting. The heads of all the legal departments come and sit down with me every month. I would rather, you know, call a Table-of-Five meeting and sit down and talk about that case and the circumstances of that case and see what we can do to make certain systemwide we don't repeat that same error, if it's an error, that resulted in the death of a child.

So if you can help me understand what accountability is and what that means and how they're held accountable?

COMMISSIONER HORN: I agree too. To lead the conversation, I'll be the expert witness. So I'm just saying there's many arguments and someone else may have a different opinion.

COMMISSIONER PETIT: I think we're in the situation we're in overall because so many families are experiencing so much crisis in their lives, which is what begs the question of people interceding for a purpose of protecting children from harm. They're in difficult situations. My condensed view is that in the end, all of it is political, in the best sense of the word. That is, our elective representatives have a duty of deciding how the culture's assets are divided, what the priorities are, what constitutes appropriate behavior. We have volumes and volumes and volumes of books that dictate what people's behavior should be whether they're driving cars or whether they're raising children, whatever it happens to be. And the fact that ACF and Children's Bureau are buried so deep within the federal government, and we look at what their tiny size is in comparison to the magnitude of the problem, what's clear to me over a long period of time is that politicians do not treat this issue seriously unless it ends up being dumped into their lap. It's too easy to blame workers. It's too easy to blame families. And we are in a very labor-intensive business. This is very labor intensive. And that translates into costs. And when I asked questions of people about what was your caseload ratios, what would you like for them to be, what about community service, we keep hearing the same thing over and over and over again, is that we need more help.

So now we've been on this tour for the last year, year and a half. We've heard from experts from all over the country, from all over the world. It's been a fascinating experience on this thing. And my very, very strong belief is if the public heard what we heard, if the public was seeing up close how the work gets done within these agencies, and I don't think we've had one session yet where, "Oh, my God, these workers are so stupid, they're so uncaring, get rid of them." We haven't run into that once. Every single time we hear workers, we hear the same thing that you keep saying, "Is what excellent work you people are doing, we're so happy you commit to the work," and so on.

So, for me, the answer -- it's not just your question, but I think your questions were different than this one, is the political process is what moves things around. It moves commissions. It moves budgets. It moves laws and so forth. And right now we've got at the highest levels of our government, whether it's in the White House or the state capitals or whether it's in the Congress, it's not treating this issue seriously. And so, for me, the only way they would treat it seriously is if the public wants them to treat it differently, and the only way the public learns about it is if we lift the veil off of what's going on. And I don't mean the interest case. And I don't mean he did this to her at this moment. I mean in terms of how the agency approaches the business, whether the laws are appropriate, whether they have adequate budgets and so forth.

So what I'm saying in the end is the -- is the press is the principal vehicle by which to communicate with the public, and they're not doing it on this because the public -- they don't have access to the information they need. And bottom line, and I'll stop here, is that I think once the public understands better that the solution isn't throwing all the parents off the Eiffel Tower, the solution is doing the kinds of things that we just heard here. We'd have less of a problem, fewer kids dying. But it needs to be made more political.

CHAIRMAN SANDERS: Commissioner Dreyfus?

COMMISSIONER DREYFUS: So I come at this and -- it's about for me as a former trial law firm director, it's about timing and quality, right? Timing in that whenever these child deaths happen -- first of all, let's all remember again that we don't know the exact number, but approximately just give me -- for today just give me approximately half of these kids aren't involved in the child protection agency at the time of their death, okay?

So I think about, first of all, timing. And I think about aviation. When a plane crashes, there's initial information that's given, right? There's not this rush to judgment. There's not the who did, who should have, what. There's initial information that's given, and then there's a quality and a confidence that the public has that the review that's now going to go on very much like the proactive safety review we talked about. If I thought the reviews of these cases, Judge, to your point were like that where they were looking at the Swiss cheese, right, coming all the way back and that the quality of what was ultimately publicly presented with that comprehensive view, I'm with you. Then, to me, it is about this is a shared community responsibility. Law enforcement was involved, health was involved, education was involved. There were more eyes on this kid than this one lone social worker, right, and just kind of right-place-wrong-time kind of thing. So I look at it in terms of the timing of what gets released when.

And then the quality of the kind of proactive safety review that gets done. It winds through that Swiss cheese. And when that's presented, it's prevented in a very professional, very comprehensive way all through the purposes of -- as Commissioner Henry's doing in Tennessee for forward-leaning CQI in the system.

The only other thing I think about is parity. I can't help but -- there's a part of me that just have a -- because it's been the work I've done, I have my own bias, but I try to step back from that and think okay. If a parent is driving drunk tonight in Dane County, crashes the car, and the child dies, what's the public disclosure there? Everything, right? I -- I struggle a little bit with somehow thinking that this is different in terms of what the public knows when a child dies. So I have my own struggles is all I'm saying, right? I'm trying to think, well, if it happened in this system versus this system, why is it so different? So, anyway, those would just be my things, time, timing, quality of the review, so that it's part of forward-leaning CQI, comprehensive in nature, and then I'm still struggling with this parity issue.

COMMISSIONER MARTIN: So that's why I started this conversation off with what does accountability mean, because if it's a drunk driver that hits somebody, hits a post and kills a kid in the backseat, you're right. On the front page tomorrow it's going to be Pat Martin had her nephew in the car, was driving drunk, hit a pole, killed the kid, so -- but when you talk

about accountability, the reason for bringing it to the public is for accountability. That's my issue. Now, if you're bringing --

COMMISSIONER DREYFUS: It's the wrong reason, I think.

COMMISSIONER MARTIN: So if you're bringing it to the public so that the public knows what's going on with my children and you give generic information, I have absolutely no problem with it.

COMMISSIONER DREYFUS: Right.

COMMISSIONER MARTIN: I have no problem with it, because you're not telling me that you're going to do something about it. You're just giving the information to the public for informational purposes, and I don't have a problem with that as long as it's generic information. If you're going to take the time and do like the FAA does after a plane crash, so they give the general information that plane number 2 went down going from Chicago to Frankfurt at 2:30 today, and then the FAA's coming in to investigate and it's going to take six months to investigate, a year to investigate, and, you know, six months later someone puts out a report about flight number two, that might be different, because then you've taken the time to actually investigate and find out what happened.

COMMISSIONER DREYFUS: And it was independent.

COMMISSIONER MARTIN: And we don't jump to the conclusions that it's the agency, because, quite honestly, every time an agency moves, the court has to codify it one way or another. So if you're saying the agency messed up by doing X, Y, Z, you should probably say the court codified it.

So I'm just asking if we're going to try to hold someone accountable, let's actually hold them accountable and do something about it. But if the purpose is just to notify the public, then I think the public information, the requirements may be better.

COMMISSIONER DREYFUS: It asks the question. I want to stop with this. It troubles me when the only reason we're doing this is for accountability. That -- that may be part of it. But it's got to be for -- because we understand that the welfare of America's children is a shared responsibility and we all benefit from understanding that as both neighbors and practitioners and professionals, right, in our communities. So it troubles me a little bit when we're even having this conversation, because the beginning and the end of the reason for doing it is who's to blame. That's not necessarily the right rationale.

COMMISSIONER PETIT: Let's agree though that that by itself, it would be absolutely not effective to do. There's multiple benefits. There's multiple spinoffs on this thing including what have we learned about the situation that we don't want to do again in the future? I mean, that -- that is part of it. It's do any of our statutes contribute to this or do they interfere with it or are they helpful? Now, is there enough money that's in the system? I mean, that's what opening it up and looking at, what some of the policy and practice issues are. It's not just accountability. It's also ascertaining whether what it is that we're doing is adequate and what else is it we need to do; not just simply who screwed up on this kind of

situation. And that's not where I'd be starting from. I'd be starting on an informed public leads to an informed legislative and public policy process.

COMMISSIONER RUBIN: Yeah. I think you had a lot of great comments in the meeting. I mean, I think there is -- just to be able to tell the news, but at the same time I find a lot of the reporting that goes on around child deaths to be exploitive of the kids. I don't think the person reporting is necessarily doing it in the best interest of the kid. It's a "gotcha" mentality and suddenly we've decided the press could be jury and executioner, and what we're having is a traumatized system that -- I was very impressed by the testimony in Tennessee, which is to really dial back the way medicine does, and that doesn't mean you can't have transparency and accountability. That, to me, this gets to how we construct our near miss and our fatality teams and what their responsibilities are and what their responsibilities are to public disclosure and that the composition of those teams can convince the public that they're unbiased and they're not just shields of the system, all right? But I actually -- you know, we would never release medical records to the press. I mean, like -- and the idea that we're talking about this and suddenly child welfare is handing everything over to the press, like it's sort of strange to me.

COMMISSIONER RODRIGUEZ: So I wanted to say two things. The first thing is that I actually think that some of the accountability and the reporting of these stories should be on the public, because I think -- and the stories never get reported in that way, but there actually are a number of things that folks who listen to the news, read newspapers can do, and they're never given sort of the action items; that if you see a child that you're concerned about or a family that you're concerned about, you should pick up the phone and report and make a phone call, because this could be -- this could be this child in this case, that we need folks who will step up and be foster parents. We need folks that will step up and be mentors. So, instead, I very much agree, and I think it's actually oftentimes worse than just demonizing the agency. I think sometimes the stories are reported for the sensationalism of whatever happened within the family and, you know, I mean, we have a whole -- I know several people who spend way too much time watching this whole channel that's just dedicated to murders. You know, it's like Discovery Murder ID or something. Don't record that. But, I mean, it's --

COMMISSIONER DREYFUS: It's like Wade and plane crashes and The Weather Channel.

COMMISSIONER RODRIGUEZ: We really do have a culture where people are very interested, and sort of we have talk shows that are dedicated to this and other people's dirty laundry. And so, to me, that's entirely disrespectful and offensive both to the child who we didn't rescue and also to the siblings and to the rest of the family who should be allowed to grieve in peace, and this interferes. So I think that's one thing, is that there should be some accountability in the reporting around the fact that it does actually take a community in order to get involved; and we don't ever tell people what they can do. So I think that's -- that's one piece of it.

The other thing I wanted to say was that I do think it's ridiculous that people comment so quickly when they have no idea what happened.

COMMISSIONER DREYFUS: Exactly.

COMMISSIONER RODRIGUEZ: I mean, it actually would be foolish to think that you could immediately within a week or even a month sort of give a story to the newspaper even about what you think systemically went wrong, because if we're talking about a forward- leaning, careful analysis of exactly how we got to that point in the Swiss cheese where the accident happened, then that actually's going to take time. It's going to take interviewing people. And it seems to me like that -- we should be slow to that.

And then the last thing I just wanted to chat with folks on is that I very much support this idea of being generic about when we do disclose information to the public around not naming names, not including identifying information, and I just wanted to check to see if there was consensus in this group around that as a -- as a principle, because that's definitely not the way -- I think that -- I don't think the news -- the news outlets even have bad intentions. I think sometimes they want to really drive home this was a member of your community. You may have seen this child. It was a real person, real child. We'll show you photos. I think they're trying to sensitize people to that fact, but I think it's -- it's really destructive ultimately to whoever that child -- is connected to a whole number of other people. And while I'm not trying to protect the perpetrator necessarily, you know, that there's more people other than the perpetrator. So I wanted to just check in with folks about that principle.

COMMISSIONER STATUTO BEVAN: I -- I do agree with you on the -- and Michael too. I agree -- and Patricia too. So I agree that the names shouldn't be listed. I mean, I don't think you should have -- I don't think you need to have a public disclosure where it's a data dump or something. But I do think in order to put a face on it for the public, we do need -- they need to know that this child died. They need to know that.

COMMISSIONER RUBIN: Sure.

COMMISSIONER STATUTO BEVAN: And I don't know, you know, how to couch it any other way. I'd also note something that Judge Martin told me. She brought up at one point the little boy in Illinois, Joseph, where his last -- the picture in the paper was he was like this. And, of course, you know, I, like everybody else, was just totally outraged and I wanted to know what happened to them and the family. I wanted everybody to be, you know, executed. And Judge Martin said, "He had -- he had a brother. I mean, he had siblings." You know, and what did -- you know, what did that do by --

COMMISSIONER RODRIGUEZ: It's devastating.

COMMISSIONER STATUTO BEVAN: Yeah. It's devastating and it didn't serve -- it certainly didn't help anybody. So, you know, I don't think it needs to be identified. I don't even think, you know, the picture needs to be in the paper. But I do think that some indication of what had happened to this child and some indication of what the agency's doing or what somebody's doing, some action that somebody should be taking. For example, when there's a child found in a dumpster, the first thing you read about -- and the agency is looking for the mother. Well, who do you think dropped -- put the baby in the dumpster in the first place? Why are we -- why are we looking for the mother right away? I mean, so there are -- okay. I know all you social workers think I'm a little bit insensitive, but -- and you can meet me in the ladies' room after. I do think -- but I do think that -- no. I want to -- I think that that's one

thing that the newspapers pick up and that a lot of people read it and they say, "Oh, they're looking for the mother." You know, then -- but why don't we learn something constructive, like what Judge -- what Commissioner -- what Patricia was saying. Why not say this is one of how many this year and how -- you know, in this state and what happened -- what's happened to them? Why can't we -- you know, some education around it.

COMMISSIONER PETIT: So when we see these cases now, we're reading about a criminal action typically. A child was killed, a child was killed, and there's complete reporting on that. The DA doesn't not give us the name of the kid. They don't not give us the name of the person who's being tried. We know all those things.

So the question is how can you balance, how far do you go with this thing? And I think, David, your point about, well, my God, in healthcare we don't do this. Well, healthcare isn't a public safety issue. This is a public safety issue, which brings a different dimension to this whole thing. It's an open-court process that looks at the criminal aspects of this thing.

So I think, Jennifer, you asked is there consensus on the specifics. There isn't a consensus if a consensus means 12-0. There's an aspect to this that the way the public learns is in a moment of crisis, not by talking generically or generally. We do that now.

The other thing, I guess -- maybe we're all in different places, tell me -- but I've been reading all these articles that Tom sends every day. I've been reading them for 25 years, 35 years, 40 years. I've been in a thousand stories myself on this thing. And I've got to say the reporting that I see on this overall I think is very good. Part of the reason sometimes is because the departments are hiding behind the confidentiality cloak. If you want to light the fire under the press, tell them no comment or we're not going to provide you with the information. So part of this is a dance between the press and the government agencies. But overall reporting I see -- I'd like to hear if you feel differently. Tom sends us stuff every day, which I think is great reporting going on on this topic.

COMMISSIONER ZIMMERMAN: I agree with everyone like Cassie. I agree with aspects of what everyone has said. Except I think it's when we're thinking about the investigations that happen after a plane crash or after a tremendous fire or some other event that has occurred that's particularly tragic, all of us -- almost all of us have been on planes, right? There's lots of air travel. We all can place ourselves in that situation and we all as air travelers -- how many of us travel how many times -- we want -- we want that investigation. We don't care if it takes two years. You find out -- you find out what happened so I can be safe.

These investigations are about somebody else's kids, not my kids, not my kids, not my -- not my family, not my neighborhood, not my community, not my people group, not my ethnicity. This does not happen.

So part of the -- for me the free press in a democracy says the public has the right to know. I agree that -- I don't agree with sensationalization of any of this, but I have to tell you the impact of that Florida newspaper with all of the pictures of those little kids said that those were my kids, because those little faces looked like -- some of those little faces looked like my grandkids. Some of those little faces looked like my neighbor's kids, you know, my best

friends' kids. So it put very much this is our kid, kind of, and so, therefore, I want the system to respond differently.

So that one of the last plane crashes was the -- it was a mental health issue with the pilot. We don't blame all pilots. We're not all freaked out about the mental health issues of all of the pilots --

COMMISSIONER HORN: I am.

COMMISSIONER ZIMMERMAN: -- when you're flying across this country, right? We realize it was this isolated incident of this particular pilot and do they have -- yes, they probably do. But hopefully there's all of these -- we learn that. Let's put in safety measures. It's the same thing with, I think, any system, but the child welfare system, as we've been hearing across the country for a year, is not just child protective services; that the blame or the heroics don't just lay at their feet. It's schoolteachers and police officers and neighbors and grandparents and child welfare workers and bakery people and taxi drivers or bus drivers. It's anybody that lays their eyes on that kid, any system that serves that kid, and I think that that's part of how we have to think about accountability and not lying just at child welfare's feet, but accountability to the community. What's this going to look like? I have no idea, but I do think that thoughtful -- as Jennifer described, I think about how do we promote this idea of child safety and well-being in the press? But I'm telling you the pictures of those babies changed me, and I think changed me for the better because those were my babies.

COMMISSIONER HORN: David, do you want to say something?

CHAIRMAN SANDERS: I can't say I agree with everything that everybody's saying.

COMMISSIONER ZIMMERMAN: I don't agree with everything.

CHAIRMAN SANDERS: Just a practical consideration. When I was a child welfare director and I got calls from the press, it wasn't as if I was releasing the information. I mean, they already knew. They knew from law enforcement. They knew from families. They had pieces of information. And I think that the response that there's nothing that I could say it seems erodes the credibility of the full system.

And so I -- I agree entirely with what David said, because I kept thinking I don't want my medical records released to the public under any circumstances. At the same time, law enforcement is involved in a quarter of these cases, at least in the jurisdictions I was part of. They released names routinely. And so, I think, it's -- if -- we all obviously have our feelings about it, but I think how we deal with that issue, that information is out there, it's usually partial information, and there's no ability to fill the public in on what the information is. I think it's a challenge regardless of kind of how we feel about it.

COMMISSIONER HORN: Yeah. You're making a turn in the conversation that -- so, you know, at the 20,000-foot level, there's sort of philosophy about what -- about this. But there's some practical sort of considerations that I think that the Commission needs to think about.

So, number one, first of all, it's just not true that nobody ever writes stories about kids who died from child abuse and neglect and don't have their names, because Tom sends them out to us on a daily basis. It's usually not the first thing I read in the morning because it's very

depressing to read these very, very horrible details. But it is -- they got that information somewhere. So the first question, practical question, is exactly what you just articulated, David, which is when the press calls the child welfare agency, how is the child welfare agency supposed to respond? And the typical way a child welfare agency should tend to respond is, "I can't comment." And then what happens then is the next newspaper article. "Veiled secrecy at the child welfare agency," and now we're going to dig even -- we're going to dig deeper, because they're obviously hiding something.

So do we as a Commission have anything to say about how child welfare agencies should respond to press inquiries, usually with a lot of information already, including the name of the child and the name of the perpetrator, do we have anything to say about that? Maybe the answer is no. Seriously, I have -- I did not come to this conversation with any -- any conclusion that was well-formed in my head, but that's one.

And second question I think we have to wrestle with is the CAPTA requirements for disclosure, because one could have interpreted some comments earlier in this conversation to mean we don't like the CAPTA disclosure requirements because they -- they don't just say you have to -- you only disclose lessons learned. That you have to disclose the gender of the child, you have to disclose the details of the death. There's lots of requirements in CAPTA. My guess is based on conversations, some might say that's too much and some others might say it's too little, and I don't -- you know, do we as a Commission have an opinion about that? That was why I asked when Amy gave her very -- I guess somebody must have planned it this way -- gave her well-timed testimony earlier, and I'm looking at her -- her -- her recommendations that, for example, that states are required under CAPTA -- to clarify, at least, circumstances of the cases for both deaths and near deaths, and some number of states apparently have done near deaths. Do we have an opinion about that? Do we think it should -- should we be strong about that? Should we clarify that disclosure is mandatory or is there -- I mean, I think there's a lot of issues here that we -- that are really at the heart of CAPTA and this Commission; that if we don't have consensus, that's fine. We don't have to achieve it. But we should at least go through those -- those questions.

COMMISSIONER PETIT: Commissioner Zimmerman, Rubin, Petit, then Martin.

COMMISSIONER ZIMMERMAN: So this is just a very brief little comment. One of the things that I do know from the discipline of suicide prevention is that when there is a suicide of a high-profile community member, whether it's a student athlete or a bank president or a United Way director, the press will cover it, right, because it's a sensational kind of story and they can sensationalize it. But suicide prevention has created the best practice around how a community responds to the media. And so they have a media tool kit where they say if you -- you know, suicide prevention in schools, here's how you can handle it. Agency, here's how you can handle it. There is -- here's a perfect -- it's an opportunity because they have found in the past through research that those sensationalized stories created higher risk and sometimes were the sort of the impetus for a suicide cluster, other students dying by suicide within, you know, weeks of that initial suicide. So there is some best practice around and then here's what you can do if you're depressed. Here how to recognize. Here are the signs. Here's where to call. Here's the crisis numbers. They did all of that. And I can see that, as Jennifer was

describing, that sort of thoughtful way of child welfare or CPS workers responding with this sort of -- their own agenda.

COMMISSIONER HORN: That's really interesting, because I'm sure there are exceptions to this, but in most of the articles, Tom, that you send around, there isn't -- maybe because they're not included the way that you have to send the articles. But there's no sidebar that says, "If you're feeling stressed, you know, call this number." There's nothing like that. That's an interesting comment.

COMMISSIONER RUBIN: Yeah. I was just going to say for -- I mean, first of all, my comments about, you know, the press, I mean, I don't want to generalize for all stories. That Tampa story was terrific, and part of what made that story terrific was that she took a lens of all the deaths and she really did an investigation of how many were being reported by the state. There was a population perspective that brought sort of a unique aspect as opposed to, okay, a kid died yesterday. Let's fire everyone today, right? So there's great variability.

That said, I think one thing -- I think it's going to be very hard for us to issue a recommendation on public disclosure. It's too radioactive. I mean, we have free press in this country. You know, law enforcement is always going to release the names and I think there is some value. We don't want to set different rules for people knowing that what's happening to our children versus what's happening to adults in society.

