COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES

TAMPA, FLORIDA PUBLIC MEETING TRANSCRIPT
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Dr. David Sanders: [00:00:00]: We're going to go ahead and get started. Welcome to everybody and thanks to our hosts here in Tampa. I want to welcome the staff, Commissioners, presenters, and those in the audience—we have over 200 who are either here in person or listening in on today's meeting. And this is the Commission to Eliminate Child Abuse and Neglect Fatalities that was created out of the Protect Our Kids Act of 2012. As you can see, actually, there are 11 members here today; our 12th member is unable to be here today, but we are a Commission of 12 members. Congress and the President are intent on creating a national strategy to eliminate child abuse and neglect fatalities and really have charged this Commission with the task of developing recommendations. Again, very specific to eliminating child abuse and neglect fatalities.

We're conducting our business in part through a series of public meetings across the country. And obviously, we've chosen Florida, and want to lay out a couple of reasons for why we chose Florida.

One, the legislative charge that we have from Congress is to meet in locations where the trends in fatalities are down, as well as those locations that have high fatality rates. Tampa, it appears that the trend in fatalities here in this community is down, we'd like to understand what's happening here in Hillsborough County. And statewide, there's tremendous controversy about the actual numbers of fatalities, and we will hear some of the information about the numbers, but I think everybody would agree that the number and the rate of fatalities due to abuse and neglect in Florida is too high. And in 2012, Florida had both one of the highest numbers of fatalities, as well as one of the highest rates. So we'd like to understand what's working, what's not working, and are there ineffective practices or policies that we need to understand and look at, are there barriers to Federal policy, and what seems to be particularly effective. And that's why we chose Florida.

I'm going to ask the Commissioners to introduce themselves, and why don't we start at the left with Amy. Amy?

Amy Ayoub [00:02:36]: I'm Amy Ayoub, from Las Vegas.

Jennifer Rodriguez [00:02:37]: I'm Jennifer Rodriguez, from San Francisco, the director of the Youth Law Center.

Dr. David Rubin [00:02:44]: I'm Dr. David Rubin; I'm a general pediatrician from the Children's Hospital of Philadelphia.

Michael Petit: [00:02:51]: I'm Michael Petit the head of the child advocacy group called Every Child Matters—it's based in Washington D.C.—and former Commissioner of the Department of Health and Human Services [in Maine].

Marilyn Bruguier Zimmerman [00:03:01]: Good morning everyone, my name is Marilyn Bruguier Zimmerman. I am an enrolled member of the Assiniboine and Sioux Tribes on the Fort Peck reservation in Montana and currently serve as the director of the National Native Children's Trauma Center at the University of Montana.

Susan Dreyfus [00:03:15]: Good Morning, I'm Susan Dreyfus, president and chief executive officer of the National Alliance for Children and Families, former Secretary of the Washington State Department of Social and Health Services, and former Administrator for Children and Family Services in the state of Wisconsin.

Theresa Martha Covington [00:03:28]: Good morning, I'm Teri Covington. I'm the director of the National Center for Child Death Review.

Hon. Patricia Martin [00:03:34]: Morning ladies and gentlemen, I am Patricia Martin; I'm a presiding judge of the Child Protection Division in Cook County, Illinois, that encompasses Chicago, Illinois.

Dr. Wade Horn [00:03:43]: And good morning, I'm Wade Horn. I'm with Deloitte Consulting, where I lead our Health and Human Services public sector consulting practice. And I'm a

former Assistant Secretary of the Administration for Children and Families at the U.S. Department of Health and Human Services.

Sanders [00:03:58]: And we also have Dr. Cassie Bevan, who has stepped out, but is one of the Commission members in attendance. And Bud Cramer is unable to attend today's meeting.

Before I turn it over to Secretary Carroll for a couple of introductory remarks, I'm going to mention our packed agenda today and the time allocated for each of the agenda items, and we will adhere very closely to the time limits. I hate to come into somebody's state and tell them that they have to stop speaking, but we have a lot of information that is really critical for the Commission to hear, and we also want to make sure that we have plenty of opportunity to ask questions as Commissioners, and so we will adhere very closely to the time lines. So as you notice that your time is running out, those aren't kind of "soft pauses," it's an actual "hard stop" and I will make sure that we adhere to that. So, Secretary Carroll.