That said, in my gut, I know that if we're going to be in a very open environment, you know -- and people react strongly to this, but I think that what Tennessee and the culture safety around in terms of how do you have meaningful behavior change within systems, you have to protect. It could be -- you know, you certainly don't want to protect the person who fraudulently or actively participated in the child -- but the perpetrator killed the child. We failed to prevent that from happening. It may be from some level of negligence, some poor decision-making, et cetera, but it's almost like these workers become the perpetrators, right? And I don't think that benefits a continuous quality improvement system. And so there has to be -- I don't know if there's -- if there's a middle ground in terms of protection from liability or, you know, people respond strongly to even protecting the confidentiality of the workers. And in that system, the potential damage that does to an entire learning system trying to improve the process who are retained caseworkers, we can't understate that.

So I don't see the public disclosure part, but I don't know if that means we should wade into some recommendations from folks who have thought about, like they did in Tennessee, some of these protections of individual workers in terms of being able to learn within a system, or is that too -- is that too much of a --

COMMISSIONER PETIT: Well, for 12 years on child welfare in America, for 12 years we conducted workshops for the states on this question of how to respond to a child abuse fatality. They eagerly, actively participated in that process every year and they knew that the wrong answer was, "We have no comment." And the question about did someone screw up, yeah, you raised this question about whether or not a social worker, did someone screw up. Maybe the social worker triage, because they had too many cases, as we heard a few minutes ago, and they made a calculation that said, "This is the one that seems to need attention." They were wrong. They would like to have gone out to both households, but they weren't able

to. They were able to only do one of the households. And at some point you start to educate the public about it.

Now, if you say no comment, what you're doing is eroding public confidence in the agency. At that point, you've got legislators that are skeptical. And the way the press starts to report it now is not the commissioners said they were actively looking to review this case. They were going to farm it out to an independent body, et cetera. What you now start seeing is language like "department admits it was involved with this case" or "admits that it was" -- as soon as you see the word "admits," you know it's going to be a bad day for the paper.

And I think, Marilyn, the point that you raised about the visual of the children, if you take a look at that cover, it is directly lifted off the cover that we wrote at Every Child Matters a few years ago in which we put 50 kids on the cover and we knew what that would mean. It had a strong mode of impact. That was the whole intention on this, to do exactly what you said; is they're not my kids, but I care about other people's kids as well. And that's what a system does, is it looks at not just family kids; it looks at everybody's kids.

So I don't see, David, that this is a radioactive topic. I think it's a difficult topic in terms of balancing it, but I don't -- I don't see it as radioactive if we say the purpose of all this is to educate. It's not to hire and fire. It's to educate.

COMMISSIONER RUBIN: What's the prescription? You know, I mean, I'm just struggling. Like this is one of those areas on what can we prescriptive about around public disclosure? Is this something for local communities, states, to grapple with on their own?

COMMISSIONER PETIT: It's in the process --

COMMISSIONER MARTIN: It's my turn. After Michael it was my turn and I waited patiently. So thank you. I don't think anyone around this table has said that "no answer" or "no comment" is the appropriate response. So we can take that off the table, because I don't believe anyone has ever said that around this table.

Secondly, I think that one of the -- one appropriate way or one way to consider responding to the press is what I encouraged them to do in Cook County; and although we don't have an independent investigatory team, we have our Table of Five. And so I tell the agency when staff -- when the reporters call you, when they call the guardian's office, which typically in Cook County they call the guardian's office first before they call the department until a few years ago, okay, for political reasons with a small fee. I would say, you know, "Judge Martin and our Table of Five were explaining who these people are are prepared to make a statement, but we'll make a joint statement." Because then we're not trying to assess liability. What we're trying to do is figure out what's going on. And the statement that I typically would put out is that a child died. The child was in foster care. The case had been in foster care for the last 15 years -- hopefully not 15 years -- but last two years or whatever, and there's a continuing investigation going on and we will make further statements as the investigation goes on. I don't even specify who's doing the investigation. Because part of it's done by the cops, part of it's done -- part of it's done by me. So there's no need for the press to know who's doing any portion of the investigation because it might need -- it might need to

be augmented, and I'm not going to make a commitment to go back every time something changes during the investigation.

And I also think that the issue about the reason I had such a problem with the question is if we're doing it for education, that's completely different, and then you can lay out something that Jennifer -- I'm sorry, Commissioner Rodriguez suggested, about if, in fact, you know -- the big one is that they leave babies, right, in alleys and they leave them in garbage cans. You can talk about the Safe Haven laws. You can talk about what's there to help prevent or to minimize those kind of circumstances. And that to me is a -- you can call it generic. That's an informational statement that doesn't deny that something happened, a bad outcome, for a kid who's five years old who's been in foster care for three years or whatever. And then you can take it upon yourself -- in Cook County I have -- I open my courtrooms to the press. I open up my court files to the press. But I have an agreement with the press that we won't print the name of the kid. Now, that's Cook County, and gosh knows, I know I can't get anyone else outside of Cook County to even consider that. But we do it because it's informational and educational. I also invite the press in when there's nontragic things going on to sit down in a courtroom and see how the cases are progressing and invite them into mediation so they have context in which to put information when a crisis does occur.

So I think there's a lot of education we can do. I think we can be proactive about education. I have no objection to educating the public and the press, but I don't want to do it on the backs of my kids and violate their confidentiality.

CHAIRMAN SANDERS: Actually, Commissioner Rodriguez has something.

COMMISSIONER RODRIGUEZ: So I just want to -- I mean, as I'm thinking about this, I think that actually this discussion, it sort of goes hand-in-hand with the -- with the concept of whether we're recommending something standard happen after there is a child death, because I think that one of the reasons that we accept when there is an airline crash, we accept an abbreviated statement like, "We are grieving with the families and this is a terrible tragedy and we'll -- we are going to get to the bottom of what happened to make sure that this doesn't happen again." Why folks accept that is because they just have trust and faith that, in fact, there will be a process, that it will be a thorough process, that there will be a set timeline for it, and that there will be a response back. I don't think anybody doubts when there's an air -- I mean, people may, you know, sort of have some conspiracy theories about how the investigation actually plays out, but people know, in fact, there will be an investigation. They know that there will be a timeline.

So I think some of this naturally resolves if, in fact, we move towards having everybody do some kind of forward-looking, you know, really safety analysis every time there's an incident. So I think that's -- that's one piece of it. And I think it's never a good idea -- I just want to say -- to say "no comment" because in my -- in my opinion, having grown up in foster care and feeling like those are all in some way my siblings, whenever I hear somebody say "no comment," it just feels entirely heartless, like they didn't care about that; and I know that that's not often the director's intent, but when I hear that, that's what I think. So I don't ever think that's a good idea. But I think there are generic things that you can say. So I think those two things are hand-in- hand.

And I just wanted -- I was glad when Commissioner Zimmerman brought up the example of children who try to commit or do commit suicide successfully, because I think for children who have something horrible happen, either in foster care or are removed and put in foster care who do not die, there actually is a journalism sort of code of ethics about not reporting the name of the child and, you know, that came from a lot of training of journalists about what the impact was on young people when -- and I remember - - I did this training back when I was doing youth organizing and it was sort of the advent of the Internet being so prevalent. But the thing is is like in the Florida case, I just remember the story of Nubia. That story was so horrific with all of the details. And so when her sibling goes and Google's his sister's name, that's going to be what comes up. It's sort of blow-by-blow the abuse that happened in the bathroom, the exact way that she was killed, and the story was written blow-by-blow with a lot of detail to make it sympathetic and sort of for people to understand how horrific it was. But she did have a sibling, and so for the rest of that sibling's life when he is 30 years old and goes to apply for a job, as is standard now and somebody Google's his name, that is what's going to come up as that first thing. And I just think all of us who have experienced that and we've been in the system, we have a right to be able to move on and at some point to have some privacy around the things that happen in our families.

So, to me, there's a difference -- it's different to say we're going to take a bunch of photos or even one photo and we're going to sort of use it in a respectful way where we don't go into all of the details but we highlight there are children in communities, but it's another thing when you are talking about sharing lots and lots of really kind of graphic details about somebody which, what's to me new, should be for a purpose. Like it's either to educate you, to tell you something that you need to know, might be naive about what news is supposed to be for, but I don't see the purpose in telling people a million details about what happened in a family.

COMMISSIONER HORN: Go ahead, David.

CHAIRMAN SANDERS: So I would just go back for a second to the question, because -- and, Pat, you touched on this issue of public accountability which is in the heading. But the question itself doesn't necessarily relate to the media and we immediately jumped to the media conversation, and I think that they are distinguishable; that saying the public has a right to know may be different than believing that the media is the right vehicle to convey that information. And in today's -- I mean, you just described ways actually, Judge, of how you do that directly, not necessarily through the media, but in opening up your courtroom, things like that.

And I -- I would go back to the question of that balance between what the public should know and what individuals should know as part of the conversation, not necessarily saying the media is the only vehicle to convey information.

COMMISSIONER HORN: It seems to -- yes. And we're probably not going to be able to solve the Constitutional issues involved with the free press and we're probably not as a Commission going to be able to dictate to the press how -- however it gets its information how it's going to write it up. I do think there seems to be consensus that we could at least say something about when the press does write about these, that, you know, we think they have an obligation to also provide resources so that people, if they are in similar circumstances, using the suicide -- coverage of suicide cases as an example, certainly; and I think also maybe even to make a

statement about the sensitivity of in today's world that information stays forever. Please don't Google my name.

COMMISSIONER RODRIGUEZ: And to make a clear statement about the process moving forward.

COMMISSIONER HORN: Yes. So -- but then there are very specific --

COMMISSIONER STATUTO BEVAN: And the law that's broken. I mean, I don't think the papers ever really say. You make it clear. A law's been broken here, I mean, you know.

COMMISSIONER MARTIN: Well, we're not the judge and jury.

COMMISSIONER PETIT: No, but the judge and jury are covered in the prosecution. There's a detailed court record. There's nothing that's shielded from the public on this thing when these are criminal cases when there's a death that is in the criminal justice system.

You know, Wade, you know, you talk about patient respect. We can read this thing and do it respectfully, but the message is also being communicated to lawmakers and to governors and others of saying do it respectfully. Fund these workers with an appropriate caseload. Pay them an appropriate salary. Give them the actual training that they need. I mean, that's what it seems to me this is ultimately about, is a public education effort that moves our policy in a different direction.

COMMISSIONER HORN: So what about the very narrow -- I'm sorry.

COMMISSIONER RUBIN: Why don't you ask your follow-up questions before I change direction?

COMMISSIONER HORN: Well, I was going to change the flow.

COMMISSIONER RUBIN: Okay. Good. So two things. Number one, is there any press still here at this time of the day? I would like -- during -- when we're finished, I would like to -- so I do want to talk to you after.

UNKNOWN SPEAKER: I'm no longer the press. I was for 20 years.

COMMISSIONER RUBIN: Yeah. No. I'm interested -- because we don't have anyone here from the media. But I also think there's an opportunity in the public accountability. I like the idea of these softer recommendations, that what does good practice look like in terms of public disclosure? And maybe that's where we end up. Because there is no codified federal statute that we're going to have around public disclosure, I don't think, because I think it's too big of a lift.

COMMISSIONER PETIT: They're working on it right now. The CB and ACF's doing that now.

COMMISSIONER RUBIN: Okay. So maybe there is. Maybe we need just to see exactly what they -- what their recommendations are. But I sort of like some of these ideas about sort of best practices, and I think if we create public accountability through our teams and how we release information about those reports, there's nothing to prevent those teams either from including the media or working with the media around the kind of Tampa story that we saw, which was a very reasonable story that gave a full-picture view of what this interdisciplinary

team had reviewed over the last six months and the number of deaths this year compared to last year, you know, and if they wanted to kind of tell that story.

So I think we're never going to control the stories that come out, but we can give best -- we can give best practices. And so I think those are the -- would be the things that I would try to accumulate.

COMMISSIONER HORN: I think that's terrific and extremely helpful and I think we should do that. In addition to that, we do have this thing called CAPTA, and CAPTA does have requirements, and there is a requirement in CAPTA for public disclosure. And there is -- there are PIQs that the Children's Bureau have issued that gave more definition to it and this is -- in contrast to some of the conversation we've had in the last year, which is maybe related to but not central to the issue of child death. This is central to the issue of child death. This is exactly the issue. So I -- to be silent on this seems to me -- and maybe we say -- best we can say is we don't have consensus on what's the best way to approach. But CAPTA does require that states affirmatively provide information to the public on every case involving a fatality or near fatality. It doesn't say they might. It doesn't say if you really think it's a good idea, go ahead. They don't say you can't. They say that you must. And then they go on in the PIQ to say it's got to -- it must include and not limit it to causes/circumstances regarding the fatality, the age, the gender of the child, the information described, getting police reports, or child neglect investigation. I mean, there's a whole list of things that says you must include and this is the minimum.

Now, do we think that that's a good idea? Do we think that's a bad idea? I don't know. This is -- I don't -- as I started to say, I don't have a fixed opinion on this and I wanted to benefit from others. But, you know, it does seem to me we can't ignore, particularly since Children's Bureau is actively asking for input from the public right now for this -- on this very issue. And if the -- and if we -- again, we can - - we can say some of us think this and some of us think that, but I think we can't just --

COMMISSIONER RUBIN: I didn't hear time, so like -- you know, so I do think that what -- we could create expectation -- I agree there should be a full disclosure of all those elements in a public disclosure, but it doesn't necessarily have to happen within 24 hours if you don't know what's gone on. And so I think our expectations that maybe this is -- you know, Teri's not here, Commissioner Covington's not here, about what is the appropriate time frame by which, you know, deaths that are accumulating during the years should be released in terms of providing that public disclosure. Maybe that's what we need to focus on, because that's the role of those teams is to provide that public accountability.

COMMISSIONER MARTIN: But can't we do it the other way? So instead of saying that within a year, we'll provide all that detailed information, why can't we say our initial response will be, you know, very generic, but there's a continuing investigation going on which ultimately will result in, you know, publishing or getting to the public that information?

COMMISSIONER HORN: And that's why I think that the woman -- our first presenter here in Wisconsin is that you have the first one published within five days. It's a very quick summary. She didn't actually guide me to their website. It's worth looking. Both the five-day summaries and the more detailed summer and then the final thing are on there. You can read them. It's

a little hard to find it, but to look at them on the website, that's better. Just kidding. But it's -- it's interesting. It's instructive to see how the initial information's relatively small and then it gets more detailed. But in no place does it say it's -- you know, Sally Jones and Jim Jones and Doug Johnson who were involved in this with names. And then it does talk about some of the issues like lessons learned. It's very instructive. I thought it was really -- yet I noticed they got a D on the report card.

COMMISSIONER RUBIN: So whoever the person is writing who's writing those recommendations for that statute that you just talked about, Commissioner Petit, like maybe it would be helpful to try to get some testimony from that person, because that person clearly has vetted some specific recommendations around public disclosure. We could at least hear -- I would like to know what those are.

COMMISSIONER PETIT: I can just tell you it's been debated in numerous states over the last year or two that we've been around. It's an active issue at the state level in terms of bringing this up. And now we've got the federal government that's in the process of this. Seems to me that we do have a consensus on the broader aspects of this thing. I don't think there's anyone at this point saying roll back the CAPTA provisions, undo them, modify them. Does anybody want to weaken them at this point? So I think part of this is just encouraging the field as well to come forward on this thing and to have governors or legislators or attorneys general; not just, you know, a few social workers in the back room with a few local providers figuring this out. Seems to be elevated to a higher level. Just as 51 million air bags killing eight people over a ten-year period is front-page news and is addressed by the White House and the Congress. So should this.

COMMISSIONER HORN: But that report also says -- Amy's report says there are a number of states that do not require public disclosure on near fatalities. You know, one of their recommendations is that Congress should make it clear. They said that, "No. You can't limit it because the statute says you can't limit it to just fatalities." Do we want to make a statement about that as well?

CHAIRMAN SANDERS: I'm sorry to -- that's already clear in the statute. I mean, states haven't interpreted it in that way, but it's already clear.

COMMISSIONER HORN: Okay. That's fine. We all -- we talked about how we were going to, you know, fine states for all sorts of things that they were doing, you know, relevant to the statute. And in this one we can just say, okay, we now know that some states are not reporting on near fatalities and that's okay with us or we can say something stronger. You know, I don't -- I don't know about it, you know.

CHAIRMAN SANDERS: So maybe I misunderstood, because they should -- I mean, it is the law and so they should follow the law or at least -- I mean, I don't know that we have to restate that or we --

COMMISSIONER HORN: Or about the issue of ACF issuing regulations.

CHAIRMAN SANDERS: Oh, okay. You're saying about ACF --

COMMISSIONER HORN: Yes. Yes. So it's ACF.

CHAIRMAN SANDERS: -- not about --

COMMISSIONER HORN: Should we say something about issuing regulations as being -- which, by the way, I'm not convinced I agree with Amy's understanding of committee language as having the force of law. Having served in government, federal government, committee language does not have the force of law. It is -- you ignore it at your peril, because they can haul you up there and question you about it, but it's not the same thing as a law. If it were the law, it would be in the law. And so there's -- you know, there's sort of -- it's -- and it's only committee language on one side of the House -- I mean one side of Congress. There's also language that accompanies the final bill, and that is more important than language that's in either the House or the Senate committees. And we were always -- we could and we did upon occasion ignore what was in even a full Congressional committee or, you know, appropriations report.

So I -- it's -- I think it's in -- I just want to correct my understanding, that it's not -- they're not ignoring the law by not doing the regulations because that's not in the law. It was in the committee --

CHAIRMAN SANDERS: But my -- I mean, if I recall from my days as a child welfare director, CAPTA already states the requirement to release information about fatalities and near fatalities.

COMMISSIONER HORN: Yes, but it doesn't say they can't release the information and regulate.

CHAIRMAN SANDERS: Right, right. So that's the piece that's not there. But in the statute it says that you have to release the information.

COMMISSIONER HORN: Yes, absolutely. And then the question is do we want to say, hey, do we want to - - we're on the side of the Health Committee and ACF should write regulations.

COMMISSIONER RUBIN: I will say the more I sink my teeth into child fatality reports that are distributed by the states to actually be to the 22,000. They're too much at 45,000 feet. The kid's reduced to a statistic, the proportion of perpetrators who were, you know, boyfriends versus -- and so I -- I wonder if part of this is -- you know, I mean, when a child dies, it's so unique and tragic and I think it's important for the public to know -- I always say this when I'm reviewing papers that have to do with fatalities. Like I want to know what the case is worth. And that you could really standardize some expectations around the reporting by states of their fatalities to actually tell the story. Like we want an appendix where you don't have to name the child, but the nature of the child's death, all the stuff they have in the public disclosure, the systemic issues that may have been identified and how they were addressed by the system, or you can come up and actually be prescriptive to the extent of how that public reporting does occur, and I think that's where I hear you're going. We could take a strong stand on wanting some basic information as part of every fatality report. I don't know if there are other groups that have thought about that as the practice.

COMMISSIONER RODRIGUEZ: So I was going to say something really similar, which is that, to me, if the purpose of the public disclosure is accountability, then it seems like actually there should be a requirement that the agency release an incredible amount of detail as to what

systemic factors they identified that led to the incident, what exactly -- what steps have they taken to address those systemic issues and what changes have they made internally within the agency, that that actually should be the focus of the release of the public disclosure. Because there's nothing you could do to go back and change the actions that were taken with that family. But as a member of the public, if I'm getting this for accountability, it seems to me like what I really want to know is how are you going to make sure this doesn't happen to any other child, period?

COMMISSIONER PETIT: So some of the systemic issues you're talking about have everything to do with policy, everything to do with budgets, and you have a number of states in which -- and I've run into this repeatedly over the years. And you've heard there's 25 or 26 states that are either in some kind of consent decrease class action litigation or -- well, consent or a receivership in some cases. There -- I have run into situations where the department head had actually said to me, "Our governor's motto is don't-ask-don't-tell." They don't want me to say what it is that we need. They don't want the full scope of this problem and how inadequately funded it is, because they're going to be forced to either raise taxes or they're going to cut the football team or do something else. I mean, there's another dimension to this besides just the straight facts. There's money, and people in some states don't want to spend it. And that's why if you take a look at the reference made earlier, some states are literally spending ten times more per kid than other states and some states have ten times the child death rate that other states have.

COMMISSIONER RODRIGUEZ: I don't disagree with that. I'm just saying in terms of if we're thinking about enhancing the CAPTA language, I would go for enhancing the requirements on the agency to detail what systemic factors they identified, what actions they've taken subsequently to prevent, and whether or not they report that accurately. I mean, it's in there sort of vaguely.

COMMISSIONER HORN: It's really not. It's really not there.

COMMISSIONER RODRIGUEZ: You think it's wrong?

COMMISSIONER HORN: You make a great point. I mean, maybe it's in a different question, but it's all about the investigation of that particular case. Now, what did you -- what did you learn? What other actions have been taken to prevent this from happening in the future? And maybe one of the recommendations we could make is to strengthen the disclosure requirement to also address that question, which would also get to what you're getting at. That's a great point.

COMMISSIONER MARTIN: So I would just ask -- and I don't know this. I'm just throwing it out. I believe one of our premier preliminary recommendations was to -- and I can't remember what subcommittee it came from, but there was something about making certain that we start looking at the system as more than just the state agency or the county agency. Is that consistent with that recommendation too? If it is, it's fine. I mean, my point is that if we're going to sit here and focus again on the agency and what the agency did, is that consistent with -- and maybe I'm thinking this wrong. But I just don't want us to give inconsistent --

COMMISSIONER PETIT: You do them both.

COMMISSIONER HORN: Sure. Sure.

COMMISSIONER PETIT: But for all other systems. "Commissioner, do you think that the state -- the government respects the budget needs you have in protecting all children? Do you have enough money? Are your caseloads appropriate?" What are you going to say? "No. I disagree with the governor and he's a jerk and he's unwilling to ask for the money that we need on this thing." What you're going to get from most people is, "We can live with the budget. We're going to make it work." There are efficiencies that we can receive on this thing even if they had the state that's the one -- that's at the bottom in terms of the appropriations and even if they're running a large surplus that year and even if you document what the needs are in the state. Don't ask me a question about whether the governor's doing a good job. Of course he's doing a good job.