Secretary Mike Carroll [00:05:02]: I don't usually get such explicit directions. [Laughter] I hope this doesn't count towards my 10 minutes. Commissioner Sanders and Commission members, thank you for coming to Florida. We appreciate the time, and we look forward to the work and the feedback that this Commission will provide, and quite frankly, we look forward to providing you with input into your work. I also would like to thank the Children's Board of Hillsborough County for hosting us today; they have been partners in this community for a long time, working upstream, to protect kids and to ensure that kids in this community are healthy. They've also been very strong partners with us, working collaboratively with the local community here to reduce preventable child deaths in Hillsborough County, so thanks for being here.

Like many states around the country, Florida has been challenged in our efforts to reduce child deaths. Specific issues at the heart of this, for us, are the reporting and classification of child deaths, and the need to improve and focus our case practice with respect to those children who we know are most at risk. Refining and targeting prevention strategies at a community level, to prevent child fatalities involving children of families not involved with the child welfare system, and the issue around confidentiality that sometimes prevents sharing of critical information and often puts the department at odds with the press and the community. I understand the Commission has already been provided a lot of the Florida-specific data around child fatalities. I'm not going to repeat that, but hopefully I'm going to be able to provide a little perspective to those numbers.

Chairman Sanders alluded to some of the controversy around the reporting of those numbers. Until recently, Florida's child abuse death review committee, which is housed at the Department of Health, reviewed only those child fatalities that were reported to the hotline and then verified to be the result of abuse or neglect.

This was different from the data that the department reports to the feds, because we report to the feds all child deaths that are reported to the hotline regardless of findings. So there is

a disconnect in numbers. It's that disconnect in numbers, quite frankly, that's led to a perception, among some, that child death data is under reported. In addition, there have been historic, and there continues to be inconsistencies in the reporting and verification of child fatalities among communities, and within jurisdictions throughout the state. Primarily with the child fatalities associated with neglect, and for us that primarily centers on unsafe sleep and child drowning, which are the two leading causes of death for us. Now the interesting thing is that child drowning is the leading cause of death for young children in our state, but for those child fatalities that are reported through the hotline, the leading cause of death is actually unsafe sleep, then followed by drowning, because not all of the drownings are reported by all communities, through the hotline.

Some communities report all child drownings to the hotline, and some jurisdictions verify all child deaths, while other jurisdictions verify on a case-by-case basis. While common sense tells us that all of these deaths are inherently preventable, the decision to verify neglect in these cases is not always as clean cut. The good news is that we think that we have begun down the road to remedy much of this. Two significant steps that Florida has taken and I think in large part from the work that the Florida Legislature undertook this year; to improve transparency was the creation of a child fatality website. The Child Fatality Prevention website in Florida now reports child fatalities on a weekly basis. Whether it's verified or not; it's in real-time, when we receive a call to the hotline, the community is notified of it. And it also provides a lot more information to that, I think you're familiar with it, so I won't go into it. Right now, that website has current-year data that begins in January through today.

It's our intent by the fall to have six years: five years historical data, plus current year. And by the end of fiscal year 2014, which for us would be June of next year, we plan to have 10 years of historical data on our child fatality website. Along with that data will also be a snippet of a quality assurance report that will be redacted, but it will lay out some of the circumstances of every single child death we've experienced over the last 10 years. We know this data will be useful to communities statewide because it's also displayed in a community-specific way.

More than two-thirds of the families and three-quarters of the children represented in Florida's child fatality numbers are unknown to the child welfare system prior to their death. The child fatalities, and I think what this points out to us, here, is that child fatalities is really a public heath, public safety issue that transcends a child welfare agency, and I can't say that enough. I don't say this to deflect blame from our system. I don't say this to duck responsibility or accountability, because I think in the department, we absolutely have to embrace accountability and responsibility for the children we serve. But if that's all the children we look at, and that's all the children that this Commission looks at, then I think we're missing the boat. Because three-quarters of the children we don't know about and two-thirds of the families we don't know about will never get to the heart of this issue.

So inherently, I think this is about engaging communities. Child welfare is not about a child welfare agency, it's about the welfare of kids, and the welfare of kids is everybody's job. And

I think that if we're truly going to reduce child fatalities we have to engage our communities, we have to work across state agencies, and it's much bigger than the child protection system. We hope that the website we've provided provides all these groups a tool to work in collaboration with the department, but also with our partners, our sister state agencies, local agencies, and our communities to improve child welfare practice, better protect children, inform local prevention strategies, and at-risk families. We have to attack this issue community by community, and I think valid, real-time data is critical to this effort. And I think that data needs to be community specific.