COMMISSIONER HORN: But --

CHAIRMAN SANDERS: I don't think we're going to solve that one.

COMMISSIONER PETIT: No. I know. That's why I'm saying it needs to be tossed into a more political public kind of an arena as opposed to inside baseball.

COMMISSIONER RUBIN: So standardizing reporting of your fatality reports -- maybe that's where we're going to land on public reporting -- you know, removes that barrier because they can't get out of their obligation for certain material being presented and maybe having those fatality reports approved that they met the requirements of the public disclosure of CAPTA.

COMMISSIONER STATUTO BEVAN: Who did? Oh, the --

COMMISSIONER RUBIN: Meaning like, you know, that states would submit their fatality reports. They would have certain elements they would have to have in them and -- and they would have to -- you know, they'd have to be approved that they were sufficient meeting the CAPTA definitions or whatever the regulations were around public disclosure.

COMMISSIONER STATUTO BEVAN: But we still haven't -- we still haven't settled the fact that there are three reviews in CAPTA and, you know, we haven't decided yet if we're going to ax two of them. I mean, here in Wisconsin they spend $7,000 for the citizen review panel, even though we got, you know, reported at the federal level that says citizen review panels, which I put in that law, don't work, are not effective. So, you know, maybe we should be looking at that as well. I do want to say one thing about the names. It doesn't say in this policy interpretation questions, PIQ, it doesn't say that the name has to be disclosed. It says either the cause/circumstances and the age and gender and information or result of any investigation, but it doesn't say the names so it was never -- the name was never an issue in the first place.

COMMISSIONER HORN: But so it seems to me maybe -- the point of this was really to try to get to something that we could start to sink our teeth into. It seems to me that one of the things that people are suggesting is that -- and then we as a subcommittees could take it back and then present something to you, but one of the things we could do is to make a recommendation that the CAPTA requirements for public disclosure be strengthened to include not just the circumstances, the results of the investigation about a particular case,

but to also broaden it to what are the kinds of reforms that based upon the review of this case did -- are being recommended; not just in a child welfare agency, but in broader sort of systemic reforms that may also help to prevent future cases. Something like that, some kind of language like that that could be inserted in. And we can -- if that -- if there's a consensus about that, we can take that back and I can work with Tom and we can come up with some items.

CHAIRMAN SANDERS: I would agree. I would also though emphasize that I think the same thing should happen at the federal level, that information that's gathered from states should be used in a way that -- beyond just reporting what they find, but there's some analysis to really look at a broader population than a single state should look at. And I think as we look at some of the accountability at the federal level, that will be one of the things that we want to look at. But I think as part of CAPTA, it seems that the federal government should do more than just receive the information.

COMMISSIONER PETIT: David, you're right, and we've talked about that before. And right now where that information stops, to the extent that any of that information is gathered, like try and get right now from the states what their caseload ratios are. You're never going to get it. But it's stopping at ACF. It should not stop in the secretary's office. It should stop with the domestic policy office at the White House and the Congress should periodically have a hearing and review on the information that's presented. And we've talked before about this thing here. There is not an annual report that's due on this topic to the Congress that's open to the public in hearings in terms of how are we doing with this system.

COMMISSIONER HORN: And the reason why there is some success with these Why Planes Crash TV shows is because they always say at the end what they did. They didn't go, "And so we took that plane out of commission and everything's great or we fired somebody." They say, "And we found out this one piece was defective." And then it's like the entire airline industry took that piece and like replaced it with a totally new thing, you know, and it's this big whole system change that happened. And I go, "Whew, thank you. I like that."

And so if we start to think about this as not just who do we blame, which is your point, which is a lot of the newspaper accounts want to blame a person and they forget that there's -- the person that's most to blame is the person who killed the kid; but, rather, to use this as an opportunity to really force them to think and publicly disclose. What are you going to do differently, not about this case, what did you wish had happened, what we can do different systemically that's going to make less kids like this die.

COMMISSIONER PETIT: And to the extent that they're not willing to do that, you have a trump card called a federal government as we've seen in Department of Justice. They could go into a state and say, "Well, here's some questions for you. We will evaluate your system, because you're unwilling to do it, and what is missing is A, B, C, and D." And that's what we've just seen with DOJ on these cop-killing situations. And there ought to be that kind of provision in this area; not just with airplanes, not just with Civil Rights issues, but also kids who are killed.

COMMISSIONER RODRIGUEZ: And practically speaking, if we're ever going to build the public will to fully fund the system and to invest the kind of resources necessary to really effectively

run, you're going to have to build some trust by saying -- like I really look when there's -- when something happens, we really look, we try to fix it, because the way this all gets covered right now in the media, it sounds like it's a disaster. It's a bunch of incompetent people who don't know what they're doing. I mean, there's no way -- it's very hard to make the case to the public that we should pour more money into that or to the legislature that we should pour more money into that. And so I feel like this is all a way of sort of restoring people's faith that, in fact, this agency can accomplish its mission.

COMMISSIONER PETIT: Consensus?

COMMISSIONER RUBIN: I'd love to hear those recommendations though from folks who are working on public disclosure. That would be good.

COMMISSIONER PETIT: Absolutely.

COMMISSIONER RUBIN: Yeah.

COMMISSIONER PETIT: Absolutely. And some of the states do have a better model on this than others. And I think it's in the stuff that Amy gave us. I'm not sure.

COMMISSIONER HORN: Yeah. So Amy does have some specific kind of model legislation. I don't think -- I have some issues with some of her recommendations in the model legislation. For example, it -- it only allows for non -- it seems to only want nondisclosure of names of the child and siblings in the individual reporting. But it seems to want to report the names of everybody else.

COMMISSIONER RUBIN: And the near misses, I feel really uncomfortable about that, because these kids are still alive, right? It feels like very much medical confidentiality, although you could come up with a public disclosure around the nature of your near misses and what you learned from them and so there is a way that we can do the same thing.

COMMISSIONER MARTIN: If we're talking about educating and learning, then I think that's sufficient. That's our purpose.

COMMISSIONER STATUTO BEVAN: And also in CAPTA it says that the language of disclosure has to be consistent with HIPAA and with other federally -- you know, federal protective like FERPA, other laws that protect privacy, has to be consistent. So it could not be --

COMMISSIONER PETIT: Just one thing on the -- that you mentioned. I don't think -- I think if we looked at it, the answer is going to be self-evident. I don't think that you can do all this disclosure on a case and not identify who it applies to. What are you going to say? Baby X? I mean, everyone knows it's going to be tied to a specific case. We're talking about a program that didn't require the name. Somewhere in there there's a presumption that there's a name. I don't know how -- you had an ongoing story. It's on the front page every day for two weeks.

COMMISSIONER HORN: And the reality is there's going to be in many cases enough detail, because you have to provide it, that they're going to figure it out and they're going to be able to sort of track it back. But it seems to me that the major sort of "a-ha" and really -- you really helped me, because I wasn't -- I'm not clever enough to orchestrate an hour- and-a-half conversation to get to a conclusion I had before is -- even occurred to me, that the real

takeaway here is requiring that this be coupled with recommendations for systemic changes so that these kind of circumstances -- it will also reinforce the notion that it's not just one child welfare worker's error and everything else just hunky-dory.

COMMISSIONER ZIMMERMAN: That it's systemwide.

COMMISSIONER HORN: You know, it's a systemwide thing and that we have to --

COMMISSIONER RUBIN: I would also like to say itemization of cases, like I think as you go into that realm to say that, "Oh, here are 100 deaths we had in this state this year and these were the general themes and this is what we did about it." To me, that's not enough transparency. I almost want to hear the case. This case you can -- you can group them; here are cases that involve SIDS or here are cases that involve -- but I want to know five-month-old died of this, you know, and the circumstances of this. I want to know, and then have something tagged to that, and it could be for a group, but I want to know the individual stories. I think that that's important for transparency.

COMMISSIONER PETIT: And I think if you looked nationwide at it, the vast majority of kids who were killed and not reported on beyond maybe a line in the paper that says, "A child is killed today," but in terms of it being covered and reported on and so forth, the vast majority of these cases just slip under the water. They -- they don't do what you said. And by opening it up, you force it to be on the table, and as grim a topic as it is, at least it would be getting confronted.

COMMISSIONER RUBIN: As we think about it, I think Commissioner Covington is going to be important here too, because this is starting to get down to what are these fatality -- if we're going to finance and fund these fatality and near-fatality teams, what are their expected responsibilities? And clearly it's going to relate to this public disclosure.

COMMISSIONER STATUTO BEVAN: And as GAO found, the fatality review teams are not sharing data and that is a big issue. So we have to -- we're going to have to tackle that as well.

COMMISSIONER HORN: So, Mr. Chairman, I move, while we are in this happy consensus, that we adjourn for the day before we -- we get into a disagreement.

CHAIRMAN SANDERS: So moved. We're adjourned for the day. We'll start tomorrow at 8, I believe.

(Meeting adjourned at 5:49 p.m.)

End of Day 1

JULY 16, 2015

COMMISSIONER SANDERS: Welcome to the second day for the Commission to Eliminate Child Abuse and Neglect Fatalities. We will forego introductions and everything this morning so we can get started.

Our host is Secretary Eloise Anderson from Wisconsin's Department of Children and Family Services and has a distinguished career in child welfare and has done an outstanding job here. And we mentioned yesterday we came to Wisconsin because of the low rate of child abuse and neglect fatalities and we heard a number of things about some of the programs in place in Wisconsin that were very impressive yesterday, particularly the work with healthcare and child welfare. And so we want to get a chance to hear from you this morning about some of the strategies to prevent child abuse and neglect fatalities in Wisconsin.

So I'll turn it over to Secretary Anderson.

ELOISE ANDERSON: Okay. Greetings. Welcome to Wisconsin. You picked a nice time to come. It's been really nice, the weather. Tomorrow the weather's not going to be really nice. We're going to be going up to about 90 degrees. Hopefully the humidity will stay low and keep it nice. But who knows.

As I prepared for this, one of the things that was very interesting to me was that your goals and our goals are pretty common. We both want to reduce the amount of child abuse and neglect that we have. We're looking to do that in Wisconsin, and I assume that you're looking to do that nationwide.

So -- but also in terms of my time here and what we've been trying to do, I really have to give a shout out to my administrator of the Division of Safety and Permanence, Fredi Bove, who I

think has done a yeoman's work on trying to move us forward in dealing with child abuse and neglect and doing some very different things than we have done before.

So how do I really talk about this? I thought about this; and so the first thing I think I want to talk about is what we view as the risk factors that bring children and families into our system.

One, there's a great deal of discussion that it is poverty. I can't remember when I started to think about poverty, but it wasn't until after I had got out of undergraduate school. And the whole notion of the word "poverty" always struck me as weird thinking because I knew too many poor families growing up who didn't do any of the things that we accuse people in poverty of doing. So there must be something else. I'm still struggling with that word and not being really happy with the word called "poverty" as it is connected with all things that we view as not very socially acceptable.

Single parents is another risk factor that we look at; non-biological caregivers, boyfriends mostly. I want to go back to something that -- in my early career in Human Services, I was working at the county, and there was a young person who worked in the primate center here. And we were looking at: How do we deal with the whole issue of children's fatality? And he said to me, "Come visit me at the primate center."

What do I want to go to the primate center for? I'm struggling with this. But I went out. And he introduced me to something that stuck in my head forever. And he said, you know, "We're primates." And I said, "Yeah. What are you trying to tell me?" He said the new male over there is going to take this female, and she has babies. And he will kill those babies because he doesn't -- they're not his. And that was all he said. And that stuck in my head forever about non-biological caregivers and the risks that sometimes our families are in when we bring non-biological caregivers, males, into the household. I'm not saying we're all like that, but I think we ought to be concerned.

Adolescent parents. Up until maybe a week ago, I would have said this would have been a high priority, though, in terms of my thinking that teen moms are at high risk. But I learned something last week that gives me a little pause around the teen moms that I have to think about adolescent parents the way I thought about poverty, is that there are other factors that go along with being an adolescent parent that drive the risk factors than just being an adolescent parent.

And the history of abuse and neglect and child welfare -- this one, I think, sticks out in my mind -- is that if you've been a parent who has been in the child welfare system, maybe we need to have special thoughts about you, as a parent, and what you may need to help you deal with the whole issue of parenting as you move -- as you move from the child welfare system to being your own parent.

I think there's a lot of things that we need to think about, in terms of children not of the age of child welfare and are they ready to parent and what we need to do when they're in our system and helping them become parents when they age out.

Substance abuse. I always like to tie substance abuse and mental health together, and both of these are risk factors on their own. My history of watching people who are in substance abuse is usually when they get cleaned out, when they're detoxed, is that the mental health comes

to surface. So this whole view I've had ever since I was a young person is that most of us take substance abuse to heal pain, so they're self- medicating, and maybe we need to figure out how to deal with those issues simultaneously.

Children under four, babies, toddlers, are really at risk. Families with a large number of children. I would think mostly a large number of children with a single mom causes a lot of stress. Children with special needs, social isolation. I didn't grow up in a community where we were isolated from one another. But as we changed, our society changed, I see more and more social isolations on the part of our young family. And I know being young and being a young mom can be kind of disturbing to one.

Domestic violence. I think we have to figure out here how to deal not only with helping moms and children, but we also need to think about how we start to deal with the perpetrators in different ways than we have before.

High levels of community violence. We have this going across the country, where people are not safe in their communities and where the stress of living in a community which you're not safe in. Now, what we've learned is also that not one of these causes a child to come into our system but usually when they're combined, when there's more than one risk factor with another.

So I get really concerned about people who live in low-income communities, communities that are low income and have violence, where the mom has experienced the violence to herself, and she's a young mom who is single. So you put all those three together and think, I guess we would call it, a toxic mix.

Each year in the state of Wisconsin, we look at -- we take a backward look, and we look at what's going on in our state around child abuse and neglect; and we look at our fatalities, and we look at, now, treatment.

And since 2013, we've had about 20 child fatalities; and between 2004 and now, we've had 20 fatalities as a low and 33 as a high. Some people would say that's good. I think that's awful. Any time a child dies at the hands of an adult, I think we need to do some things to try to make that different.

What we also learned is that most of our maltreaters are moms. They're mostly neglectful, not necessarily abusive. Most of the abuse, physical abuse, is from boyfriends or partners. Most of the children in our system who are maltreated or die are under the age of five. Many of them are under the age of three. So it's pretty hard to look at this data and not be affected by it.

Yesterday I think Fredi talked to you. So she hopefully went over all the intricacies of the data with you and what we're trying really to do. But I think on a larger scale, one of the things we need to pay a lot of attention to is children under five.

And for me, children under five are usually not under somebody else's eyes. At five years old, they start school, so their visibility is so much better. If they're in childcare, I think also we have to train our childcare providers to be more aware of children's issues.

And then because I've never been a person who believed in just saving the child -- because I used to call the child welfare system a catch-and-release system, you know, we go and catch the kid and then release them back -- that I think we need to be more of a family-centered system, which I know we're trying to move towards more and more. And what we do -- try to be more sensitive to the non-biological parent and how we deal with him or her and reducing the risk of -- for the child in our programs.

What I'm also beginning to see in our system is probably something that I'm not sure our system is ready for, that we weren't really designed for, and that's neglect. Our systems have really been coming up around the whole notion of abuse, physical abuse. Neglect comes to us very differently.

And I'm not so sure that how we've seen it in the past and how we're looking at it now, we are totally ready for it. I think we're trying to do that. I think trauma-informed care that we're trying to put in is much more down the road in dealing with neglect. But it seems to be a very different presentation that it brings to us.

You asked the question how can we use this information about what we know about families to prevent maltreatment. I think we, in Wisconsin, have three strategies. One is to do some early intervention. I think it's really hard for Child Protection to be an early intervener. We're very much like police officers who are there after the fact than before the fact, so how do we move ourselves downstream?

I think the second thing we're trying to do in Wisconsin is strengthen families, not just move kids and say -- being very negative about the family they come from. We're trying to really kind of support families.

And the next one is build community connections. One of the things that we know about these families is they're isolated, they feel alone; and if we can get them connected to the community in various ways, we think we can change the tide in what's happening in abuse in Wisconsin.

So one of our major programs in how we think about things is the home visiting program. Now, I've -- every time I think about the home visiting program and even when I first heard about it when it was put together, it always sounded to me like the old ladies in the neighborhood. You have to grow up in that kind of a community. You know, moms come home with the babies, and the old ladies, some of them would be called aunties and grandmas, would pool themselves around the moms so she wouldn't feel alone when she came home.

So the home visiting program has always stuck in my mind as the old ladies program. I know it isn't, but I call it the preventive approach to it. And, you know, these women would bring their wisdom with them about how you manage a kid. It would be a respite.

So the home visiting program, we target high-risk communities. We target women from birth to age eight. It's a voluntary program; and it improves parenting skills, which I think is really important because, you know, there's no manual for this stuff. I tell my daughter all the time that she was my learning piece. So she got all the worst stuff, my son got all the best because I got all my stuff out with her.

So for a lot of our parents, they don't know how to do this because it wasn't done to them well. So the home visiting program helps them change or develop parenting skills. It provides community connections, and it's something that the mothers feel comfortable with. And we also have - - which I think is an interesting piece -- we also have a program for -- in our home visiting called -- for dads, which is fathers involved with a father-involved specialist.

I've always thought our Human Services system was dominated by women, thoughts about women, and the family to us looks like women. And -- but there are men in these households or at least hanging around somewhere. So the father- involved specialist, I'm very excited about. And this -- it's a steady program for us which I hope never goes away because I think we'll probably always need it.

Post-reunification services. Now, this one is also very interesting because one of the things that we found out is that we were bringing kids back into child welfare system in the foster care, and so we started trying to look at what were some of those reasons. So we put a program together for 12 months after the kid goes -- the children go home, we stay with the family for 12 months. We try to address the stressors the family is having. We try to provide services around that family.

And this kind of gets rid of this notion of catch and release that I so much rail against. We're there for the family until we think the family can get stabilized, which we think is about a year. So that -- hopefully that program will turn out to be like the home visiting program, another stabilizer for the families.

Community response program. This is a program that provides case management, home visiting -- working with the families to figure out what the family wants to do and where they want to go and financial supports. It's -- it's another way to try to bring connections with this family.

What I also like about this is that we don't come in and say this is where we want you to go. We try to find out what your goals are, try to help you meet your goals. And I think we're moving away in a larger sense from believing that we know best for families and know that families actually know best for themselves. And they do know where they want to go. Often they just know how to get there.

Connection Counts. Connection Counts is one thing we just got approved in the budget. This is, again, another one of what I call my grandmother programs where we're going to look for people in the communities who people consider as leaders. These are not politicians. These are not people who run for elected office. These are people that if you say, in your community, who do you go to for advice, this would be the person. And these people would offer guidance. They would help you identify needs, and help connect you to services in the community or other issues that you need. We got a large increase in our domestic grant, domestic violence program, which we think will help solve some of the violence in the family.

And then my next program, which I loved this program for almost 20-some years, called Families and Schools Together, the FAST program. And what it does, it goes at two things. It goes at parental relationships, the two, the father and the mother, even though they may not be together, their relationship and trying to strengthen that so they can support the child. It

goes after mom and her mom so that the two parents can raise the child and work together, and I don't think we think about how much the grandmas or, in some cases, the in-laws, get in the way of families -- interfering in them working. And then the most amazing things, it teaches parents to play with their children.

And when I first saw this program, the person who developed it asked me why did I like it? And I said I like the play. I think the play is the most important piece to this. Oh, no, no. It can't be. I listed all these indicators. So they've got to evaluate what it is to play because it does a couple things. A lot of parents really have never played. The play is really important.

Also, a lot of parents have to play with their children, which also very important. So the program establishes this different kind of relationship between parents and children that I think is so important. So I'm very high on this program.

So those are kind of the base programs, you know, that we're doing that may be slightly different than other things that you've heard.

What do we need -- the next question that you asked of us is what do we need the feds to do? I guess my off-the-cuff response would be nothing, just get out of our way. Just give us the money and go. That would be my favorite response.

But pretty close to that, I think I would like to have far more flexibility in our 40. I think the 40 program should take its focus off of foster care and out of home and put its focus on child welfare in a larger sense. I think that would be helpful. 4-B, I think, is probably much more prevention. I like the early stuff. I like being able to do the prevention stuff. I just don't think it's enough resources to be able to do that.

So I'm pretty -- not always one who wants the federal government to give us more money; but if they want to do something, this is where they ought to put the excess money if there ever is any excess. So those are two things that I think about.

So in conclusion, I think we're doing a lot of things. I think we're doing a lot of positive things. We're thinking about how to support mom in a larger sense. We're thinking about how to have fathers involved, which are really -- people who know me know that's really important. We're talking about community, how do we get communities engaged because we can't do this by ourselves. The communities have to be engaged in this. And I think we're moving in the right direction.

And thank you for asking me to speak to you.

COMMISSIONER SANDERS: Thank you very much, Secretary Anderson. Are there questions?

COMMISSIONER HORN: Secretary, it's good to see you again. Always a pleasure. So I'm curious about this non-biological-related male issue. Obviously most non-biological-related males don't abuse their kids, but we do know that it is a risk factor, and there are far too many stories that we read about the boyfriend who either is the sole perpetrator or is a co-perpetrator of abuse and neglect and too often resulting in fatalities for kids. But I'm not quite sure what to do about it.

You know, I'm not sure that it's the -- I'm pretty sure, in fact, I'm confident, it is not the responsibility of the state to tell somebody that they can't have a non-biological-related male move in the home. But what it is that we can do about this issue? It seems different in my mind from the father issue where the guy that is the biological father of the child. There's something different about this. So do you have any thoughts about what we do about that?

ELOISE ANDERSON: A few. I think one of the things that I've been looking at, so I don't have a lot of good answers about if this is true or not, is that some of the fathers that have been on the violent end of this have been in our correctional institutions. So this is the non- biological. So one of the things that I think we need to do inside of our correctional institutions is talk about child development, have more understanding of children. I think they're a captive audience. We ought to be able to pull this one off.

A lot of men, unlike when I was growing up when men -- boys were asked to babysit their younger brothers and sisters, they knew about crying babies. A lot of these men have no idea what to do with a crying baby, so they get -- they're left alone with the crying baby, they get frustrated, and they throw, they shake, they do all the things that you shouldn't do.

So some of it we can solve by introducing child issues in the prison. Some of it we could handle by when they come out, having the correctional institutions tell us where they're living. They know where these guys are. We don't know the child welfare side, so let us know. So that then puts the mom and the family on one of our prevention sides of the fence.

So we would do home visiting. We would do different kind of things, and we make sure that we include -- and we have a tendency in the Human Service to ignore him, even if he's the biological father, ignore him. We just talk to her, and that doesn't get us where we need to be. So we bring him in. We try to deal with his needs and his stresses and issues. I think that would help solve some of it.

When they're looking for jobs, a lot of our men, we put through our job-training programs. We never talk to them about childcare issues. Mom's going through a job-training program. We talk to her about childcare, all kinds of things she has to do with the stress. Why don't we talk to him? Same issues.

So I think we just have to bring men into our system better and don't look at them as needing different things. Just look at them as needing the same things but given to them differently. So I think if we got that mentality, we might solve some of it. Some of it we might not be able to solve, but I think we could drive it down.

COMMISSIONER PETIT: Thank you for your comments on a wide range of topics here. I have one just to follow up on a point that you made about the federal government get out of the way. We've had a number of people say that the federal government isn't getting in the way enough and there's a very weak oversight of the state system and the feds are failing to exercise some accountability or assuring that children from one end of the country get the same level of care.

When you say the federal government should get out of the way -- and I think all of us would like to receive money from people without having to answer to them in any way. That's certainly something I would pretty much. But other than 40, which you make reference to,

how should the federal government get out of the way and is there any role you think they should play in addressing child fatalities nationally.

ELOISE ANDERSON: When I say "get out of the way," they're focused on in-home care. I don't mind them giving us money. I don't mind them telling us what to do and doing it because it's their money -- well, it's kind of our money too -- but I don't want the focus to be on just here. I want it to be more of a child welfare look. If you're going to play with us, then play with us on the larger issues. Don't just play with us on a narrow scale.

COMMISSIONER PETIT: How could the federal government be helpful in supporting what you've just said?

ELOISE ANDERSON: I think the waiver system is helping that because we're now allowed to do the reunification things. If they did more of that, that would be fine.

COMMISSIONER PETIT: How about any standards of practice or policy issues?

ELOISE ANDERSON: Considering -- I look to the counties like the feds look to me. My view is that they do have some -- because they're giving us money, they do have a right to say to us what some standards ought to be. I don't have a problem with that. I just want them to be realistic.

I'm not sure it is very easy to set standards that can go across all our states and have an equitable impact. We're different. And I think -- like me looking at our counties, I've got some counties that have a lot of resources. I have some counties that have almost none. To have the same expectation of them and not paying to make that balance different, I can't do that.

So I think the feds need to look at the states. We've got some very wealthy states, and we've got some very poor states. And so when the feds are developing their standards and unless they're going to mitigate that imbalance of the state's resources, they have to make sure they set standards that we all can meet. And I think that's probably where the issues are. Sometimes for some states the standards are too high. For some states, they may think the standards are too low. So getting equity across the states is difficult for the feds to do.

I'm not putting down what they -- they need to do with their money. I'm just saying I just want more -- more -- more of the funds to be less focused on the out-of-home care issues and more equity across what I think are the needs that we have from early prevention all the way down to bring the kids back home.

COMMISSIONER PETIT: Thank you.

COMMISSIONER SANDERS: Commissioner Martin?

COMMISSIONER MARTIN: Again, thank you so much for coming and sharing your testimony with us this morning. I am particularly interested in the work that you're doing around fathers.

I know that Commissioner Horn asked you about the non-biological father. I like the idea of bringing men who are involved in the family into family and helping them understand children and child development. Since you've been doing this work, you've one of the -- well, there are other jurisdictions that are doing similar things.

But since you've had such a concentrated effort, has it made a difference? Have you been able to see a difference in your numbers in the cases of families that stay in the system, reduction in fatalities? Has it made a difference in the reduction of physical abuse that we see sometimes with biological and non-biological males in the home?

ELOISE ANDERSON: Let me share where I think I see the difference. I see more fathers getting custody.

COMMISSIONER MARTIN: Great.

ELOISE ANDERSON: I see a difference in some of our courts as it relates to looking to fathers. We -- we used to have the tendency to -- we're removing a child. The maternal family is where we want to put the child, so we go to a stranger. We're changing that.

Now, especially with our family finding, the mother's not capable. Her family's not ready to step up. We go to the other side. So we keep the child connected to its family. So I'm seeing much more of that.

I'm also seeing, not just in child welfare because we're doing this in a lot of our other systems, I'm seeing more fathers willing to come out what I call hiding to make themselves present than I have seen in the past. It probably is -- I see in our bigger city the most, in Milwaukee. I -- our emphasis on dads has gone to the child support system. The child support system has effects on the child welfare system. As I see dads step up, it doesn't feel like we're having less kids come in, but I'm seeing in that community more fathers stepping up.

COMMISSIONER DREYFUS: Hi, Secretary Anderson. I'm sorry I was a few minutes late. I sat back there and listened to you, so thank you very much. I've always appreciated not only your skill and your experience and knowledge but your common sense. That's always really refreshing.

So one of the things I heard you comment on when I was sitting back there is you talked about the larger system and that child services is like police, right, coming on after the fact. And there's a whole lot that was going on before that would stop the flow of kids coming to CPS and a whole lot better CPS could respond and greater partnership and relationship with the actors in the community that make up the child welfare system.

So as a commission, we're kind of wrestling with that. We're trying to figure out if, as a commission, all we focus on is the Child Protection Agency as being the be-all-end-all and the answer to eliminate fatalities, and then we'll probably do what past commissions have done before successfully. So we know we have to test the larger people. We also know that the Child Protection Agency is crucially important.

If you were to advise us if we went about this, would you say that the Child Protection Agency, which is not the child welfare system but an integral and crystal piece of it, is a right player in this ecosystem that we're talking about, is the right player to provide the convening community leadership and interconnection that needs to happen, to have a plan, to eliminate fatalities within a community, to shore up where the gaps are in this ecosystem that we're talking about, is the child welfare agency the better leading -- because somebody's got to play from a backbone, leadership role. In all your experience, I mean, California, Wisconsin,

national, would you say yeah, build that. Yes, it's integral. Yes, there's many moving pieces, but build it through the leadership of the child welfare agency?

ELOISE ANDERSON: Wow. I have to say yes, but I've got a no on the back of that. And the reason why I say yes is because I view my role as pushing that forward. So where the -- where the child welfare agency is in the community, it has to be in the community to do this, I think it should take its leadership role and do -- and push for a larger child welfare conversation in the community. The problem with that is most child welfare leadership are not in the community. So - -

COMMISSIONER DREYFUS: But if you had the funding --

ELOISE ANDERSON: I'm not so sure it's just funding.

COMMISSIONER DREYFUS: No, but could you make that happen, to affect the law enforcement system, the education.

ELOISE ANDERSON: Then we probably have to think about hiring people who bring that kind of leadership skills with them, because mostly we don't hire people to head these organizations that can do that work. I mean, that's not where their strengths are. Their strengths are internal to the organization and the surrounding agencies within them, the courts, the DAs, the whole Child Protection system is where their focus is. If you ask them to do this, then the leadership skills are different because now we're talking about whole community issues, and we're asking them to go in the communities in which many of them don't develop relationships.

So I'm not saying that I wouldn't ask them to do that, but we have to train a whole new flog of people in order to do this.

COMMISSIONER STATUTO BEVAN: I just have one question about the 40 waivers. You know they expired. Do you think that we should just -- you know, this is debate, which you know, that we totally reform the financial -- you know, the 40 e-system and make it flexible, turn it into more of a block rent, allow the flexibility? I mean, that's a big bite, and I don't see people ready -- I don't see the appetite for it yet on the help.

But I think -- but continuing the waivers is something that is doable. Do you think that's something that the commission should push to expand the way, extend the waivers, not have them, you know, expire every five years, or is there some other tinkering with the financial system that we should be doing?

ELOISE ANDERSON: We just got a waiver so it hasn't expired, so evidently they added some new waivers to it.

Waiver versus block grant. I'm going to have to go both sides off it. Sitting on this side of it, I would like to have a block grant with goals and where -- where the feds think we ought to go with that. To me, that's what I'd like to happen. Sitting on the fed side, I would say no way because the states -- some states could do a lot of stuff with that. Some states wouldn't be able to pull that off at all.

And there's a control piece sitting in this. The feds are going to give you money. They want to make sure you don't spend the money in the direction they want. So I don't know how we find a happy medium between. You let us have a lot of freedom and control that I think the federal government needs, but we've got to find where that is because this -- we need to be -- have more latitude to be able to do things than the feds are letting us do. We need to be able to try new things without having to go mother, may I, all the time. So I don't know where that is, but I think we really need to figure that out.

COMMISSIONER STATUTO BEVAN: Thank you.

COMMISSIONER SANDERS: Commissioner Rubin is on the telephone.

Commissioner Rubin, do you have any questions?

COMMISSIONER RUBIN: Yeah. So I -- I just want -- I really appreciate the testimony. I think you really sort of solidified a lot of the ways in which you can move upstream, but I have no specific questions. Thank you. I'm sorry I can't be there in person. I'm on the way to airport. Sorry.

COMMISSIONER SANDERS: Secretary Anderson, I have a question about you -- I'm paraphrasing, but you talked about the distinction between physical abuse and neglect and that the system was more focused on neglect and at least seemed to raise the question whether that was appropriate. And maybe I misread that, but could you talk a little more about that?

ELOISE ANDERSON: No, you didn't misread it, and I'm struggling with it. When I look at -- the way we design, the way we deal with things, it really is focused around the old notions of abuse. A lot of what we're getting in our system, now our kids are coming in because of neglect. There's a lot of different kinds of neglect, and neglect has -- as we're learning, has far more negative pieces to it than the abuse has had.

I don't know that we really have our hands around as a system, as a field, of how to deal with neglect that's different than how we deal with abuse. And I -- I think I'm listening to our county directors. I'm listening to our ongoing people in Milwaukee, and the kids that are coming out in these systems, the ones that we see, and issues that they're bringing with them suggest to me that we need to rethink the design. We need to rethink the service system we've got around these kids.

They are -- they are presenting behaviors that are much more intense than the behaviors in the past when the child was just abused. I think they're coming in with many more mental health issues than they've had in the past. I'm not sure we've got the resources or know how to put the resources together yet to deal with this. And I'm concerned about that. Systems don't change facts. Our kids don't have a lot of time to wait for us to get our act together. So I'm observing this and trying to figure out what's the best way to move ahead.

COMMISSIONER SANDERS: And I guess as a follow-up question, and it's been referenced before, about what the federal government can do, it seems like waivers -- and I'd have to probably look to my colleagues and our policies. But waivers would not necessarily allow for rethinking like you just described how you deal with neglect differently because neglect is

defined in capita. And I don't know that the waivers in 40 allow for that. Is that something that states might want to -- or you specifically might want to test a different model? Is that -- or is that far beyond how you're thinking about moving forward in Wisconsin?

ELOISE ANDERSON: I haven't thought about the feds -- the federal government being a part of change, wherever we need to -- I mean, I just hadn't put it in my head for that. I was -- I've been thinking about what am I seeing and then what are -- what the response of the state should be to do that. I never think of the feds as being a partner in change. I mean, it's just -- that's a new question, so I have to think about it.

COMMISSIONER SANDERS: Any other -- any other questions for Secretary Anderson?

Well, thank you very much for taking so much time and sharing so much with us.

ELOISE ANDERSON: I hope that you have a good time while you're here. The next time you come back, please don't come way so far out on the other side of town. Come at least to the center of -- of Madison. Thank you.

COMMISSIONER SANDERS: When we were -- I actually flew out here and Tom Ward was on my flight so we drove out here. And he kept asking, are we going to hit a city any time soon? Aren't we supposed to be in Madison?

ELOISE ANDERSON: So he's from the East or West Coast? Which one?

COMMISSIONER SANDERS: East.

ELOISE ANDERSON: So he's coming to flyover country.

COMMISSIONER SANDERS: All right. Well, we will move into our deliberations, and we have the policy committee recommendations. I'd turn it over to Wade and Cassie. I see a discussion about final report.

COMMISSIONER HORN: It is the documents that you received before, so what we'll do is really talk about the content of that and what we -- other opportunities we can -- we can talk about it afterwards too. I can catch you up on what the conversation was because that will be an involving document. But the input is from the subcommittee recommendation, so that's really --

COMMISSIONER PETIT: But one of the things I'm concerned about is what additional materials are needed to fill in the picture of what case was needed. There's a to-do list.

UNIDENTIFIED SPEAKER: We have Commissioner Rubin on the line.

COMMISSIONER STATUTO BEVAN: We'll proceed. If anybody has questions, they'll stop me. So we are going -- much of this is going to be a repeat of what you've heard in terms of our approach.

But, number one, is that we want child safety to be paramount. That -- that has to be the framework that we're working with. Yes, there are other agencies we also need any recommendations to be politically feasible, and we also want to make a measurable

difference in preventing fatalities and near-fatalities. That's the outcome. The -- are you doing the clicking thing or -- I'm on the next one.

So in analyzing policies, you know, we know that we have reviewed much of legislative history and current laws and regulations as well as congressional intent. I know back in January we sent out a guide of like 35 different policy areas. Of course, child welfare helps public health and education.

So we are -- you know, we're recognizing that their -- that this is not just a child CPS system that we're concerned about. We're concerned about a lot of different policies, unfortunately crossing a lot of different committees and jurisdictions and agencies, which we have not yet even touched really in terms of having a good discussion with these agencies to effect any type of change in terms of how they operate, and that's something we feel we need to do.

In the next one, our organizing principles remain what we've looked at all along, which is clarification and understanding, accountability, effectiveness and efficiency. Those are organizing principles. That's what we're trying to get a handle on, what policies we're looking at and what recommendations we need to make.

The next one -- so in terms of clarification and understanding, you know, we're starting with this because that's what our charge was in terms of Protect Our Kids Act. It was finding No. 6. We were told the deaths from child abuse and neglect, and that we needed to learn more about the circumstances surrounding these and the deaths in the agencies systems involved and what we needed to do to change. So this --

COMMISSIONER HORN: Can I add something on that one? So I think it's important to know that the -- clarification of current policy, but the understanding pieces that I wanted to just sort of speak to first for two minutes.

So one of the things that has struck me as we've gone over the last year, and this is going to come as no surprise to this commission, is how bad the date is. It's not just bad about how many deaths there are, but it's bad about who's killing these kids and what circumstances.

My feeling is that the only thing that's worse than no data is bad data. When you don't know it's bad data, you draw conclusions off of it and the conclusions are often bad because it's based on bad data.

So a good piece of this is going to, in my view, interact with the measurement and subcommittee as well, and I think that one of the things that is really central to the way that we think about this is -- is making very strong recommendations about collecting better information.

And I think that some of this commission's ultimate recommendations are going to be constrained by the fact that we don't have good data yet. And that's unfortunate and somewhat surprising to me in the last year, how bad it really is.

I'm still confused, for example, whether Native American information is collected or not. I -- I mean, I heard yesterday sometimes it is and they may have it. And how good is that and what do they have and so forth. So I just -- I just wanted to emphasize that piece of that.

COMMISSIONER STATUTO BEVAN: Yes. And in terms of when we get the recommendations, you'll see that that's improving the measurement, is extremely important. And we are relying on the 2011 JO report and other prior reports, as well as existing legislation to sort of get a better handle.

The -- this particular case that's here talks about the need to pay attention to prior referrals. This particular child had prior reports, and there was -- it was not picked up, and it wasn't put in the context of that which Emily Hutton does, which she told us -- she testified very clearly that prior reports are the single best indicator of risk and fatalities and abuse and neglect, and what she stated was the single best. So I do think we need to use that in terms of our understanding of what's going on.

The need for accountability is the next one. And here, you know, we've talked about examining accountability practices such as beginner, such as the CFSRs so that we could look at not the findings that have already been discovered, but also look -- think about new approaches to these -- to accountability.

We talked yesterday a little bit about media, and we talked about public disclosure methods. But what we're -- what we're trying to the at is something that Alice Anderson was talking about. How do you -- how do you get accountability in the system that -- you know, general system. How do you intervene and get the -- get the implementation of current legislation.

For example, in this article, it -- CPS had intervened for years with this family. He's 19 months old. The mother lost custody under abandonment. The state did not have to go through other reunification efforts with the sibling. This child is a sibling. The 19-month-old child died. Well, there's current law already that is not being -- that is not holding the states accountable for what -- for what is happening to kids.

So we do -- accountability, we want to look specifically at current law as well as how we can add flexibility and maybe some help with disclosure, media attention, to the extent that it creates accountability.

So the need for greater effectiveness. We have talked about the lack of effectiveness of policies that we have. When we talked to ASPI, we did ask them specific questions about that. Their response was no national evidence.

To the extent that evidence-based practices are being used in this area, they also acknowledge there's no federally fund financial disclosure research specific on child fatalities or serious harm and that, in fact, no research had any funding in the past ten years related to the validation of safety and assessments, instruments or protocols. So, I mean, there's an issue.

Here, again, but what we know that works, safe haven laws. Already in place. And yet, you know, 50 states have these safe haven laws, and yet -- you know, they have not really been explored to the -- to the extent that they're saving as many newborns as they're able to, as they promised to.

Okay. Greater need for greater efficiency. We also talk about here the prenatal abuse. This one is a top goal of our -- of the commission is to assess and ensure that existing resources are

allocated in the most efficient way. And so what do we know about the allocation of federal funds and how do they align with best practice. What do we know about the collaboration and corroboration efforts of public agencies. We believe that there's very little corroboration and cooperation on the federal level.

COMMISSIONER PETIT: Can we ask questions while they're -- look, this issue that you just mentioned about coordination on the federal level, I mean, there is a full-fledged, staffed large federal committee made up of all the agencies and everything.

COMMISSIONER STATUTO BEVAN: Yeah, 25 of them, the child abuse working group.

COMMISSIONER PETIT: So there is a vehicle there.

COMMISSIONER STATUTO BEVAN: It's a vehicle, but the only people sent there are interns. It is no longer a functioning interagency group.

COMMISSIONER PETIT: Believe me, I'm not sympathetic to the current system. I feel the same as you do. We accepted for the first meeting when we were just introduced to the staff chair on this we haven't had any conversation and I don't think we've asked them for anything at this point, and I think we need to actually confirm how ineffectual that process is and that it needs to be replaced by something that's much more serious and not staffed by summer interns.

And I don't know what they have out there, but we -- all of us know what it means when you start staffing with junior staff something like this, it's just not a high enough level. So I'm wanting to return to the point that says what we have present in federal is ineffectual. There isn't anybody that would say there's not a strong role needed. There needs to be something else developed at a much higher level, et cetera.

COMMISSIONER HORN: Can I -- let me ask you a question about that because it's something I struggle with, and I don't know what the right answer is.

So -- so there are lots of coordinating bodies in the federal government because we have developed a -- a system where there's lots of different agencies that have pieces of a problem or a solution. Is the solution to, in your mind, Michael, is it to have a better coordinating process or is a better solution to have a clearer focal lead who is responsible for driving policy and oversight in this area.

COMMISSIONER PETIT: For my part, it's clearly the latter and it all involves what the political leadership say. I think this is an area where political leadership -- and by "political leadership," I mean elected officials, I mean the White House and Congress, have not been clear what they expect.

What we know is if the president said "I'm having this person in our agency and her future is dependent on tying all of this together," the process moves. I mean, those of us who have been involved in one way or another know that electeds matter. To accept this is not an area they focus on, I mean, they don't. It gets dealt with at a lower level.

We talked earlier, after the first 50 years, the keynote speaker at the celebration of the 50th anniversary was John F. Kennedy as a sitting president. 50 years later it was, I'm sure, a very capable individual, somewhere in the middle class. It was vastly different.

So I would argue that form follows function and that I'm not worried about a federal committee being responsive or not. If the electeds say this is what we expect, we're here today in this congressional hearing and there's a battery of press here, we want you to tell us why you have or have not done this, we would be responsive. So it's not so much the structure. It's getting a committee to do something about it.

COMMISSIONER DREYFUS: I want to say it has to go even further. So I agree with you, Wade.

Cassie, I saw this in your draft, and I really appreciate how you kind of pulled that all together -- is the idea of the Children's Bureau and its positioning within HHS; right? I'm not sure what the right answer is, but something that elevates and makes a clear assignment of where responsibility lies.

I do think, though, my own experience is we put all the great coordinating committees together and tell this one entity, you're responsible, right? But nothing holds those entities liable like the Department of Justice, the Department of Labor, the other entities within HHS, CHS, as an example, to really be accountable.

So I want to make sure we're hardwired even further and ask Congress to pass something that makes it clear to these other entities that they too share responsibility and accountability for the reduction of fatalities from abuse and neglect for kids in the country. It's got to get hardwired a little bit more in the accountability of not 25 different agents, but what we see as the really key and pivotal ones that can make this work.