This is sometimes hard for people to hear, but folks in Tampa don't care what's going on in Miami, they care what's going on in Tampa, and they care by neighborhoods. Sometimes our issue, we've done a lot of work in this area and you can actually pinpoint issues to certain neighborhoods, and that's where we have to get our data to. Florida Legislature, this year, also made a significant change that will ensure the child abuse death review committee reviews all deaths called into the Florida Abuse Hotline, not just those that are verified as was previously the law. I think that's a big step forward. This change will give the committee a fuller picture of the challenges families are facing and allow them to provide better, and I think more comprehensive prevention solutions that really encompass all children, not just those that have been involved in the child welfare system.

This change will also help to make child fatality data more clear and it will correspond more readily with what is already reported to the feds. To ensure a more consistent approach in our reporting, verification, and analysis of child deaths, we've also made several significant internal improvements. We've created a statewide child fatality specialist to coordinate many of the functions around this at a state level that's housed directly with our Assistant Secretary for Child Welfare. We have provided training to all of our local child fatality specialists, we have streamlined our incident reporting system, and we have now engaged our child fatality specialist on a statewide basis in the decision-making around whether to verify or not verify a death report. And I think that's important because we have got to get a more consistent approach across jurisdictions because we'll never get a truer picture if we don't.

The other thing that we are about to release, at least with those jurisdictions that the department has control over, because a lot of the deaths that we deal with are what I would term are due to neglect, drowning, co-sleeping, and other things like that. Some jurisdictions currently drug test in all of those cases and some do not. We're going to mandate that all do, because one of the things that we need to determine is what condition the parent was in when this happened. And it will begin, I think, to standardize whether we verify or not, across jurisdictions.

We also engage Casey Family Programs and will engage the newly created Florida Institute for Child Welfare in order to integrate a more national perspective regarding classification of child deaths, particularly involving those deaths related to neglect. And quite frankly, it's my hope that through the work of this Commission that it will lead to more consistency in how states report these type of deaths on the national level. Currently comparisons are very

difficult and the extent of issues to me really unknown, because there is such a discrepancy in the way states report this data.

I am optimistic that we have made significant strides in our efforts to better protect children already known to the system. We are implementing Florida's safety methodology, which significantly changes how we conduct protective investigations. It moves away from incident-based or point-in-time investigations to a full assessment of ongoing family dynamics. On the case management side, we're shifting away from compliance-based, task-oriented decision-making, to ensuring positive behavioral changes enhance the protective capacity of parents and caregivers.

This shift will allow, we think, investigators and case managers with necessary information to enhance safety decision-making and improve outcomes for kids and families we serve. Even more important than that, I think, is that we have embraced the use of data analytics to help guide and focus daily investigation in case management work on those children that are at the highest risk of the most severe outcomes. This work has enabled the creation and deployment of the Rapid Safety Feedback process that you'll hear more about today, but Rapid Safety Feedback moves traditional quality assurance away from a retrospective review of casework into real-time technical assistance, mentoring, and coaching.

Sanders [00:16:28]: Secretary Carroll, we're at our 10 minutes, so you will be part of a panel a little later, because I want to make sure that the Commissioners are able to ask you questions, and that will be the case with the later panel, but I'm going to ask you to wrap up.

Carroll [00:16:44]: Okay. In closing, I'll say this, Florida is uniquely situated with a comprehensive community-based care approach to child welfare. Communication and coordination in our system is sometimes difficult because it is decentralized, but I can tell you that our community-based system is an absolute strength in terms of community involvement, empowerment, the diversity of stakeholders and partners who do this work, and the passion and commitment that they bring to it. When that public/private partnership is kept in the right place, it also leads to lots of innovation, which I think Rapid Safety Feedback speaks to that. It is my fervent wish that the more we begin to infuse science and data into real-time case practice in practical ways that don't create yet another thing for our workers to do, we're going to be able to focus on those highest risk cases and I think we'll end up getting better outcomes for families. So I think that's the future of where we need to go and we'll talk a little about it later in our data analytics panel. Thanks.