COMMISSIONER PETIT: Again, I would just work backwards from the political progress itself. If members of Congress say I'm going to do something about this issue, if you have a president for whom this is a priority, the issues moved. And with all due respect to our system of government, what it needs to turn around on a dime, it can. If something happens this week that warrants the Congress's attention this week, they'll address it this week in some fashion, whatever it is. So I think it's less structure than it is saying we want a structure that works. And once that happens, they're plenty smart, they can create the vehicle that they need that delivers the goods. Right now what we have is a federal role that is operating in obscurity.

Can I mention one other point that goes back to the earlier remark that you had about the predictors?

COMMISSIONER STATUTO BEVAN: Uh-huh.

COMMISSIONER PETIT: I think we need to be just a little bit cautious of the fact that there was a prior referral to the department. That's because the states vary widely in generating those reports coming in. So you could have two states. One state says the public school teacher says to others, you need to report these things. When a case comes in, you have an exact same identical situation. You're absent. Hence, that first referral.

So that's what I'm saying, the states vary. All the states and citizens are reporting. Some states -- if you see the sidebar piece with the articles, plenty of newspapers do do that. Not all of them do. So I'm saying as just a cautionary note that that can't be the only thing.

COMMISSIONER DREYFUS: But one last thing, I think it fits in as this policy as we think where we want to go with this, we're making -- and I was thinking about this last night. We're making a set of assumptions about the quality and the consistency of a Child Protection function, right, that I don't think we should be making. I mean, if we've heard anything around the country, it is the wide variation. We heard folks last night talking about caseload sizes, supervisory ratios. The quality and consistency of Child Protection in the country is very uneven.

The question I have for the commission as we think about policy is should not a bedrock of what we're talking about be about yes, there is this thing we call the system, but there is this critical piece that is that Child Protection agency, right? It's critical within. I'm not saying in absence of the other, but critical within it.

And a lot of what we have here is assuming a quality and consistency of that Child Protection function that I think we have to address. Yeah, I think we have to address it. Is it that there is a -- that we're saying there is a core minimal standard that all Child Protection has to meet in the country; and yes, we do have to put more money into capita in order to get that done. But I just am not seeing enough. I think a lot of this assumes a quality and a protection of the Child Protection agency that I don't know we're talking enough about in terms of quality and consistency for every child every time no matter where they are.

COMMISSIONER PETIT: That -- that gets to the question of Kids in America, Children First, Wisconsin Children's First. I made reference yesterday, and that's why I asked about the materials. I think we could sum it up quite quickly. We did it 20 years ago.

If you take ten common indicators in the field and you assign what the rate is per state in each of those indicators, knowing that they're not directly comparable, you could see this difference from one state to the other supporting exactly what Susan has said, is that the variation is tenfold between the bottom state and the top state. 900 percent difference including actual deaths themselves. Deaths, tenfold difference, removal of children from their families, termination of parental rights.

And I think we need to actually show that, not just say it. We need to actually show, here are the statistics that support what you've just said. We've heard it now and you show it with data, and there is data available on it.

COMMISSIONER STATUTO BEVAN: Did you have something?

COMMISSIONER HORN: So let me go back to this issue of -- because there is this recommendation about elevating the Children's Bureau, and I want to see if there's consensus on the commission about doing something about that.

I know something about this because I actually held the title chief of the Children's Bureau at one point and never used it. That's how -- how little the impact -- how little the importance people place on that agency. It was the title -- it was the position for which I was formally

confirmed by the United States Senate, but what they did is they double-headed it with the Commission for Children, Youth, and Families. So my business card didn't say Children's Bureau. It said Commission for Children, Youth, and Families.

We've gone through this history before, but when the Children's Bureau was first started, it was direct reported, not to the secretary of some agency, but to the president of the United States. And I -- you know, are we -- I think it's kind of -- it's an interesting recommendation to have, to say, you know, let's -- you know, if this -- if the importance -- if the nation sees the Children's Bureau so unimportant that it is buried three or four layers below and then you say to the director, well, the one thing you know about Washington is it is very hierarchical in structure.

So the assistant secretary is not going to go to a meeting that is chaired by someone that is four levels below them. They're just not going to do it. So they're going to send somebody that is four below them in order to go to this meeting. Then we wonder why nothing gets done.

So, you know, I'm even thinking maybe we should be bolder and say let's go back to the original legislation established in the bureau and make it a cabinet position. Say this should -- this is so important that the future of America's children is so important, this person should be having direct conversations with the president of the United States. And, in fact, it was established initially to do that. And then just over time has gone back down and down and down and down. I mean, I'd love to --

COMMISSIONER DREYFUS: Was that -- was that -- back again, the history, I don't know the history, I would just hate to see that be focused solely on child safety and not this safeguarding of America's kids through a larger lens of well- being.

COMMISSIONER HORN: There is no bureau that is charged with the well-being of children. They attacked infant mortality, child labor laws. I mean, it wasn't just about child safety. But it was -- and just a little side note in history, the two social workers that came and talked with Teddy Roosevelt about child welfare, some agency should be established, they tell this story in which the middle of the meeting they said the boll weevil have started to attack the cotton crop down south and he jumped up and started giving orders, my God, we need to do something about the boll weevil.

And then they said we need to have a vehicle to get the president's attention on children's issues in the same way that we can energize him to worry about the boll weevil. So - - you know, it probably -- I think the odds of that happening is very, very, very small, probably non-existent. But we should at least make a bold statement about the fact that you can't -- you know, how we structure ourselves as a society reflects what we think is important. And if we think it's so unimportant that the person who holds the title doesn't even put it on his business card, and yet I have a little plaque on my wall that says I was once -- you know, it's just -- I just think this is really -- this is symbolically important.

COMMISSIONER DREYFUS: I'm going to miss the quote, but Nelson Mandela said if you want to truly see the soul of a nation, look at it through how its children are doing.

COMMISSIONER RUBIN: Hello? I was having a hard time reaching you guys a while ago.

But I just -- you know, I think this is terrific, what all you guys are saying. And I -- you know, this isn't a matter of profit. I think we should put that off the table, Wade. We created the Department of Homeland Security because we realized that different departments and agencies were not coordinating well with each other. And I think the similarities here in terms of how we think about planning for children's services, and infant mortality and child abuse or neglect and the federal things on that issue.

You know, what I was going to say, and I'll bring it up a little bit later, is that as we now move into the specific recommendations, you guys moving the policies and stuff, I think there might be value in -- we all know -- like, you know, I -- how would we define the steps of our report if -- if we had impact. And obviously the ultimate argument is that we reduce child abuse, neglect, and fatalities.

But short of that, I think it might be a useful exercise to actually ask a question. And each of our subcommittees could do that exercise and maybe do it in a group and -- does the evidence, does the testimony support that theme on our list. And so I'm hearing a lot of "if" statements. I would define success or we would define success if there was an elevated position or elevated accountability within the federal government. You know, whatever you decide on waivers or flexibility, and so on and so forth.

And I would get very granular. I think the staff could organize all those "if" statements into themes. And once we do that, we can actually then create a grid that actually asks, well, in order to create that executive action, that federal legislation, is this more of a state issue or state organization or et cetera, because as we try to get more specificity, I think -- I just worry that we're going to miss things that we talked about in previous meetings, and I would love to see that grid take place before we arrive at the final recommendation.

COMMISSIONER RODRIGUEZ: I was just going to say that in addition to sort of elevating the level of importance, I think the other thing that I feel like I've learned through our conversations is how much this particular field needs to learn from other fields.

And I think part of the benefit of elevating it higher up in -- in the administration is that there's also more of a direct link to department of defense or people who are thinking about things like the FAA or any of those other agencies because to me that's an overall theme, is that this field is so isolated from all of the other innovations.

And even though all of the different fields are struggling with similar issues around how to use the 21st century technology that we have available, you know, in the most efficient way or how to effectively incorporate customer service, sort of customer satisfaction or hear from folks in the field, it's as if none of that exists in this field. Like, we're just completely cut off from it.

So I think also ensuring that there is a constant sort of cross field and not just within the related fields somehow is really important to making sure that this work that we're doing is as cutting edge as possible.

COMMISSIONER DREYFUS: I want to put something out for the commission, but it's a little bit disruptive, so get ready. So we're -- I look at March as being tomorrow it's going to go by that fast we get into the holidays, first of the year, boom.

And I think our subcommittee work has been fabulous, right? It's allowed us to go deep. But at some point, what I worry about is a report that could ultimately look like whack-a-mole, that it's -- it's disconnected, this, this, this, this, and we end up getting nothing.

So I start to think about, if I think about the committees -- our committee, there's some clear themes we've got. When I think about your committee, there's some clear themes you've got. Clear themes we've got. Maybe it's time for us to pull those themes together, come together as a commission, not as the separate committees any longer, and drive this report through a singular mechanism through which we're going to achieve those goals. What do I mean by that? I've heard this commission talk about data. Is it --

COMMISSIONER STATUTO BEVAN: Excuse me, but aren't we discussing the commission's report later on?

COMMISSIONER DREYFUS: Yes, but I'm talking about policy. I think there's a mechanism. As I look at all this, what you've put together here is a lot of those themes; right? So I just want to put on the table that I hope this policy work starts to really become the core of how we're going to advance anything that we're talking about. And it starts to coalesce, is all I'm saying, especially being everything you've got on these identified areas of consideration.

COMMISSIONER STATUTO BEVAN: I just want to get -- I know that we have a group -- another subcommittee behind us, so I don't want to be too late on the time.

So let me just get back to this, and I'm sure we'll be discussing Susan's points, Commissioner Dreyfus's point, something that I know Commissioner Horn has been supportive of.

So in terms of this GAO report, this GAO report, that only came out in February, is very clear. It recommends a focal point and the need - - it talks about the need for a focal point, just on the prenatal area, because this prenatal area, there are nine different agencies, not departments, agencies, that address parental opioid use as well as neonatal syndrome. So the fact that there are so many gaps and the fact that there is also duplication is a real concern, that we have to address this in some way, and a focal point is probably -- is certainly, according to GAO, the way to go about it.

The next one is need for information- sharing. I think we've discussed this one. In terms -- this one cuts across several of our themes. And that's because here we really want to focus on interstate and the problems with interstate. You know, we do have laws that cover protecting kids, both enforced care and adoption, across state laws. The Safe and Timely Interstate Placement Act, which was never funded, in 2006, is one. That, you know, established a federal deadline of 60 days for completing a home study and a 14-day deadline for a state that requests the study to act. I mean, it moved it along. Of course, it wasn't funded.

COMMISSIONER DREYFUS: Cassie, are you aware of -- because I know what Wisconsin is doing the NEIS. NEIS, are you aware of that for the interstate contact? Because I do think there's a mechanism there that could go further than home studies.

COMMISSIONER STATUTO BEVAN: Isn't that just starting? Is that just starting?

COMMISSIONER DREYFUS: I know Wisconsin is one.

FREDI BOVE: We were in the first rollout. There were six states. The target is to have it nationwide by 2016.

COMMISSIONER STATUTO BEVAN: Well, I know Marcy is on that study.

COMMISSIONER DREYFUS: Well, it's not a study. They're rolling it out.

COMMISSIONER STATUTO BEVAN: She's part of that study in some practice or policy.

COMMISSIONER DREYFUS: I just think there's a technology -- if you study NEIS, there's a technology that lays underneath it that has larger applicability beyond coordination of home studies between states.

COMMISSIONER STATUTO BEVAN: The point is, something needs to be addressed. If it's already being addressed in some way, then we should address that. If there are other things across state lines, including background checks, including not sharing information about, you know, where a child's prior history is from one state to another, and that was the case in this particular case of this child who's 15 years old. She died at 15 after years of neglect and abuse. And she had a report in Oregon, and there were several efforts to gain information from California, and that information was not forthcoming. So the point is this is an issue. If we address that as well, that would be great.

And eliminating child abuse and neglect fatalities, we just wanted to show the which to which there are different policy areas that already exist, that we need to examine in a way that we decide ages and sectors, all involved in preventing child abuse and neglect. How can we focus on child fatalities. So in terms of what's needed, our recommendations are in draft form. We really want to look at GIPA. We want to look at results. We want to look at family services reviews.

We've just discussed elevating the Children's Bureau. We've also discussed looking at the center for Medicaid, including -- including SCHIP, childcare, and others -- all of it needs to be examined. We also -- Judge Martin, that we would like to say that we -- that the states define child abuse as a misdemeanor. And the fact that we would like to move it to a felony in the cases that we're talking about, deaths.

Again, we want to continue to focus on child safety. I know you said the Children's Bureau as we elevate should be more than just safety has to be the paramount goal for everything that has the word "child and family" in it. Safety has to be number one. And in every single decision that's made has to be safety. We do need to look at -- and talk to GAO about another report and looking at the existing strengths and weaknesses of programs.

Clearly, we've been discussing this and we looked at the findings of the 2011 GAO report. We have not sent a clear message, I'm not clear on what we're recommending in terms of data collection. And we do need to be very clear that we need all of the agencies involved in data collection, all of the places that this -- that these agencies could -- including the final statistics.

And the death review teams, every place with data collection, we need that to be brought into the federal system and coordinated and used so that we really get a good handle on what

the numbers are. So we need it from birth to death, and we need to be very careful about how it's all brought together because right now it's everywhere.

COMMISSIONER DREYFUS: Aren't we also talking about needing data, not just because we need to get to the right final in, the numbers, but the commission is spending our time with MITER, the time we spend with data analytics, aren't we also talking about the quality of data collection, not just to give us good numbers, but to also be embedded within continuous quality improvement processes.

COMMISSIONER STATUTO BEVAN: We're also looking at circumstance.

COMMISSIONER DREYFUS: Larger use of data.

COMMISSIONER STATUTO BEVAN: Yeah. And we want to get the circumstances. Some of the data has circumstances clearer, and we don't have that data set in the federal government as a contract.

COMMISSIONER SANDERS: But I think I would suggest -- I think it's actually another section on the role the federal government has in analysis. So beyond the collection of data to actually play a role in analysis, that may mean more direct where there are themes across the country.

But at a minimum, having something that's a value to present back to the states to identify based on all of the data that they've gathered, to identify some strategies that might be effective or better classification of a variety of things, I think those have to happen at a federal level.

COMMISSIONER STATUTO BEVAN: Yes. Effectiveness, I think we're pretty much aware that we do need to look both at what we already have in existence in terms of federal law and implementation and also what -- what we need to be doing in terms of establishing best practice.

In terms of improve reporting, we do need -- again, we don't have -- I think Commissioner Dreyfus was saying we don't have -- the states are not equal. But we do need to prohibit states, for example, from screening out reports for children under the age of three.

If you're screening out a report for a child that's been reported abused by mandatory reporter under the age of three, I think we need to have -- we need to be investigating that. Any report by a mandatory reporter shouldn't be screened out.

They're -- they are charged with knowing something, so, you know, hopefully they're report -- and I think we've shown this. Studies have shown that reports -- that the reports from mandatory reporters are right on as opposed to anonymous reports.

COMMISSIONER SANDERS: I guess I'd like to see what we've learned from Wisconsin, as a second review of those screened-out -- because it sounded like very few actually ended up being turned around. And I don't know if those were by mandated reporters or by others.

But if that's the case, I think that we might have to modify it a little because I -- because I'm not sure -- I don't know that we have -- if, for example, screening continues to be based on criteria related to proving something might have happened, then I think it's very difficult to

say you can't screen something out from a mandated reporter because they might not know what the law actually is.

COMMISSIONER PETIT: But I think what we heard yesterday is 44 percent of the kids who were killed had previously been involved with the department. Those cases, in effect, closed. So those would be the exact same type of cases that presumably a secondary look or review, an intense review of more experienced staff and different discipline, is looking at that backlog might say - -

COMMISSIONER SANDERS: Right. But they're doing that now. And that was the point I'm taking, is they're doing the second review for cases that are screened out in at least one or two counties. Very few actually ended -- those were by physicians that were doing the second review, is my understanding.

COMMISSIONER PETIT: That might or might not be the best way to do --

COMMISSIONER SANDERS: No, that would prevent screening-out cases. In fact, very few of those are turned around after they've been screened out and sent in. I think we have to re-examine whether it's a blanket prohibition on screening-out cases or there's some additional nuance to it that we have to consider.

COMMISSIONER PETIT: But I don't know that you can take Wisconsin as one of the 50 states and say it's representative of everything else.

COMMISSIONER SANDERS: But I don't think we should do a policy that's nationwide without examination what the impact may be.

COMMISSIONER DREYFUS: Tennessee is doing this. Remember, Tennessee told us they're doing 100 percent redundancy check on screen-outs. My only concern is I believe Tennessee and I believe some other states after the Sandusky debacle eliminated mandated reporters and said everybody's a mandated reporter. So we have to be aware of how the laws have changed over the years.

COMMISSIONER PETIT: If you did that, which is not the case now, there would certainly not be a substantial --

COMMISSIONER SANDERS: I have no issue with three and under. But this looks, as it reads, it would be for everybody. If it's three and under, yeah, somebody has a concern about it.

COMMISSIONER RUBIN: Yes. Just because I know we're not going to be talking about the policy stuff for very long, but first of all, I think the issue of screen-out and differential response probably spans the level of attention not just for this but that's very restrictive and I agree with Chairman Sanders.

We need to think about a little more about that because the states might not -- might consider it a burden to have that as a federal requirement. But we may still conclude that given the risk to the children under three, if that's appropriate. But I think there's also some other opportunities to tighten the accountability on screen-out around what do you do if you have -- do you keep a record of those screen-outs?

Right now I know there's very little -- there's a lot of confusion about whether states even knows when a report comes in, whether the child was screened out previously and how those -- how the data perspective, whether screened out or not, whether they're open for services or not, you can sort of use them as a petition for the child.

Now, lastly, I think the other two issues that I have for Commissioner Horn and Commissioner Bevan are two major issues and how you guys have thought about it. Number one, what are we going to do with capita? Are we going to strengthen capita? How are we going to enforce and improve accountability at the state level, and then lastly, although we may not be able to agree how to do child welfare reform, whether grants or this or that, it's hard for us to ignore that every DHS secretary is asking for more flexibility.

And so can we at least agree to come up with a set of recommendations that independent of that larger debate greatly reduces the barrier for flexibility?

COMMISSIONER STATUTO BEVAN: Yes. Yes, we do need to address both of those issues. In terms of capita, I think because the regs have been pulled, was still trying to figure out because there's so little money, we are trying to figure out what -- you know, what's appropriate to ask about capita. And in terms of child welfare financing, the exchange we had with Secretary Anderson highlights the need to look at both the waivers and also the financing reform.

COMMISSIONER DREYFUS: But, Cassie, Commissioner Bevan, when do we, from a policy standpoint, as a commission, identify where indeed more investment by the federal government is indeed needed? The -- this isn't -- I mean, it just seems to me again, there's just a number of - - all of these things when you break them down boil up to a set of consistent themes.

I've heard this commission talking about for thirteen months or whatever we've been together. And I just don't understand why we're not at a point that we're looking at a policy mechanism and starting to say that the answer here isn't just moving around the deck chairs and changing this regulatory provision and the other, but that there is a financial need in the system as well.

COMMISSIONER MARTIN: So one of the things I've been somewhat concerned -- I've been concerned about for some time is our process. And I think you're getting to the issue of process again. So when I brought this issue up before, I thought I understood that the process we agreed on was that the subcommittees would come back to the full commission with recommendations that they found through the testimony that related to their topic, right, and that once we got all those on the table and kind of agreed that the recommendation, one from the policy subcommittee, was given in testimony or given in written testimony, one way or another, is on the record, then what we would do is take all these recommendations that we found from the committees. We would compare that to the list of recommendations that the staff prepared so that we know that we've got all the recommendations so we don't leave anything out, and then we would kind of prioritize them. What were the ones that we really felt were going to change the number of deaths for our kids and near fatalities for our children.

And then we would talk about how to get those so they had meaning. So we would look at whether we would start talking about changing it in Medicare or whether we would change it in -- wherever it would fall and how it would go through the system.

So, again, I guess I'm the only one sitting around the table, but I'm confused, like, what we're doing there.

COMMISSIONER SANDERS: So this is the first time we've heard the recommendation from the policy committee; and similarly, recommendations that we'll hear from the American Indian Subcommittee. We have not yet -- we have accumulated the recommendations and themes that we've heard from the other three committees. This is really the first time we've heard them from the two committees that are reporting today.

COMMISSIONER MARTIN: I guess my concern is -- or maybe -- I guess my question is, if I understood Susan correctly, she was saying, well, we have all these things going in different directions and we don't have any major themes coming up from the commission. And so I guess --

COMMISSIONER DREYFUS: I don't think I said that. I'm not saying that we're going all these different directions. I'm saying -- I'm feeling, after seeing -- I had not seen the policy committee report until we all did, right? But I'm feeling like we're getting at a point in our maturity where you're right. All these committees have been working. We all have a set of recommendations. But at some point, Judge, we've got to find a mechanism through how we're going to get this done. It's all going to come down to a set of policy recommendations we're going to make to Congress, right?

I don't see these as separate boxes anymore. I'm starting to think the themes are indeed emerging. How do we will come together collectively, as you just said, to figure out, okay, what is the best political policy mechanism through which we're going to advance this convergence that's starting to happen.

COMMISSIONER MARTIN: The reason I'm confused is we haven't heard all the recommendations from all the subcommittees. So how can we get -- that's my problem. I guess that's what it was. We hasn't finished with all the subcommittees, so how can we start -- I mean, there's nothing on the table from the Native American Subcommittee.

COMMISSIONER SANDERS: Disproportionate.

COMMISSIONER MARTIN: So how can we pull our themes together when we haven't finished the subcommittee work? That's why I'm confused.

COMMISSIONER DREYFUS: So, I apologize, but it seems to me then -- then maybe before -- so many of the things I've heard us talk about ultimately come through these kind of policy recommendations in terms of the vehicles through which we get stuff done; right? And maybe what it is is that there's a policy piece that almost has got to come alongside all this committee work as it's identifying the mechanisms, right, through which all of these recommendations would have any life.

So maybe -- maybe it's -- maybe I'm looking at the policy work too early before hearing all the others because I just -- from a public sector perspective, I look at the policy and say, okay,

it's starting to coalesce through a set of policy recommendations, that all these different recommendations, right, need mechanisms through which we get them done. And I think that's the work of the -- I apologize for any confusion.

COMMISSIONER HORN: May I say something here? As most of you know, I've never been a big fan of the subcommittee structure, and -- but I got my eye on the fact that, okay, the reason -- the value of the subcommittees is that we can't all go deep in each of the areas. And so we're going to kind of specialize a little bit. And some of the -- and so some people will go deeper in certain areas than others. It makes sense.

I think where it -- I get concerned is that the subcommittees have been charged with developing recommendations, which then gives the idea -- at least the dynamic in my view, I think played out, that the committee -- subcommittees give their recommendation and now have a need to defend them. What I would like to do get -- is finish the subcommittee work. We've got two today. We've got one in New York.

And then I think we have an official eulogy for the subcommittee structure and we come together as a commission and we start to say, what are we really going to say, what do we think, what are the recommendations, because there's not 100 of us. There's 12 of us, you know? You know, it seems to me that we should be able to have conversation among the 12 of us and then start to come to a resolution.

So I'm perfectly fine with continuing with the subcommittee structure, but at some point, if I understand you correctly, Commissioner Dreyfus, that I'd like to see us come together as a commission, and I think we are perfectly capable of having that conversation as a commission, as a whole.

COMMISSIONER MARTIN: The only thing I differ with you on is I did not recognize that the subcommittee was to take the information that we learned of, that we have not had the opportunity to share with the full commission and develop our own recommendations. I mean, our subcommittee pulled the recommendations from the testimony that we brought to the commission. But anyway, that may be a minor issue.

COMMISSIONER STATUTO BEVAN: I think we're up to our subcommittee, unless somebody wants to discuss any further the policy subcommittee's draft.

COMMISSIONER SANDERS: I think we have the universe of recommendations from the policy subcommittee with the additions that I think --

COMMISSIONER STATUTO BEVAN: Yes. It's a draft.

COMMISSIONER SANDERS: That's the full document that we have, done drafting, that is available today, which includes all of the recommendations from the subcommittees and the theme so far.

COMMISSIONER MARTIN: While he's unmuting, when you say that the document that we've gun drafting, is that the first -- the initially reduction that we have right here?

COMMISSIONER SANDERS: No, the themes and recommendations document. That's trying to catch the themes we talked about and then mapping the recommendations to those themes.

COMMISSIONER RUBIN: So I guess -- I want to say I agree with everything that was just said in that last round in terms of when we move from subcommittee to group.

Judge Martin, I totally agree. We have to let everyone play out their process. I also agree with Commissioner Dreyfus. We're running some revision, sort of, wow, there is a policy that beats every one of our subcommittees, and the way I sort separate with some of these larger issues with federal policy and that's what -- you know, what Commissioner Horn was saying. But some of these, when they do come together -- and I agree with Commissioner Horn there's the whole part here where we start to integrate in.

So larger states like we'll define success in the future, and then we can think about each of the contributions for the subcommittee for that achievement or outcome and how they all pertain to achieving that and that we would like to say, state and federal level, that we can then start to integrate our individual subcommittee work.

COMMISSIONER MARTIN: So first of all, on behalf of our subcommittee, I would like to thank each and every one of the commissioners for being so gracious to the guests that we invited to come and testify and provide testimony to you, both in Arizona and yesterday.

Let me just explain how we went about our task, and maybe we're all saying the same thing, and I'm just not hearing it the right way. Let me just say how we went about clearing our task. We tried to identify people who had information about how to best address and eliminate fatalities in Indian Country.

And then we asked them who else could we talk to and who else would they recommend we talk to. We asked them what are the major issues to curing this issue in Indian Country. And from that, what we did is we started talking to individual people and inviting them to our subcommittee meetings over the phone and having conversations and asking them questions and trying to learn what they felt the major issues were.

From there, what we did was we selected people who we thought were the best experts in those areas and brought them to your attention so you could learn the information that we were learning. So if you remember in Arizona, we had a full day of panels. And a lot of that -- and we tried to bring the information in groups or issue groups or topic groups to be more organized so that you could have a way of wrapping your head around and putting into context the information you were receiving.

And if you remember, those topic areas loosely were jurisdictional issues, data issues, service delivery issues, and the sharing of information or the coordination of information from state, fed, and tribe.

And all of that accumulated into really having a good understanding of what sovereignty meant and how each of the tribes is considered a sovereign nation, and how that differs than working from county to county, state to state. Then what we did was we went through and actually ordered the transcripts and went through all the transcripts to make certain that we pulled all the recommendations.

The recommendations that were given in a -- a concise form where some of the speakers said I recommend one, two, three, four, and also the speakers that coordinated influx with

recommendations in the topic or the narrative in their conversations with us. So what we are offering you today is a list, basically, of the recommendations that were pulled out from all of the speakers that have been presented to you by our subcommittee on this topic.

And for your edification and to make it easier for you, we actually put the cite of the person that made that recommendation and gave you the page of the testimony that you can find that recommendation. So if you have any questions about it or concerns about how we summarized it, you, yourself, can go back to it.

The supplement you got this morning is a list of the recommendations that were offered to us yesterday, so we couldn't have done that prior to and gotten those two prior. But what we did was spent time last night taking the testimony received yesterday and trying to do the same thing, itemizing out and summarizing the recommendations that were offered yesterday. So that's how we went about our work.

First of all, does any -- and I'm not trying to be simplistic, but I want to make sure that you understand how we went about our work. So does anyone have any questions about what we did and tried to do?

COMMISSIONER STATUTO BEVAN: You had in your subcommittee, you had conversations with witnesses or potential witnesses?

COMMISSIONER MARTIN: So if we were talking and we said that Sally Sue knows a lot about jurisdiction, I invited Sally Sue to come to our subcommittee over the phone, we didn't have in-person meetings, but then to talk to us about jurisdiction and tell us what she thought the major issues were, the major barriers about jurisdiction, and give us what she felt needed to be done to improve jurisdiction. We had a lot of people talk to us about jurisdiction, and not every person we spoke to came before you. But what we did try to do, we found the people that knew the most about jurisdiction to bring to you, and those are the people who we itemized their recommendations. Does that make sense?

COMMISSIONER HORN: So this is an itemization of all the recommendations that people have made, not necessarily -- you have not attempted to filter that through in terms of what you think the commission should --

COMMISSIONER MARTIN: No. And I think that's the big difference that I'm finding. I want to be clear that we did not prioritize these as a committee. We did not then synthesize or try -- synthesize is not the right word. We did not make decisions about this recommendation's not important and that one's more important. What we did was take every recommendation that was offered, either in written testimony or verbal testimony to this commission, from the witnesses that we brought forward and recommended to the commission and listed them out.

COMMISSIONER ZIMMERMAN: And I think we did that purposefully because there's too -- well, there's 557 or 567 federally recognized tribes that we can't all have here testifying before us. But we did it purpose fully because so often the federal government creates these commissions, and it's remarkable that there is an American Indian voice on this commission. But we did that so that these recommendations are literally coming from Indian Country, not from a preconceived idea about what we think is good for Indian Country.

COMMISSIONER RODRIGUEZ: Commissioner Martin, I just want to say I very much like the process you used, it's very organized, but I do not think the subcommittees all functioned under the same understanding that you did around being sort of being objective, hearing from folks, itemizing, presenting back. I think every subcommittee functioned differently, so you're correct in that.

COMMISSIONER ZIMMERMAN: Let me add -- let me add that it's not as if we walked into this blind. Obviously, you have me here. I've participated in the Attorney General's Children Exposed to Violence Task Force; therefore, I knew some of the issues that had bubbled up from my experience on that task force. And so we had at least a beginning direction about what we know about what's important in Indian Country so that at least we can have -- jurisdiction is huge. That's the biggest piece. We began the conversation around jurisdiction and what that looks like in child welfare cases.

COMMISSIONER PETIT: Where's the recommendation on that?

COMMISSIONER MARTIN: So let me just finish before we go into recommendations and finish this issue about how we did it.

In addition to what Commissioner Zimmerman said, the other thing that was important to us was to never put forth anything to the commission that wasn't sensitive to the Native American culture to the tribes, and that's why we tried to bring their voice to the table as opposed to our voice to the table. And the last thing that I will say, we have to really commend Cheryl as our staff liaison. Cheryl was tremendous. Cheryl never let us down, and we called her at the last minute.

Likewise, we could not have done this work without DCG. They have been fundamental in not only helping us find people but getting people who we didn't even know we could get to talk with us and be generous with us with their time. So thank you, all three of you. Now -- we have no more questions about --

COMMISSIONER SANDERS: No, I would actually just make a comment. I think what you described in the history and the cultural issues about how these recommendations came forward makes tremendous sense, and I would distinguish that from the other subcommittees, which I think is -- I think is absolutely fine and gives us a chance to perhaps do some things that haven't been done in the past. I think it would be helpful to hear as you go through the recommendation how we avoid doing that screening that happens all the time at this point because we now have a set of recommendations that at some point we'll have to do something with them. And so how we need to think that through.

COMMISSIONER MARTIN: Are there any other questions about our process? And then I think Michael, you had a question that I --

COMMISSIONER PETIT: Well, I'm just trying to find in here where you repeatedly said what an issue jurisdiction is, and it is, but what's being recommended that addresses that.

COMMISSIONER MARTIN: I think you'll find quite a few issues that go to jurisdiction. Do you want to go down the line or --

COMMISSIONER ZIMMERMAN: I think that we just -- I don't want to take a lot of the time of this commission today because there are some bubbling themes that came out of all of the testimony that focused basically on funding to Indian Country, how that's done, how that can be done, what the services are, how the services can be provided, very strong recommendations about collaboration in not just funding, not just saying, feds, fund us, but collaboration, data collection, the need for data collection, how to do that, and then jurisdictions.

COMMISSIONER PETIT: Yeah, I want to withdraw my question because I somehow missed this draft recommendation. I was responding to yesterday's summary.

COMMISSIONER RODRIGUEZ: It's a supplement.

COMMISSIONER ZIMMERMAN: So the themes that seem to go through these recommendations, there's a lot of themes around doing it in a -- I mean, it's all framed in being culturally appropriate and honoring local culture. But the themes are funding, services and collaboration to basically be creative about how the services are provided.

As we talked about yesterday, the testimony that we know that child welfare -- child protective service practice in Indian Country can be a state issue, tribe issue, or the Bureau of Indian Affairs. So there's a real strong recommendation by many people with the coordination and collaboration of all of those agencies serving American Indian children.

So it's about collaboration of federal and state agencies, what it looks like, where it's at, what doesn't exist, where are the databases that do exist, what do they have, where are the databases that could be created, who's responsible for it, is it PIA, is it health services of the child.

And then finally, jurisdiction, when there's a child that dies, what does that look like. That goes back up to coordination and collaboration of services. You know, the tribal investigation turns into a Federal Bureau of Investigation investigation that's passed off to the US Attorneys. Is that what it always looks like and where are the gaps?

Strong encouragement around tribal sovereignty and increasing the building of local capacity, basically procure criminal jurisdiction over those -- that do harm to children in their -- the citizens of that nation, basically.

Do you want to go through them individually?

COMMISSIONER MARTIN: I don't want to insult anyone's intelligence and read them individually, but giving you the groupings of how we saw these will be helpful.

COMMISSIONER SANDERS: Can I just -- I think there's actually a question I would put to the subcommittee and to the full commission, and it goes back to what we talked about. I think when we get to the discussion of the final report, it really has to be about a story. It's not kind of 15 or 20 or 30 different stories.

But this area, to me, is one that we -- I would lean towards saying we want to separate out issues related to American Indian children because of the issues of sovereignty. I guess that's

a question. Do we think about incorporating the themes under the broader themes for the report, or do we think about this as a separate kind of chapter within our document.

COMMISSIONER MARTIN: So I think, one because of the sovereignty issue, but more importantly, when we talk about data, in Indian Country, data is not just about everybody agreeing to the definition of what child abuse and neglect is. At least there are numbers that are being collected state side. There are jurisdictions that aren't even collecting anything.

Just like you heard yesterday, here in Wisconsin, who has a pretty extensive and sophisticated system, they're not distinguishing between an adult death and a child death in Indian Country. So I think that Indian Country has such particular issues that it would be difficult to then just have a section on data including Indian issues in that section. I think Indian issues should be a separate identifiable section in this report, but it should mirror the issues that we talk about state side.

So if data's important to state side and in Indian Country, there should be two data sections, one obtained within the Indian issues and one in the state court.

COMMISSIONER DREYFUS: I like the idea of a report, because of the sovereignty and our respect for our tribes, that there's a separate chapter, you know, very specific separate chapter on that. The fact that it's reinforced by other things, right, is fine. But I think it should be a very separate chapter.

COMMISSIONER ZIMMERMAN: I think it could be a separate chapter with very good footnotes and notations that link it to the state recommendations in other chapters so that it's standalone but it links. Because we -- I don't want -- I don't want it to be seen as something that seems irrelevant to the broader American public.

COMMISSIONER RUBIN: Yeah, I think this is great. Hold on. Let me make sure -- can you guys hear me?

COMMISSIONER SANDERS: We can hear you, yes.

COMMISSIONER RUBIN: This is great. I'm happy with it, the separate chapter or -- the other way you can frame this is it's really about the population and the nature of the consideration, really demanded their own carveout in terms of thinking about the structure in terms of our report.

I would put the military in there too. The military is a very unique population that has its own sort of barriers. So whether we do separate chapters or talk about equal protection or special acts of population, I guess we could accomplish that.

I guess the first thing I have for Commissioners Zimmerman and Martin, we sort of touched on it yesterday during the testimony, which is to the extent of the tribe, the Indian -- the Bureau of Indian Affairs and state child welfare, you know, if our goal is to get more resources into the communities of these individual tribes, having -- you know, the outcome from the table for me has always been, you know, you're talking about three different sources of resources, so there's nothing left at the end of the day, so it's very hard to dribble down to the community.

And you guys have heard testimony around that and incorporated -- like there are newer models of the ways we should be reducing redundancy but still reducing tribal --

COMMISSIONER MARTIN: I'm glad you brought that up. If you look at Recommendation 27 at page 4 of 4 that's in your binder, you will see the beginning of a recommendation that was offered by one of our witnesses that talks about this very issue.

Our recommendations -- yeah, we could have said throw money at Indian Country. But what we were trying to do is make certain that we utilize the resources that are currently there and make it better for the families and children. But we did ask for more resources when we thought that was the only answer.

But if you look at 27, it's talking about reshaping and making certain that the resources are centralized so that there's someone at a White House level that has the answer, they can say yes or no. When there's a conflict between BIA and the state, there's no one there to work that conflict out. It basically has to talk out or tire each other out. And it seems to us that if you have some centralized place where there is a final answer to be given, that would help a lot in this coordination of information services and resources. And Marilyn wants to add --

COMMISSIONER ZIMMERMAN: I want to add sort of a philosophical or ethical vent to this. For the benefit -- I'm going to presume and speak as one native person, as one American Indian, from what I think I understand about the collective belief about this.

American Indians, while they are a special group, they are not the military, they are not special needs. They are unique because they have a direct relationship with the federal government. And that unique relationship sets them apart with any other people group in this Country. And that unique relationship was brought about by treaties that are still unfulfilled and the belief that because of those treaties, that we gave up land and freedoms in exchange for education and healthcare and a safe place to live.

And we are still saying that the federal government in this government-to-government relationship has to come and fulfill those treaties through what now in this modern time looks like things like funding Indian health service at full capacity, funding child protective services through the Bureau of Indian Affairs, creating some sort of mechanism with the tribes. That's where -- that's where it's different and unique. So we're not necessarily -- so it's different than to say, "Feds, pony up." It's feds, honor treaties, and let's think about how we do this.

One of the issues that drives all of this is just trying to say we need parenting in Indian Country in child protective services. We need at least the minimum of what states have, even the poorest counties in states. We are loathe to even equal that. That's at least the basics of what all of these recommendations around funding are about.

COMMISSIONER SANDERS: So do we -- and I think it will help in guidance both for the discussion and in the report, obviously, I've heard from some. Are we okay with this being separated out as a chapter in our report, or are there ways we want to approach it?

COMMISSIONER STATUTO BEVAN: I wanted to think about it. Can I do that?

COMMISSIONER SANDERS: The reason I mention it before you do the themes, if it's a separate chapter, then we can think about it as a set of separate themes. If not, we probably

need to think about it as we look at all the recommendations. So I think it's practical in terms of how we approach it.

COMMISSIONER HORN: So I'll just voice my opinion. I believe it should be a separate chapter, but I don't think it should be a subsection of a section about special populations. There's something very special about this. And I look forward to the conversation, but the BIA is actually the right agency.

We do have this thing called the Administration for Native Americans, which is supposed to be about any Country. And maybe that's a better place to -- to -- so I look for -- particularly given the titles with 4-A and 4-B and child welfare.

COMMISSIONER SANDERS: So do you want to quickly go through the themes and then we can have the bigger conversation next meeting when we have all the information and see if there's consensus.

COMMISSIONER MARTIN: Sure. So why don't we start from 1, page 1 of 1 in the book. If you remember correctly, one of the overriding themes when we heard about the history of Native Americans was generational trauma and there were issues around fatherhood -- and this is similar state side -- that fathers are not really included as really the primary provider for children, development and children care. The women of the family. And so the whole idea of fatherhood, and I think we all kind of understand that and remember that, unless there's a question about that.

So -- you can jump in and do some of them too, Marilyn.

COMMISSIONER ZIMMERMAN: Sure.

COMMISSIONER MARTIN: So when we talked about strengthening the funding available for programs to reconnect culturally, one of the issues that we found in talking to a great deal of the witnesses was that particularly in Indian Country, the older children, the older youth, are having serious problems with suicide.

And part of that is from generational trauma and the fact that their parents haven't really healed, so it's difficult for the parents to help the children. And part of that is with mental health issues, but part of it is from the divorce from their culture, not having the language, not participating in pow-wows, not being involved in their tribe, trying to run away from their culture on some level.

You also had the opportunity to view that video about kill the -- "Kill the Indian, and Save the Man," and how we as a culture have tried to make Indians more American -- more English, more American as opposed to allowing them their special cultures and their particular cultures and language. And so there's been a lot of recommendations about making certain that we support the culture of native land and not try to change their culture or make their culture our culture in order to look at their children.

They know how to raise their children. We've heard that from Wisconsin today. People know how to raise their own children and to lead their children into the culture in which their children are born.

There's also this whole issue about a lack of history and knowledge of Native American history. You know, we can talk about some of the things that we've heard in high school history class, American history class, but the issue really about the intergenerational comment and how that has impacted Native American culture is one of the -- is kind of how Recommendation 3 came about from all that testimony.

Mike, are you about ready to say something?

COMMISSIONER PETIT: Yes. I have to leave, and I'm sorry. I wish I was here for all of this. I didn't have this document. I didn't know what it was, so I never went in to get the thing. So she helped me. So what I would like to do -- of course I want to hear more about it. I'll give you or Marilyn a call if I've got any questions about it. And I know I'll be discussing this further. Thank you, all.

COMMISSIONER SANDERS: Thank you.

COMMISSIONER ZIMMERMAN: I'm not sure if we want to go through these line by line. That's my thing. I think that -- yeah. So I think that I'll just go with the funding, and sort of mark out those themes that -- the funding themes with the line by line.

So No. 5 addresses funding. In a way, No. 10 addresses funding because they're asking for MDTs to become much more than just a prosecutorial mechanism for child abuse or sexual abuse in Indian Country where they come together to think about resources, and No. 4 is also a structuring federally funding social service delivery to accommodate the realities of these impoverished communities.

No. 11, using Medicaid dollars to support some of the 4-E funding for services around mental health and behavioral health. Funding of -- from the executive branch of Congress to bring tribal criminal and civil jurisdiction systems up to parity with the rest of them, No. 14.

COMMISSIONER HORN: Can I ask you a question about 11?

COMMISSIONER ZIMMERMAN: Sure.

COMMISSIONER HORN: So are we talking -- so I would assume that if a Native American were in foster care as with most -- you know, 99.9 percent of kids in foster care, they're eligible for Medicaid and Medicaid will pay for -- you know, health and things that meet the child. Is there something else that you're getting at here? Why would -- is it a broader use of Medicaid?

COMMISSIONER ZIMMERMAN: I think so, yes, yes.

COMMISSIONER HORN: Okay.

COMMISSIONER ZIMMERMAN: So, for example, there are some states that are mandated to document that the services they're providing are trauma informed, otherwise Medicaid won't reimburse them. It's just little subtleties state to state for the tribes and what the tribes are --

COMMISSIONER HORN: Okay. Thanks.

COMMISSIONER ZIMMERMAN: I think often the Bureau of Indian Affairs uses a lot of the dollars and can support the child with that, and therefore, the Medicaid mechanism doesn't kick in. So as you -- further on, No. 18 has really in particular got funding, jurisdictions. We still are hearing stories. I hear stories in my work as I go. I do consulting work across the country, and the work I do in the trauma center where we have one law enforcement covering two million acres for a shift, and sometimes there's two officers covering for the entire time. So if one of them gets sick, there is no coverage. The same thing when -- we've heard stories of one social worker covering two million acres during a sequestration.

COMMISSIONER SANDERS: Pat, I have kind of a broad question. So looking at the recommendations related to funding, it seems in some ways No. 14 kind of captures the intent. A question that I have is how do we think about this, considering both sovereignty and parity with the rest of the United States? I mean, how do we think about those two together because it seems to me that there could be an argument, that there should be a different level of funding with sovereign nations than there would be with using US territory.