Sanders [00:18:12] So before turning it over to our first panel, just a couple of operational issues. For audience members, there will be an opportunity to submit positions or questions in writing. There won't be the opportunity to raise questions during the proceedings, but afterwards if you want to leave written testimony, you can do that here or you can also submit written feedback through the Commission's website. For the Commissioners, we have built in quite a bit of time for questions but we probably won't get to everything and so there are index cards, again, that Commissioners can use to ask questions, and I'm going to now

introduce our first couple of presenters, Dr. Richard Barth and Dr. Emily Putnam-Hornstein. And Secretary Carroll just mentioned the idea of science into practical solutions and that's a lot of what we're looking at in our first three presentations. What is the latest research and how do we translate that into policy? So I'm going to ask Dr. Barth and Dr. Putnam-Hornstein to come up. For the Commissioners, each will have 30 minutes to present and then we'll have 45 minutes for questions for the two of them. So we'll hear first from Dr. Emily Putnam-Hornstein, followed by Dr. Richard Barth.

Dr. Emily Putnam-Hornstein [00:19:37]: Thank you very much Commissioner Sanders. Thank you to all Commissioners for your service and for the opportunity to speak this morning and thank you to everyone in the audience. My name is Emily Putnam-Hornstein. I'm an assistant professor at the USC School of Social Work, director of the Children's Data Network, and also maintain a research appointment at the Child Welfare Indicators Project at UC Berkley.

I'm here today to talk to you about some of the data we've been working with in California, which we've been able to pull together in a way that I think has some important insights in terms of child abuse prevention broadly and also our understanding of risk factors that contribute to child maltreatment fatalities, specifically. So just by way of background, I think this will be familiar to many of you. We have this ongoing problem when we think about child maltreatment from a policy and program standpoint, which is that currently most of the data that we're working with continues to reside in what we'll often call "data silos," so we collect different information that is very, very relevant to understanding children's risk factors in different systems. We have mental health data, we have substance abuse data, we have child protection data, we have early intervention data, and in each of those data systems there is tremendous information, but when we don't have the opportunity to pull that together so that we can understand children and families through a more comprehensive lens, and through systems over time, we are limited in our development of informed policies and programs.

So ultimately, I think we all hope we get to that future standpoint where we have, in real time, different data systems that speak to one another. What we've been doing in California from a research standpoint has been building on longstanding university and public agency partnerships to be able to link large amounts of administrative data to follow children over time through systems, particularly the child protection system, and studying outcomes such as child fatalities through those data.

One of the key things that it has allowed us to do was mentioned right at the outset, which is a lot of the work that we have done in looking at child fatalities, unfortunately, has been retrospective in nature. And so what that means is that we've observed this outcome we ultimately wish to prevent, a child abuse or neglect fatality, we've looked at the children who have died, and we've looked backwards to say, "What systems did they touch?" and "What risk factors were observable?" And while that's incredibly important descriptive work, what it doesn't help us to do is actually to figure out what risks could have been observed

before that bad event, what adversity occurred so that we could have potentially done something different in the way that we intervened.

So what we've been able to do with the data is to move from just a snapshot of children who are involved with the child protection system to looking at information concerning what the risks were before CPS became involved, looking at an outcome afterwards, specifically death, and looking at children who were not reported for maltreatment. We've done this by linking large amounts of birth record data from the state of California to both child protection records as well as death records for our state, and again, that's important because the birth record data provides a lot of rich information concerning risk factors, but also because what it allows us to do is to follow children over time, not just those children who were known to the child protection system but also children who were not known to the child protection system. So we're able to look at things such as child abuse and neglect fatalities from a population-level standpoint.

This work, which has been done in partnership with the California Department of Social Services to date, has led to the linkage of more than 6 million birth records to over a million child protection records. And what I'm going to talk to you about today are some analyses that are based on birth record linkages from around 1999–2006, in which we were able to follow different groups of children, about a half million of whom were known to the child protection system, and look at different fatality outcomes.

Because time is short, I'm going to tell you the "end story" right off the bat. I'm going to touch on five specific points. The first is that the problem is big in terms of how many children are abused or neglected, and I know that we probably all have some sense of that, but the data that we have would suggest that perhaps we haven't even been thinking about it properly in terms of just how many children touch the system over time. The signal is real, and by that I mean, we know that children who have been reported to the child protection agency do represent a very distinct, high-risk subset of all of our children. So while certainly not all children who die from abuse and neglect were known to the CPS system, those children who are known are distinctively high-risk. The scope should be considered and so while of course there is a desire to focus specifically on inflicted or intentional injuries, obviously we know that neglect is important, that SIDS and other sudden infant death syndrome fatalities are a real problem. Our ability to intervene just through the child protection system is limited and so that speaks to the importance of engaging other community partners, particularly in that public health framework. And finally, I'm going to touch on something that I know will be addressed more fully in this afternoon's panel, but it surrounds opportunities to be more strategic in how we think about "front-end risk assessment" and the tools that we currently employ within our child protection system.