COMMISSIONER ZIMMERMAN: Right. So one of the ways -- one of the ways that I also thought about this when I would talk with, like, Sarah Kostelyk, for example, was when thinking about the work that this commission could do with a -- we were already thinking it would probably be a separate chapter, that sort of thing, we also looked at and shared with the tribal law and order the tribal law and policy report, I can't remember -- Tolowa, and the Attorney General's report because there's no use re-creating the wheel, right?

So we looked at those recommendations, and when they're linked directly, thinking about that. So one very strong recommendation of the Attorney General is asking the Department of Justice for at least 10 percent set aside specifically for tribal issues, for tribal jurisdictional issues. 10 percent of the entire Department of Justice for tribes. I don't know how many millions and millions of dollars that would be, but that's one mechanism that would come through a federal agency with federal dollars for tribes to be able to do that. Is that kind of answering your question?

COMMISSIONER SANDERS: No. I think I'm asking more, the argument made here is to bring funding to tribes into parity with the rest of the US. But we're also talking about the issue of severity, which suggests there are differences in how the federal government might fund states versus how they might fund tribes. And so how -- how do we make the link between looking at parity while at the same time arguing that sovereignty is different. I'm just thinking -- thinking that because I'm not sure that's fully --

COMMISSIONER MARTIN: So one of -- and I'm not sure this will answer your question. If it doesn't, please let me know. But one of the things that I keep coming back to is how surprised I was when we were just talking about the issue of data and how the infrastructure for even gathering the data in Native Country doesn't exist. So you can talk about states or courts that don't have, you know, updated computer systems, Cook County included.

But at least we have something to start counting. In Indian Country, they don't even have the infrastructures for counting. So I would say the way to do that is look at the needs and start addressing the needs. I personally am not saying, you know, the state courts give two million a piece for refunding or something. What's the thing that -- oh, child -- what was it? Court

improvement funds, so states are getting $2 million for court improvement funds and automatically give the tribes $2 million.

What I'm saying is you look at the needs of the tribal communities. They might need $3 million instead of the two for court improvement funds, but to make certain that what's provided for states or provided for Indian Country is based on Indian Country's needs. So does that answer your question or not?

COMMISSIONER SANDERS: I think it's -- let me think about it. I see Cassie has a question. Let me think about it.

COMMISSIONER MARTIN: Okay. The only thing in addition to what Marilyn was pointing out, there was a question about jurisdictional issues, and I don't know that Mike drew the conclusion. But I do want to point out that a lot of Judge Thorn's testimony was around jurisdictional issues. You know, it is amazing to me that depending upon whether or not there's going to be a filing for a particular crime as to whether or not the FBI, Attorney General, or if the client has jurisdiction over that criminal incident, and you can imagine in the beginning and during the course of that investigation how that may impact the investigation.

And hearing stories about when children die in Indian Country, that the body is removed from the tribal territory, which is, you know, very contrary to their culture but for autopsies and how doing autopsies in and of themselves by people who are not from the tribe and out of the tribal locale is so much against their culture and why can't we talk about developing investigatory methods so that they can jive with the culture, do it right on the territory, as opposed to insulting people and taking the body off the country, little things like that, to improve the ability of the tribes really taking care of their own but also making certain that we have the ability to count and identify.

COMMISSIONER STATUTO BEVAN: Okay. My question -- I tried to ask this yesterday and I didn't get the answer because I don't think I framed it right.

What I'm trying to get at is if -- rather than -- I don't think it's feasible to say let's go to the tribes and ask them what they want and how much they need and give it to them. I don't think that's feasible. I'm trying to think about this about based on how we allocate money to the states. And the states, for money of these services, there's a Medicaid match. It's based on their Medicaid, a number of people that had Medicaid, and that varies any from a 40 percent match to an 80 percent. There's a formula. It may be flawed, but there's a formula. For Indian Country, is there no formula? You know, what is the formula that -- and would there be a match to this money, a federal match or state match or tribal match or something?

COMMISSIONER ZIMMERMAN: For many, many tribes in this country, they are just now beginning to scale up Medicaid reimbursements for their tribal programs. So they've been literally operating without accessing those Medicaid dollars, right?

COMMISSIONER STATUTO BEVAN: Right. Okay.

COMMISSIONER ZIMMERMAN: So if they had a tribal behavioral health program with people providing licenses, that salary was being paid through a 638 compact rather than billing the

Medicaid for the clients they were seeing or private insurance. Now, they are beginning -- many tribes are up and running. But the smaller ruralized tribes are just now beginning to build that capacity.

COMMISSIONER STATUTO BEVAN: I'm sorry, but what is 638?

COMMISSIONER ZIMMERMAN: I'm sorry. So during self-determination -- Richard Nixon was a great president with self-determination. He did that very well and very right. They created a mechanism for tribes to be able -- who in the capacity to manage their own health programs, like a diabetes program, a behavioral health program. The funding was then contracted through the tribe directly. Those are called 638 tribes or programs.

COMMISSIONER STATUTO BEVAN: Okay. So - - I guess we -- the Medicaid -- using Medicaid as a formula to get money to Indian Country is not viable? There must be -- you would have to come up with something else?

COMMISSIONER ZIMMERMAN: It's beginning to be.

COMMISSIONER STATUTO BEVAN: Okay.

COMMISSIONER MARTIN: The only thing I would remind us of is the sovereignty issue also requires this nation to provide safety for Indian Country and to provide services to Indian Country. So I think that also has to be taken into consideration when we talk about formulas, right?

COMMISSIONER SANDERS: So I think that - - and Cassie asked it in a slight different way. Parity -- for 40, there's a formula. There is a required match from state. And that's the structure of funding. And so when I see the argument that we should have parity for tribes, I'm just trying to understand how that fits in because maybe parity is a different definition, but I'm not sure parity is what we want if -- because then it's going to be very difficult it seems.

COMMISSIONER MARTIN: I see what you're saying, yes. I mean, tribes often don't have the matching funds to access or apply for 4-E funding. They need consultants. In my opinion, you know, it would be helpful to have consultants to help them apply for some of that funding because they don't have the infrastructure to do it. But I think if we look at the needs of what the Indian Country need, their needs, then we have a better sense of how to allocate or give the funds, is what I'm trying to say. Does that make sense?

COMMISSIONER HORN: Can I -- and -- and -- let me share my perspective, which everyone in this commission can feel free to disagree with. It's not -- even if Indian Country had all the capacity in the world to participate in exactly the same way as states do, in my view, that would not be the answer because fundamentally the relationship between the federal government and tribes is different. It's not just that they're poor states. They're different. They're sovereign nations.

And so the struggle I think we have to figure out is how do we deal with tribes, given the fundamental different relationship that the federal government has with them. So this, for me, it's not just simply there's a bunch of poor states. So once we help them, we'll get them

to be not so poor states and treat them the same as the other states. That's what parity does to me.

Rather, it seems to me we should -- and believe me, I do not know the answer how to do this. But it seems to me that that should be the goal. And in some ways, that's very different than thinking about this, as how do we do this in a similar fashion. We should think about it differently.

COMMISSIONER ZIMMERMAN: Well, I think obviously we heard yesterday from the Bureau of Indian Affairs and because of the different government-to-government relationships but because how it engages in relationships with the tribes, it has been established through the war department when they were beginning to make treaties, back in '17 or '18 whatever, still making treaties. The bureau -- that's when it was called by another name -- was established.

So historically, that conversation and often a lot of funding and self-determination programs and economic development is done through the Bureau of Indian Affairs. Is that the right place for it to be? That's the question you posed before. Yes, no, maybe. That's a conversation that has to occur with tribes.

And I think that -- I just want to sort of say a clarifying thing. I know what you were saying, Cassie, but I want to say for the record that we have to ask tribes. We don't say, hey, you know, what do you want to do with it? Let's throw some money at you. What has occurred in the past, as I already spoke to this morning, is that states do not authentically collaborate with tribes or consult with tribes.

Historically, they have not done that. They continue -- many, many states. I'm not saying Wisconsin is one of them, but many, many states continue to have an adversarial relationship with the tribes that are in their states and there's very little consultation that goes on. And again, the funding does go to those states believing the funding is going to the states and it's not. The state will come up with what they think is a brilliant idea for Child Protection or for, you know, delivering Child Protection that won't work in that tribal community. So they say, "Well, here, you can do it if you do it this way," and they say, "No, thank you."

COMMISSIONER DREYFUS: Can I put an idea on the table to Wade's point? Because I do agree with you. We need to look at this in a different way, and we keep saying we want to look at in a different way but keep applying the same tools in the tool kit. In Washington state, I just happened to stay very aligned with government to government and the processes that we used, I communicated with tribes differently. I negotiated with tribes differently. I had regular consultations with the tribes. And in that centennial core that brought us together every year, government to government, right, created the mechanism of an agenda of what we were going to be working on together, government to government.

I don't think this is one where we're going to throw out a bunch of recommendations on this, as much as that there's some things that need to happen but they need to happen at the government-to government-table with the Bureau of Indian Affairs because I don't think this is about bringing them up to the level of the poor states, right? I think this is about the treaties. This is about our full realization of those treaties.

So I -- I just think we've got to be thinking about this, and it might not be so much all these series of technical recommendations, which is just going to keep us doing the same thing we've always done. Maybe our biggest recommendation is a process that needs to happen between the federal government and tribes about how to get that done. Because I just -- otherwise I think we're just going to be five years from now having the same conversation.

COMMISSIONER MARTIN: So I would just like to add, when we're talking specifically about what that looks like, what does parity look like for Indian Country, the one example I keep coming back to when we talk about 4-E, 4-E requires matching funding. And so from fostering connections, one of the things that was offered was that Native Country can bring any kind of services to -- to make that matching. And so those are the types of things I think of when we talk about parity.

Now, I'm not sure if that really addresses your question. But, you know, when Deidra testified before us, she gave us a lot of information about 4-E and how it was developed and how Native tribes started applying for 4-E and some of the challenges that were confronted by the legislature in developing the 4-E application for tribes.

And, Deidra, not to put you on the spot, but when you talked about parity when developing this legislation, what were some of those challenges.

UNIDENTIFIED SPEAKER: So we spoke directly to Commissioner Horn's last concern. We had language that said in the same manner as states. I think that -- that was one of our greatest challenges. The beginning of that conversation about direct 4-E to tribes, we were a little misguided in how to really think about sovereignty.

And I think there's been maturation on the issue. I think there's been maturation because of the issue of tribes where people may have caught up with Commissioner Horn to really think about this differently, not as the core states, as Commissioner Dreyfus just said, but really as a completely different relationship. And I think watching tribes go through this process, 87 tribes that were interested, 27 in the pipeline, only 5 able to meet the exact criteria that are applied to states.

Yesterday, Commissioner Horn, you asked about specifics. I don't have them. I'm not representing any kind of tribal government, and I think those questions need to go to the tribes. But some examples that I have heard are things like the data infrastructure. The 4-E application is exactly the same as it is in states so they have to submit the exact same data with no infrastructure to do it. Even if they have qualified personnel, they may have to hire and use a full FTE just for the data requirements.

Things like termination of parental rights, most tribes do not want to terminate parental rights even if they're removing a child. It's just culturally, your mom's always your mom, your dad's always your dad. You don't -- even if you go to another clan, you don't change that history. And so I think we try to give flexibility in that conversation about there can be guidance on different ways that tribes can address termination of parental rights, i.e., they don't have to do it, but it really hasn't trickled down appropriately, I don't think, from ACS as was the intent was.

Am I getting at your question?

COMMISSIONER MARTIN: Yeah.

UNIDENTIFIED SPEAKER: The sovereignty issue was the biggest one.

COMMISSIONER DREYFUS: Just a question to give me an example of how this plays out, when the feds put out SACWIS, enhanced funding for SACWIS, were tribes able to directly go for that - - those SACWIS dollars to build their own, quote/unquote, SACWIS system in the tribe.

UNIDENTIFIED SPEAKER: I'm not sure if they could if they didn't have a waiver or something different. We didn't contemplate it in direct in 4-Ethere's there was no contemplation of it.

COMMISSIONER DREYFUS: To the 9010 funding?

UNIDENTIFIED SPEAKER: You know what we did? We thought about -- we thought as tribes as poorest states thinking they would get the highest Medicaid match. And then to supplement that match, you could use in-kind contributions. So you could take into account the your tan I have program may have some sort of resource, you're using that building and you're using that building for your child welfare program. Or you're -- a different program may have a van or some sort of transportation methodology that you use for picking up kids overnight.

So we're letting tribes take into consideration every possible resource that they had, whether they were physical or financial to try to meet their match.

The other data systems, honestly, Commissioner Dreyfus, I don't remember a conversation about them. So how tribes are going about accessing some of that funding, I'm not just not sure. I think that's something that can be found out pretty easily, though.

COMMISSIONER MARTIN: Thank you. We really appreciate that.

COMMISSIONER SANDERS: So it seems that we want to -- there are a couple of things we need to think about, and I'm not sure we can finish this today. One is if this is a separate chapter, but I think the issue of the parity or what exactly the overriding theme should be about how we recommend the dealing with tribes as an issue. And I -- I just don't think parity captured it personally.

COMMISSIONER MARTIN: I think I understand what you're saying.

COMMISSIONER RUBIN: Here I am. Hey, guys, I just wanted to ask a question. I think there's a lot of focus on can we figure out the flexibility of funding to, you know, increase the availability of six types of services in Indian Country. But then I always think about particularly rural areas, not just in Indian Country, but sort of the workforce. Have you guys thought you can provide funding but then have no one to hire. Have you guys thought about that at all?

COMMISSIONER ZIMMERMAN: Commissioner Rubin, this is Marilyn. It's something that we always think about. It's a day-to-day reality for Indian Country, and it often isn't about funding. For instance, I think I described yesterday that the Rocky Mountain region has -- over 50 percent of its FTE is lingering and languishing and is unfilled because the communities are so isolated and people aren't willing to go there.

So I think there has to be a way -- they've gotten creative about who they hire now and what they -- how they can hire, and I think that it was a question that I asked yesterday at the bureau. Can -- how do we do professional development in Indian Country. What is that going to look like? Can we access tribal colleges? Can we access centers like my own, the national trauma center to provide that training because of funding that we've received. It's a conversation that has to occur. We have to be creative like in small rural communities and do the best we can; but obviously for tribal communities, it isn't necessarily about the salary.

I've worked with a supervising social worker for the Bureau of Indian Affairs who was probably making somewhere around 70,000 when the median income for that family was 12,000. And she left that federal position because the administration of her tribe changed, and the tribal leadership asked her to come to a tribal program and serve the children of that tribe in that capacity. Her salary was cut in half, but because of her commitment to the tribe and to the community and to being a citizen in that community, she was willing to leave that very stable federal job to take a position for a grant- funded job just because her relative asked her to come help.

So the way we think about the priorities and why people do the work in Indian Country might be another way of thinking how we build that capacity.

COMMISSIONER SANDERS: I would suggest that we finish this for this meeting, come back next time, having done some more thinking, and I think we can begin to -- as we put together additional drafts of the document, both begin with the separate chapter as well as when incorporating and decide after that how we want to proceed. But it does seem that the way this has been approached, we should reflect that in the document, that we're not -- that we really are looking at -- at this point, listening to establish a foundation, which is part of what I'm hearing.

COMMISSIONER MARTIN: And just another comment on whether or not it should be a separate chapter or separate section, the fact that we intentionally did this different than the other subcommittees, I think it should be brought to the attention of the reader in the audience. And that, in my mind, also goes to the issue of whether or not it should be a separate chapter and be able to identify that this was done differently, so that we can make certain that the Native American voice is heard through these recommendations.

COMMISSIONER DREYFUS: I just have to -- I have a little bit of a problem with that only because I don't think it was done different than our subcommittees. I asked her staff to go back and tell us all the things that were related to our area, that we heard through all the different meetings, right, and testimony. We've gone and specifically talked about various federal agencies and other key players, right, in this space of our subcommittee's emphasis. So I don't know that it's true that we haven't -- or at least with respect to the public policy -- the public health group, that we have not done that.

How we came to it may be different, how we ultimately -- but I don't know that it's so radically different in terms of taking what we've heard as a commission, what we've learned in the various you did it through a series of calls, we've done it through a series of calls and meetings with key people, right, that we've done very much the same thing, the broadest net to then help us to bring to this commission, how are we going to wrestle through the framing

of this issue that's larger than just about Child Protection. So I just don't know that it's true that it's radically different, at least forever our committee.

COMMISSIONER RODRIGUEZ: I mean, I think I see the key difference that you have not applied sort of any of your own. You have literally itemized and presented sort of authentically exactly what the recommendations were. And I -- it may be that you did the same, that you did no analysis within your subcommittee and just give us exactly what you heard, sort of, and who you heard it from, but this is certainly the first time I've seen something that's like that.

COMMISSIONER MARTIN: And I think that's what I wanted to make certain was clear, that our recommendations aren't -- they aren't our recommendations. They're the recommendations from the testimony that was received, either written or verbal, directly from the transcripts. So -- we did not do an analysis and prioritize.

COMMISSIONER HORN: I know that.

COMMISSIONER MARTIN: That's what we thought the commission was going to do as a whole.

COMMISSIONER HORN: Yes. I'm just a little bit confused by this conversation. The recommendation that we make in this report will be our recommendations. They're not going to be just a collection of recommendations presented --

COMMISSIONER MARTIN: I apologize. I didn't mean it --

COMMISSIONER HORN: So I think I agree with Susan, but I also agree with the thrust of what you're saying. I understand. At the end of the day, a lot of testimony was given, a lot of recommendations were made to us, a lot of opinions were made known, and then what our job -- as a commission, whether it's in your chapter or the rest of the chapters, is all going to be filtered through us. We're not simply scribes that write down what everybody says. "Here's our report. Everybody said that." So I'm not sure calling out that there was a different process -- it's true that you did carry a different process. I'm not sure that that's --

COMMISSIONER RODRIGUEZ: But the process was -- the only reason I thought it was worth noting was that it was a very deliberate process that was based on what the historical sort of context has been around American Indian issues. And so it's not sort of -- it was -- I -- from what I'm hearing, and I'm not on your subcommittee, but what I heard you say earlier was that there was a look at sort of how there have been multiple misunderstandings and how inappropriate it is to have other folks speaking and sort of synthesizing what are really sovereign nations with the whole concern, so with the historical context in mind. And I do think that's worth noting, no matter what we come to at the end, to say it was done respectfully, and sort of with that time.

COMMISSIONER MARTIN: I guess what I want to do is make certain that the reader of this report, the overall final report, understands that this isn't a bunch of Americans sitting down and telling Indians what they need to do. I want them to understand that these recommendations originated from Indian Country.

COMMISSIONER DREYFUS: And I support that. So the way you just articulated it is very different from the way I heard it originally stated, in that -- in the section, how we describe

how this commission, not just a committee, but how our commission went about organizing the way in which we sought and brought in Indian Country voice and experience into our -- I get that.

COMMISSIONER MARTIN: That's all I'm trying to say.

COMMISSIONER DREYFUS: I'm sorry. The way you articulated it --

COMMISSIONER HORN: Well, plus, the indication is we didn't do that for the rest of the report, and we didn't want to hear people's opinions. It was just people sitting around, you know, coming -- it was a small point. It's fine if you want to say that.

COMMISSIONER MARTIN: Actually, it's not a small point, in my opinion. And the reason it's not is because of this whole sovereignty issue. It's not a small point that we didn't allow Indian Country to listen to Indian Country and say what they say they needed to make certain they reduce their debts for kids and families. I mean, that's kind of the whole point. We're always in this mode of telling everybody what to do, and this is an opportunity for them to come to us and tell us what they need, right?

COMMISSIONER HORN: That's what we did. But I think we did that not only for Indian Country, but we did it for states. We did it for county officials. We did it for -- I just think it's disrespectful for the rest of the process to say that we listened to Indian Country. We're not going to listen to anybody else.

UNIDENTIFIED SPEAKER: But if the whole report both used by this commission as a whole as well as our committee work, but when we talk about the -- the chapter that is specific to this, that we make it really clear, right, that it wasn't -- that in addition to what we've done as a commission, that we were very intentional -- because of the government-to government sovereignty to tribes, we were very intentional to even go one step further. And -- and I could see that as worthy of note. Not that it should in any way diminish what's been a very inclusive process for this committee in the way that we've gone out and gathered prospective experience and recommendations.

So I think it's just -- it's just that we went an additional step to really make sure that the sovereignty of tribal governments was recognized and honored. So I -- I think it could be done.

COMMISSIONER ZIMMERMAN: I think it could be done, but I also think that there were maybe seven, ten people who are listed here. I mean, there's -- there's not like a whole 567 or whatever it is, the numbers of tribes. There's, you know, ten people. And not all of them are present -- I mean, DDG is not an American Indian - -

UNIDENTIFIED SPEAKER: Eastern Band of Cherokee.

COMMISSIONER STATUTO BEVAN: Okay. But my point is not -- you know, we don't have -- we are assuming a lot of things here. Okay? We're assuming, first of all, they're in poverty, when there are some tribes like Florida and Connecticut where they have gaming and they're not poor. So I think there's some diversity here as well that we should be able to mention and not talk as if everybody -- every American Indian tribe is poor because I don't think that's true.

COMMISSIONER HORN: If I could just clarify because the last -- if what you're saying is we approach this issue with Indian Country because of the sovereignty are the tribes, which is different than the states, then you want to say that. Not only do I say fine, I say I strongly encourage you to say that because it's true. I just -- I just -- and I misunderstood what you were saying. I thought you were saying this is the one area where we actually listened to people. And I just -- I took homage to that. That's all.

COMMISSIONER ZIMMERMAN: So, again, I just want to add for the record that there are casino tribes. There are a handful of casino tribes that's less than 1 percent -- way less than 1 percent of the 567 tribes are casino tribes. So while there are -- there are remarkable tribes that we can practically all name. That's how few they are. So Indian Country is not casino tribes. Casino tribes are unique in Indian Country, and they do have the resources and funding in order to provide those things. They're a casino tribe. They are able to provide those services for their families. They realize that they are in a unique position to be able to have the capacity to do that. I just want, for the record, that the majority of Indian Country are not funded through their casinos.