Conversation one: "The problem is big." The first thing I want to point out is that with these birth and child protection records, one of the things that we have been able to do is to move from simple snapshot estimates of how many children touch our child protection system in a given year, to thinking about how many children are exposed to abuse or neglect and touch

the child protection system over time. And this makes perfect sense. We know that if a child is abused or neglected in one year increasingly the research would suggest that there are very long-term consequences that manifest throughout the life course. So we shouldn't think in terms of, "it occurred in this year and therefore that child was only impacted by the abuse in that particular year." Annual estimates of children reported for abuse or neglect at least in California, and these numbers do parallel national numbers, it's about 5 percent of our youngest children, children 0–5 years old. I want to point out that most of my data today is focused specifically on children 0–5 years old, which of course we know is the group that is most vulnerable to child abuse and neglect fatalities. So we think about 5 percent of children being reported in any given year, but when we use the birth records to follow cohorts of children born in our state over time we see that before or by kindergarten, 15 percent of children have been reported for abuse or neglect at some point. So the cumulative number of children who have touched our CPS system is three times that which we think about as having been reported for abuse or neglect based on a single estimate.

And even that 15 percent underestimates the risk for certain groups. So when we looked specifically at children who were born to teen mothers, we see that one in four children is reported for abuse or neglect before age five. When we look at children who are born without paternity established we see that it's one in three. So what we, as a public, have often tended to cast as a somewhat rare event, which is contact with that safety net of child protection, when we start to look over time we see that in fact the cumulative risk is much greater.

And I want to point out that I've been talking here about being reported, which does not necessarily mean that these children were substantiated as victims of abuse or neglect. But there was a recent national study by my colleague and friend, Chris Wildeman, where he actually used what is called "the synthetic cohort" approach, and national NCANDS data, to look again at cumulatively how many children in the U.S. are substantiated as victims of abuse or neglect. This was just published in *JAMA Pediatrics* and what we see is that even though, again from a public standpoint we may think about it as being a relatively rare event of 1 in 100 U.S. children being substantiated in any given year. That by the time children have turned age 18 in any given birth cohort, roughly 1 in 8 children has been substantiated as a victim of abuse or neglect. And the prevalence for different groups is much higher in some cases; the prevalence for black children is over 1 in 5.

Conversation two: "The signal is real." One of the reasons I first started linking these data is actually that I was very interested in better understanding whether children who had been reported to the child protection system were in fact at higher risk of very, very bad outcomes such as fatalities, or whether these children were simply getting caught up in a safety net, because of their poverty status and their contact with mandated reporters. I found this quote that comes from an anthropologist, "Mortality-based standards for evaluating parental behavior may be the closest we can get to culture-free definitions of neglect and abuse."

I was interested in looking at whether the population of children who'd been reported to CPS in fact had higher death rates than other socio-demographically similar children who had not been reported. It can be summarized as this: We have two children, Child "A" and Child "B"— Child A has a CPS report. I was interested in whether or not that child had a higher risk of injury death before age 5. Child "B" had the exact same risk factors, in terms of, let's imagine, being born to a young mother, being born into poverty, not having paternity established, perhaps being low birth weight; and the question becomes for that second child, do they have the same risk or higher risk?

I want to add that you'll notice I'm looking at injury death here for the same reasons that we're talking so much about how we define child abuse and neglect fatalities, which is I realize I'm not alone in recognizing death records are an imperfect source of information when it comes to defining deaths that are specifically due to abuse or neglect. But there's a large body of research that would suggest that injury deaths can be broadly thought of as "preventable deaths." Not always preventable in the sense that the parent was at fault. We can think about these as preventable even from an environmental standpoint. But I wanted to look at something that was broader than just abuse or neglect, so I looked at injury deaths overall.

What I found was that after adjusting for all of those other risk factors that are known to be related to both a child's likelihood of being reported for nonfatal abuse or neglect and being known to the child protection system, as well as being at higher risk for a fatality injury, a prior report to CPS was the single strongest predictor of a child's injury death before the age of five years. And a prior report to CPS was a significant predictor of not just intentional or inflicted injuries but also unintentional, or what sometimes are called "accidental injuries."

To get a sense of this, I'm going to try to not throw a whole lot of numbers at you, but if you just want to focus on that statistic up there in the upper right-hand corner. These are children who have had a prior report of abuse or neglect and you can see that those children had a risk of any injury death that was about two and a half times higher than other young children with the exact same risk factors at birth, who had never been reported. On a relative basis, what you can see is a list of other risk factors that were controlled for and that we commonly think about as being risk factors for child fatalities. You can see things such as, low maternal education, young mother, public health insurance status, and you can see that those are all certainly risk factors for a child's fatality, but are much more modest in risk size than is a prior report to CPS.

I also broke this out for "unintentional" and "intentional" injuries, so when I looked specifically at the risk associated with a prior report to CPS for unintentional injuries we see that those children had a risk of unintentional injury death, was about twice as great as other children who had not been reported. And when I looked at intentional injuries, you can see that it's almost six times as great. So 5.86 percent or 5.86 times and you can look at the other risk factors there.

The picture overall shows you all injury deaths on the top panel, unintentional injury deaths in the middle panel, and intentional injury deaths on the bottom panel. The short version is that a prior report to CPS definitely tells us something about the risk faced by these children and it's not just poverty, it's not just the other risk factors, it provides new information.

One of the other things we were able to look at with these data, were differences by maltreatment types. So in addition to developing population-level analyses, where we were able to follow children who were known to the CPS system to look at risk of injury death but to also follow children who had never been reported. We could also look at children of those and who had been reported to child protection, were their differences in risk of injury death based on whether the child had only been reported for reasons of neglect, compared to children who may have been reported for reasons of neglect, but also at some point had an allegation that they had been physically abused.

What we found was that overall children who had a prior report for physical abuse had a risk of death that was 1.7 times greater than children who had only been reported for reasons of neglect. So we found a heightened risk overall, but what we also found were important differences in terms of the form that those deaths took. So we found that if a child had a prior report for physical abuse relative to children who'd only been reported for neglect, their risk of an intentional or inflicted injury was five times greater.

In contrast, the risk to children who had been reported only for reasons of neglect, they had a significantly higher risk of accidental or unintentional injury deaths. So from an intuitive conceptual standpoint it makes sense that there might be connections between the form of alleged maltreatment and the manifestation of that in an actual death. But it's interesting to still see it emerge in the data overall. And I think it does have some important implications in the sense that we know a much smaller number of children are reported for reasons of physical abuse and so if we know that those children in particular do have a heightened risk of inflicted fatal injuries, is there something different we should be doing from a prevention standpoint or a case monitoring standpoint.

Third point: "The scope should be considered." I think that this section is as much about underscoring some measurement challenges as it is showcasing, again, how high risk, certain children who have been reported to child protection are. One of the other things that we did with these data was not just look at injuries but we looked at another leading cause of death among young children, specifically deaths that are related to sleep. So we looked at Sudden Unexpected Infant Deaths. In the U.S., annually about 4,500 children die during the first 12 months of life without any immediately identifiable cause. And we looked at three different subtypes of unexpected death. We looked at SIDS, which is probably the death you are all most familiar with. We also looked at accidental suffocation and strangulation in bed, and we looked at those deaths that were declared to be undetermined as of the death record.

One of the things I want to point out is that the reason we had to look at all three forms of those deaths is that we often think about an incredibly successful public health campaign as

having led to dramatic reductions in the rate of SIDS deaths, because of "Back to Sleep" and other safe sleeping campaigns; but researchers have recently been looking more closely at that claim from a trend perspective, and what we've observed is that there's been a clear diagnostic shift that's occurred. And so in these data you can see, this is actually not my data this comes from another published study, we can see that over time, the postneonatal death rate has declined modestly. What we see is that there has been that notable drop in rates of SIDS deaths, but at the same time, what we see is that there has been an increase in the rate at which we have been declaring deaths to be undetermined and coding it as such on the death record, as well as due to accidental suffocation and strangulation in bed.

So we wanted to look at all three forms of those deaths, given this shift of how the deaths were coded, and the short version is that regardless of which type of death classification we look at, children who had been previously reported to the child protection agency in our state had significantly heightened risks of those deaths overall, three and a half times that of other infants who had never been reported. Their risk of SIDS was 3.2 times as great; their risk of having a death that was undetermined on the death record was 4.2 times as great; and their risk of dying from what was called accidental suffocation or strangulation in bed was 2.3 times as great. So again, underscoring that infants and young children known to the child protection system are at high risk of not just injury fatalities but also other forms of death.