COMMISSIONER MARTIN: And when we were in Arizona, they specifically told us they chose not to take federal dollars. They preferred taking tribal money for a variety of reasons. But we're making generalizations all over the place, right? Not every jurisdiction that -- not every state side court runs the same way. Not every agency runs the same way. We have county agents. We have state agents. We have some jurisdictions that are combinations. So we're making generalizations all across the --

COMMISSIONER STATUTO BEVAN: All right. Let me just say I agree on this living up to treaties and we haven't. I think pointing out where we haven't and what the implications of that for fatalities is important. I think that some of this, talking about self-esteem and that kind of stuff, I don't know how connected that is to fatalities. I don't know.

COMMISSIONER ZIMMERMAN: So as Wade described, this is almost verbatim. These are the recommendations that were literally taken from transcripts, right? We, as a commission, need to go through it together to think about what that's going to look like and what that has to do with child fatalities, right? Will the self-esteem issue become -- no, probably not. I'm not sure. It will be woven in potentially or a part of just -- assuming -- like we assumed that there are certain things in a marriage that create better well-being for children. What does that -- connectiveness, cohesion, support, that sort of thing. It's assumed, right? That's -- but we're not -- I'm -- I don't know that this commission needs to make a recommendation to the US Department of Education to make sure that the curriculum in all the schools in America, particularly on Indian reservations provide local tribal history. What does that have to do with fatalities? But they had an opportunity to come before a federal commission to speak about what they found was important in their tribal communities, about why eventually children and families may be in this position of neglecting or mistreating each other because of a lack of understanding and a loss of their own language and history and culture.

COMMISSIONER STATUTO BEVAN: Okay. I get it. I get that you're an expert. I get that DCG has some recognize of a tribe. I misspoke. So I'm sorry. I'm not sorry, but you know what I mean. Sorry's not the right word.

COMMISSIONER SANDERS: So in terms of what we will ultimately recommend, so I suggest that we probably figure out a way to -- in the next couple meetings to come to agreement. And it seems like the themes that we should come back and have a conversation as much as about the themes next month as opposed to all the recommendations. Because it does sound like the themes are really focused on what did we hear and ultimately how does that translate into what we put in the reports. So why don't we take a break for 15 minutes, and we'll reconvene at 11:15.

So, Dr. Rubin, we'll be back in 15 minutes, and we'll start on the discussion of the themes and recommendations in the final report.

(Recess)

COMMISSIONER SANDERS: Okay. So we can start -- actually, I was going to start with a couple of comments from Dr. Rubin, since he has to leave early, and then we'll go to you, just about the final report, probably not -- probably more focused on some of the conversation we've had earlier and how to structure it, and we'll think about a single report. Because right now we have a series of themes and recommendations. We have an initial chapter, but we haven't really talked about what the themes might be that we want to have in this report, the story that we really want to tell with the report.

And so -- so I think if -- and, Susan, you mentioned that earlier too, that we should be thinking about that. And I think that's exactly right. I think that we can give guidance to staff about what we might even address that talks about what are some of the themes, how do we pull this together.

So I know, Dr. Rubin, you had made comments on those lines and maybe we can start -- if you have some thoughts, I'd love to have everybody share them because what we've done to this point is pretty much just regurgitate the information that we've already kind of agreed to, but we haven't talked about that issue of how we pulled this together. And it doesn't look like a single report. It looks like ten or fifteen different reports. And so how do we do that?

COMMISSIONER RUBIN: Can you hear me? All right. You know, my feeling for everyone there, I don't think there's anything novel that I'm going to say specifically. The last couple of days we just talked so formally. I think everybody is feeling that need.

But I thought, you know, the early documents -- and I know it was -- you know, it just reinforced, to me, a need, that once we finish the New York meeting, like the real big work of this group really begins, and I do think we need to get together again for just solid deliberations about how we organize the facts to this report and how we tell the story.

You know, in my mind, it's one option, you know, that, you know, obviously we need to tell them in a way that people can understand. We're in the weeds. And so, you know, I think we tell the story about how, you know, maybe some individual cases of examples of how we missed the mark today in a lot of places and then potentially try to present a vision for -- you know, given the weight of the evidence, the weight of the testimony, et cetera, what our vision for the future might look like. What are we trying to achieve?

And -- and -- that -- you know, so those same cases, how they might have been handled differently had X, Y, or Z, occurred and really lay out that vision in the early part of this report and then have -- align, like I said, some way those -- you know, those intermediate achievables up with sort of, you know, the issue of federal versus state, the issue of -- of -- you know, where -- areas where we feel like there's less certainty that this is -- there's a direct connection. We think it's on the pathway to fatalities.

We might need more room for state experimentation. That seems to be my opinion, that we could have state plans or state deferment here. We might let states have a lot more freedom to define how they want their community approaches to look at it. And the other issue is we need to be very descriptive because we feel there's a tight connection in terms of some of the issues that we have found.

And so I don't know how we arrived at that. I think I just want to commit myself to more time in the fall to really help bring this together and really bring a level of specificity to our recommendation and also to recognize that there may need to be a backbone to these recommendations, that some recommendations are going to be considered foundational to achieving and with a lot of subrecommendations underneath it, so there's going to be a hierarchy there.

COMMISSIONER SANDERS: Wade?

COMMISSIONER HORN: I apologize. I have to leave for the airport momentarily. I think it's fine what it is. And I'm going to just, I think, reinforce a lot of what Commissioner Rubin just said.

First of all, I think the themes are more appropriately labeled "findings." So they're not themes about what we want to do about it. These are our findings. We found these other things that we learned.

And then after -- you know, this is what we learned, now what are we going to do about it? And -- and I know that this was not meant to be the report itself, but the way it's structured here, you know, a theme and then our recommendation, it gets so broken up, there's not a centralizing organizing principle to this, which -- I'm not exactly sure what that is, or a core recommendation.

But in my experience, a lot of the most impactful sort of commission or advisory committee reports are ones that have a very -- like a core - - this is the -- this is the headline. The National Commission on Children, the headline was a $1,000 refundable tax credit per child, with a $62 billion price tag, annual price tag, that I signed on, so I'm willing to spend money.

And -- but it was -- that was the headline. And there were lots of other stuff in it, but there was this headline sort of thing that everything else was sort of wrapped around. So I think what we need to do is sort of have a -- as a commission, have a conversation, is that even possible? If so, what might that be? And I think that that's going to -- and then lots of other, sort of, recommendations will flow around that.

But I -- you know, I found this to be a good compilation of what we found and what some of the recommendations are, but it -- at the end of the day, I hope we have a report that is very

compelling and that says this is -- this is -- this is the issue. Something needs to be done about it. We can't wait. We need to do it now, and here's -- here's, you know, our best thinking about what that is wrapped around some kind of proposal.

COMMISSIONER SANDERS: And it does seem that -- partly what Dr. Rubin mentioned, it seems part of the headline has to be that we can do better. I mean, that there's enough in front of us that says we can do better. And there -- actually, I had given a speech at NGA and reviewed a case that had happened in Los Angeles 10, 15 years ago. And had we applied some of the things we talked about today, my guess is that that child would have been alive. And I think that we can -- we really need to start with something along those lines.

COMMISSIONER HORN: I agree. And one of the things that I -- in some of the e-mail exchanges we've had, I've said how would our recommendations have saved this child's life? And so I think that one way that we may want to think about it is to have some cases where the outcome was the death of a child. And then, you know, sort of at the end, you know, the rest of the story is if we had done these things, how would this child's life have been saved and how would the outcome have been different? That's just one thought.

Because at the end of the day, this is not about changing systems. It's about changing - - saving individual kids' lives. And if we can't show the pathway between our recommendations on how individual kids' lives would be saved, then I think we -- I'm not sure what we have accomplished.

COMMISSIONER SANDERS: Let me just quickly mention -- so we will -- we have -- we will schedule, far enough in advance, at least one if not two meetings to kind of -- in-person meetings that we can go deliberate kind of face- to-face about what we're able to put together. So I just wanted to make -- and we'll do that far enough in advance, and I'll try to get something out later this week or next week about when that might be.

I'll quickly mention one other thing because it's on the heels of that. The -- probably the most powerful story that I ever read was a child who died in Hennepin County. And the reporter -- this was now six months later, and the reporter wrote a story of me in the hearing where I was testifying in the legislature with the girl there beside me.

And I think that really -- that there are probably 1,400 kids a year that -- whose lives are cut short, that it could look very different if some of the things that we do are applied, and I think we can capture that in the report.

COMMISSIONER RODRIGUEZ: Yeah. I was just going to say that I know as the -- the months have passed, spending on this commission, when I talked to other people who are in the field, who are, I think, important stakeholders about this commission and the work, overwhelmingly sort of the response I've gotten back is like, "Well, you know, it's a good learning experience for you, but there's nothing that really can be done about this issue. So, you know, don't -- don't invest too much."

So, to me, what this report really has to reflect, I think, is some hope. I think it has to take a really helpful tone around, in fact, we can. There are -- there are some very specific things that we can do that haven't been considered previously. And they're not around blame, and

they're not around, sort of, needing to destroy entire systems and go through a 20-year planning process to rebuild.

But to me, just the reception I've already gotten from some of the people that I really respect and I know their opinion matters, is they're feeling sort of cynical about what -- what actually can be accomplished on the ground. And so I feel like, given that, I would like to be responsive to that in the -- in the report and set out a tone of there really are things that can be done, and we all believe that they'll work.

COMMISSIONER HORN: And can I just add that -- because you're exactly correct, and you reminded me to say something about one of my reactions to the way it was written. The way it's currently written, it kind of has a flavor of we've not found anything that works. Well, that's not true.

I think there's a lot of evidence that the Back-to-Sleep campaign worked and dramatically decreased, you know, kids suffocating. I think that, you know, we've looked at these, you know, cribs, these very low-cost cribs that can be distributed and that can prevent some of the co- sleeping that can also cause issues. I think issues around public education campaigns around -- around swimming pools. I think there are things that -- it seemed very, very heavy on the report as currently drafted, and I know it's not a full report. So I'm not being critical. It's just an observation that it seemed to suggest that all these kids are dying from abuse, but a lot of kids are dying from neglect.

And about half of them are, you know, because of neglect deaths. And those kids' lives are very much worth saving as well, and I think we have a -- we need to have a stronger focus on the neglect cases and not just the -- not just the abuse cases. And now I have to run, and I apologize.

COMMISSIONER DREYFUS: May I ask you a question?

COMMISSIONER HORN: Sure.

COMMISSIONER DREYFUS: So you said about this past commission you were on and the headline. I just want to test something on you, getting to the earlier conversation we were having. I always go into every process beginning with the end in mind. What are we really trying to get done? Right? What -- when we want something to happen, right, we want to effect change.

And I think about right now where we're at, and it kind of feels like a Christmas tree to me. And the worst thing that could happen -- what we're saying as a commission that I love about this commission is this commission has opened up its mind to the fact that this is an adaptive challenge that isn't going to be fixed by a series of technical fixes. That's what we've been doing for years, and that's why people are cynical. Right?

So -- so when I think about that, I think the worst that can happen is we present a Christmas tree, and it's got all these shiny balls on it. And somebody picks that one, and somebody picks that one, and somebody picks that one. And you're absolutely right. The cynicism was right because we will not have moved the needle, right? So I keep thinking, what pulls it together?

And I just want to ask you, one of the things I've been talking about for years, probably before this commission, is that our child protective services function is very antiquated. I keep saying it's a 20th-century model in a 21st- century world, and we wonder why everyone is so frustrated with -- with it at times.

And we've heard that there is a lot of reason to -- to improve that function, right, that that's a critical thing. But we've also heard, let us not make the fatal attribution error, that this is a larger shared community responsibility. And as Eloise told us today, the context within which these kids are living their lives every day is what's perplexing her about neglect, right? So, I mean, we've heard that.

But we also -- and I asked her specifically the question about the CPS agency. Is that the entity through which, right, larger community change needs to happen? Right? Because somebody's got to stick with it over the long haul. And so I guess my question to is: As you think about that, what is that galvanizing thing that could move it forward? Could it be that we figure out a way to take all of these little Christmas bulbs, right, and we figure out a way that we pull them together through what might be one significant investment by Congress that achieves multiple levers [sic], right, to get it done? Is there a way for us to frame -- to get this framed in such a way that that could happen?

COMMISSIONER HORN: That's a question?

COMMISSIONER DREYFUS: You've got experience at the federal level.

COMMISSIONER HORN: So I think -- I hope the answer is yes. I have an idea about that, that -- I don't want to throw it on the table and run, but I look forward to, you know, sharing that idea with that because I do think what you're saying is: Is there a core recommendation that everything feeds into? And that that core recommendation is something -- if this -- that -- that it's -- it requires changes in the entire system.

So it's not just here's -- here's a menu. Pick three from Column A, whatever. It's -- it's predicated on systemic change that this core -- this core recommendation is predicated on providing incentive for systemic change.

And I don't have a -- it's not fully baked in my head yet, but that is -- but I've been doing some thinking about what that might be. And it may be the exact wrong answer. It may be part of the answer. It -- I don't know, but I -- I'd want to -- so the answer is yes. I think we --

COMMISSIONER DREYFUS: Okay.

COMMISSIONER HORN: Ideally, that's along the lines I've been thinking.

UNIDENTIFIED SPEAKER: We have Commissioner Rubin on the line.

COMMISSIONER SANDERS: Go Ahead, Commissioner. Commissioner, we're not hearing you.

Thank you, Commissioner Horn.

Any other comments around the table about the document and/or this issue -- this issue of how we structure it? Are we headed in the right direction? Are there things that are amiss?

Commissioner Bevan?

COMMISSIONER STATUTO BEVAN: I just want child safety to be right up front. I mean, right up front. This is about preventing fatalities, and I just don't think that -- if we don't put it right up front, it's not going to change anything. We have to keep putting it up everywhere we can.

UNIDENTIFIED SPEAKER: We have Commissioner Rubin back on the line.

COMMISSIONER RUBIN: Can you hear me?

COMMISSIONER SANDERS: Yes, we can hear you.

COMMISSIONER RUBIN: Yeah. I just want to make a comment about the use of the word "evidence." I mean, one of the things we talk about is does the evidence show that we can reduce child abuse and neglect fatalities.

And being a researcher, I think that that term can sometimes be helpful, but it also can sometimes be not helpful. And I think particularly as you -- you know, it -- it's very clear to me we don't have a ton of mantra that says this specific program or X or Y actually will reduce fatalities.

And in -- and it's not uncommon in large public systems where there's a lot going on that you can see a reduction in child fatalities that is quite believable, but you can't disaggregate exactly was it this program or was it that program.

And so, you know, for me, the way I sort of handle that tension, because people are going to ask if there is evidence that this could reduce fatalities or are we making a stretch here, you know, I just want to say that where there is stuff where it's very clear there's a linear relationship to fatalities, that's where we get pre-scripted. That's where, like, we should not have a choice about whether -- about whether everyone is offering X or Y.

But, you know, those opportunities are rare. And in that context, what you want to do is have we identified foundational principles from our testimony of practices that seem to align or correlate with communities that seem to be having an impact. And so when I -- so I don't want to discredit the fact that we just spent the last few days in Wisconsin hearing about both their structured decision-making but also the many ways in which they connect people to community-based services, not just inside the child welfare but after, and that's strong public health history that this place has, the same thing we found in Oregon, the connectedness of military civilian authorities in El Paso County.

And so I do think we can form very strong foundational principles that don't have a randomized trial behind that because if we're asking for that, is never going to happen.

COMMISSIONER DREYFUS: Hey, David, I want to ask you a question. Do you think that what we're really talking about -- I was thinking about this yesterday when we had the staff here and they were talking about the decision-making model they're using from action.

And I was thinking to myself, are we -- one of the things we do in Social Services is we kind of -- we kind of think it's okay if there's just a lot of variation. And I think the field is starting to

recognize, no, we're getting smarter at what works better, and we need to show greater consistency of that practice, right, every child, every time.

Is what we're talking about here creating child welfare's version of a standard of care? That medical science uses standards of care for an ear infection or whatever, there's some variation depending upon the patient and where you're at and the unique needs. It's not, like, cookie-cutter. You know what I mean? But there's this notion of standard of care.

And I'm wondering if that's not what we're talking about here and that that standard of care is not just what this lone initial assessment worker and their supervisor does or does not do, but it connects into this larger ecosystem around kids, right, in connection to those resources and other systems, that it's a unique standard of care, not just doctor/patient.

But I'm just wondering if that's not a frame for us to be thinking about, that we really are starting to identify an evidence-based standard of care in Child Protection.

So anyway, I just wanted to see what you thought about that.

UNIDENTIFIED SPEAKER: Commissioner Rubin just dropped off the line.

COMMISSIONER DREYFUS: Does that make any sense to people? Do you understand what I'm saying? There's a crosswalk between medical science and --

COMMISSIONER SANDERS: Yeah, I think it does.

I think the question is: What about the 40 to 50 percent that aren't known to Child Protection? And so I was trying to think about your question in that context too.

COMMISSIONER DREYFUS: Right. I think it's -- I think you're right. I'm talking about for those that do come to the attention.

COMMISSIONER SANDERS: But if we broaden the system, that's no longer 40 to 50 percent. And if we think of practice standards cutting across different fields but around the same theme, then -- then it's no longer 40 percent that aren't known.

COMMISSIONER DREYFUS: Right. Under my version of standard of care, more of these kids would be known.

COMMISSIONER SANDERS: The testimony yesterday about the sentinel injuries and kind of the significance of those sentinel injuries, it raised, I think, along the lines of what you're saying because the physicians have to know that to know there's a danger signal there. And, obviously, some would, but some wouldn't.

And that becomes part of the notion of standard of care because that's not just about making a report, but it is really -- if it -- if we have safety at the center of this, then it is as much on -- incumbent on the physician to know enough about sentinel injuries that they might say this is one of those where we have to -- we have to do more.

COMMISSIONER DREYFUS: Well, what we heard yesterday, to me, as I was listening to it -- the only reason I'm thinking about it is, in another part of my world, we're really talking about

what is the standard of care for the high- cost/high-need Medicaid populations, right? And we all know that the social determinants, right, is a critical piece of that.

So it's not just about what happens in that integrated public primary care, mental health. There's other factors for this population. And I was listening to these folks yesterday. And really, what Wisconsin is doing, is it's perfecting a standard of care. So anyways --

COMMISSIONER SANDERS: So we seem to be losing a little energy.

COMMISSIONER MARTIN: Losing? It's lost.

COMMISSIONER SANDERS: Well, that -- speak for yourself. Not everybody. Do -- and we've done a lot of work, obviously. Is there anything else critical that we need to do today before --

COMMISSIONER DREYFUS: Can you just talk about these in-person meetings? So are we thinking -- I guess I just want to test with the commission. Are we assuming that these will take place Monday through Friday, or would we ever think about getting together on a weekend? Is that just, like, off the table?

COMMISSIONER MARTIN: You know, it's interesting. I never considered weekend meetings until some other organizations I belonged to, they started doing board meetings on weekends. So as long as I know in enough advance, I guess it's okay.

COMMISSIONER SANDERS: Fine with me. We'll offer different times and consider that as part of it.

COMMISSIONER DREYFUS: I just think it would be great if we got together an evening, you know, and did some work and then a full day, versus -- everybody's flying in. Some people's flights get late. You know what I mean? People have to leave. I just think --

COMMISSIONER SANDERS: And we could do a longer one. It could be two days.

COMMISSIONER DREYFUS: It could be two - - I just think that we need the time together, and I just want to put that on the table.

COMMISSIONER SANDERS: Well, we'll send different configurations of time. We'll send one meeting, two meetings, full day, three days, a week maybe.

COMMISSIONER MARTIN: Do you have any sense of where these meetings will occur?

COMMISSIONER SANDERS: Someplace convenient. No, I mean that seriously. Chicago, Detroit -- not Detroit, Atlanta, Denver. All are accessible by airplane easily.

COMMISSIONER MARTIN: Somewhere where there's a major hub, not Reno.

COMMISSIONER SANDERS: No.

COMMISSIONER RODRIGUEZ: And timing on the meetings, approximately? Are we thinking, you know, like, early fall, September --

COMMISSIONER SANDERS: Uh-huh, yeah.

COMMISSIONER RODRIGUEZ: Okay.

COMMISSIONER SANDERS: Yeah. I think early fall because we'll have -- we have plenty of time for conversation before then, but we'll need to finalize things, and that's the timeline hopefully that we can. So --

COMMISSIONER STATUTO BEVAN: Can you tell me what we will -- what will be in front of us at that time? I mean, do you think we'll be -- I'm kind of worried about having a full draft in front of us. On the other hand, I guess we have to have that.

COMMISSIONER SANDERS: Yeah. So the next meeting, we'll take this information. So what we did was just the themes or the findings of the recommendations and then draft it in the first chapter. But all of that is dependent on this conversation, so we'll make modifications based on this conversation and probably try and get some ideas about is there a central theme, is there a way to do this, and just have something to test.

So we'll -- next meeting, we should have conversation about a document that we've provided. And then get input on that document, make changes. And so by the time we get to the fall, I would anticipate we would have a document that's been fully informed by the commission that we're -- that we're looking at and can kind of go through in as much as detail as we need to.

And ultimately, we will vote on that document and are we supportive or not. Does that get to your question, Cassie?

COMMISSIONER STATUTO BEVAN: Uh-huh.

COMMISSIONER DREYFUS: Uh-huh.

COMMISSIONER SANDERS: I see nods. Does that work for people?

COMMISSIONER MARTIN: It works for me.

COMMISSIONER SANDERS: All right. Well, then we will adjourn.

(Proceedings adjourned at 11:46 a.m.)

End of Day 2