Briefly, in terms of the interpretation of that, I think that there are three possible interpretations: One is that children who are known to the child protection system have unique physiological risks that may be associated with those deaths because of heightened rates of prenatal drug exposure. Also, infants who are reported to the child protection system may have or there may be a lagged penetration of some of those safe sleeping messages or a reduced adherence to those messages. And also, of course we have the ongoing problem that it is incredibly difficult to differentiate SIDS from infant deaths that are caused by suffocation in bed, whether it's accidental or inflicted.

Conversation number four: So I've talked about the fatality findings, I want to talk a little bit more broadly about children who are known to the CPS system, because I do think that the best way to prevent and reduce the number of child abuse and neglect fatalities is to do a better job at triaging children through our system and a better job at serving infants and young children who are known to our child protection system.

So one of the things that we also wanted to look at were how many infants who had been reported to this CPS system were remaining at home, following that first report. And what were their outcomes, as measured by a second report, and how many of them received formal services through our system.

What we were able to do was look at roughly 564,000 children who were born in our state in 2006. We found that roughly 5 percent were reported during the first year of life, and then we looked at children broken out into three different groups: We looked at infants who had their first reports substantiated and remained at home. We looked at infants who had their

first report deemed to be unfounded or in California we also have the classification called "inconclusive" but the child remained at home, and finally we looked at the population of infants where there was actually no investigation conducted. So after that first report came in to the hotline, there is no CPS investigation, no worker actually went out. What we did is we looked at just those children who remained at home following those first reports and we tried to explore how strongly our initial determination of risk translated into the likelihood that the child was re-reported a second time, before age 5.

What we found is that 82 percent of infants remained at home, following this initial allegation, but less than 10 percent of those infants were provided with formal CPS services in the form of a case being opened. Now we were not able to look at how many of these infants and families were referred to outside community-based services, but we were able to look at in how many instances a case was actually opened.

Then we simply followed those children over time to see how many came back into the system. Was that initial report truly a report where there wasn't any needed intervention, particularly for the group of infants where we evaluated the child out? Was there really nothing going on, no good cause to go out? And what we found is that regardless of the initial decision that was made, that first report again clearly signaled that something was going on just by the nature of how many children were re-reported a second time. So what we found was that regardless across all different disposition types, a significantly heightened risk of being re-reported for all groups, we found 69 percent of children who remained at home following an initially substantiated report and for whom services were offered were re-reported. We found 65 percent of infants where there was an initial substantiation but no services were provided were re-reported. Among the unfounded and inconclusive group it was 57 percent - 62 percent, and for those infants who were initially evaluated out, 59.6 percent, almost 60 percent, were re-reported a second time.

So, here's where I kind of close, and hopefully leave us feeling somewhat optimistic about our ability to be more strategic in our decision making. And I'm going to steal a quote from Richard Gelles, which is, "One might conceptualize child welfare agencies as social service agencies, but that would be incorrect. In reality child welfare agencies are gatekeepers, and the workers, decision makers."

So if you think about it, at every single point, we're making a decision whether to investigate when a report comes into the hotline. At the investigation stage we're making a decision as to how to handle that case. Are we going to substantiate it? Are we going to deem it to be unfounded? Are we then going to provide services? And if we're going to provide services, what types of services are we going to provide? But while as a field overall, we've invested a tremendous amount in trying to figure out what types of interventions have evidence behind them, we've actually paid very little attention to how it is that we triage children through our system and how we ensure that our child protection workers have good tools so that they can make the right decisions. Because it doesn't matter how good a service is, if it's not the right

service for a particular family or if it's offered at too low a dose, or alternatively if we're overintervening and it's offered at too high a dose.

A lot of the tools that we have developed fall in that actuarial risk assessment category. So we've moved from, kind of, "gut responses" and we've moved from "consensus-based" assessment tools, which have been shown to not perform particularly well, to what are called actuarial risk assessment tools. I think the one that comes to mind would be "structured decision making" or SDM, which is used in a tremendous number of states in the U.S. But one of the problems with SDM and with other tools such as that, is they're attempting to help workers make decisions based on statistical models and yet you are inherently introducing the bias that comes with an individual or operator-driven tool. So at least anecdotally, when I've spoken with child protection workers and administrators in California, what I will frequently hear is, "yes we use SDM, but often it's completed after we've already made a decision about a case or about a family" or "we know exactly which boxes are going to get us to the answer we want" and so it's not that people are intentionally misusing these tools, it's that people don't trust the tools and people also feel as if their clinical judgment is superior to the tool.

This opens up possibilities, and again, I'm not going to spend a lot of time on it because we'll be talking a little bit about it this afternoon in terms of predictive risk modeling. But I think one of the things that's happened is we've been fairly static in our thinking. First of all, we haven't paid enough attention to the decision-making aspect of child protection, and additionally we've been somewhat static in our thinking. We've used the same tools for decades and we haven't thought about how the vast amounts of data that are now available could be harnessed and harvested to make better tools. And predictive risk modeling is an approach where it's using that same statistical model but it's removing the operator-driven component. So it's a computerized algorithm, and it's never going to replace clinical judgment, let me be very, very clear about that. But as much as we're looking for tools that can augment and provide checks on clinical judgment and can potentially help us to identify cases that may have a higher risk profile. So perhaps we want to make sure that there's more supervisory oversight or that we have a more experienced worker that's going out or perhaps we send two workers out for an investigation, there are opportunities there. And it also ends up being a very, very cost effective way, because there's no additional data entry that is required. And so I want to just talk a little bit, very quickly, I've got the 2-minute mark here. From a public health-framework, where could there be opportunities for the use of predictive risk modeling in child protection in such a way that would improve the safety of children?

First would be the area of primary prevention, where it would require some kind of upstream data system, which has a set of variables that will allow us to screen an entire population and figure out which children are highest risk, and therefore perhaps should be prioritized for a limited slate of early intervention service slots. It could be used to prioritize children, voluntary services, large-scale screening.

From a secondary prevention standpoint, we could imagine it being deployed at different child protection decision points. Either with just the child protection historical data that a

given jurisdiction has, or through linkages with other data systems. Again, not intended to replace clinical judgment, but intended to help triage cases so that we're ensuring that good decisions are made.

And finally, from a tertiary prevention standpoint. I think there's been less work that's done here but we often talk about the fact that we don't want services to be "one size fits all," that we need to tailor it. So the question becomes how could predictive risk modeling and data be used to make sure that we are better matching clients to different service interventions, because we have data that would suggest that these services may be more effective at minimizing the consequences of the experiences that have occurred.

Some of this work has actually been taking place in New Zealand, and we've been doing some parallel work in California, trying to look at, from that primary prevention standpoint, is it possible to use birth record data to screen all children at birth and figure out which children are at the highest risk of later being reported to CPS and therefore, could be targeted for early intervention services. When we look at it from a simple count of risk factors, we can see that clearly there is a very strong, integrated relationship between the number of risk factors that are observable at birth and the likelihood a child is reported to CPS, substantiated, or entering foster care. Of course, where we draw the line in terms of who would be targeted for services really comes down to how we want to tradeoff, kind of an overintervention if you will, of providing services to children who may not need them versus missing children who perhaps do need services.

And so we've been working on some predictive models, where I want to know race/ethnicity is never a factor, it just doesn't emerge in any of our models. So what we're talking about are other socio-demographic risk factors, such as prenatal care and maternal age. All proxy variables, but still information that's universally available in the birth record data. And as a first pass, what we've found is that if we were to take all children born in California and stratify that population into the deciles of risk, based on the likelihood of being reported to child protection, before age 5; that if we served just the highest risk 10 percent of children, then 48 percent of those children, almost 50 percent would later go on to be reported to CPS. And so the question is, if we serve that 10 percent, how could we start to make that red area of my pie chart start to shrink so that a smaller share of those children go on to be reported? In contrast, if we look at someone who falls in the lowest risk deciles, we can see that only 1.5 percent of those children would go on to be reported. Again, from a policy and a resource standpoint, the question is where do we want to begin to think about risk, and targeting services, but certainly the data are not going to be perfect and they're not going to tell us every single child who's going to be reported or experience abuse or neglect, but they can help us to be more strategic theoretically in how we deliver services.

Dr. Sanders [00:52:19]: Dr. Putnam-Hornstein, I'm going to have to ask you to wrap up.

Dr. Putnam-Hornstein [00:52:21]: All right, perfect. So I just wanted to close with, there are no simple answers, but I do think that through a greater use of all the terrific

administrative data that jurisdictions are capturing from a research standpoint, there are tremendous opportunities to advance the evidence behind the policies that we're developing and the programs that we're funding and from a real-time data usage I also think that there are tremendous opportunities to better use data for decision making. Thank you.

Dr. Sanders [00:52:57]: Thank you. And again for the Commissioners, we'll have about 40 minutes after Dr. Barth, for questions for both of them. Dr. Barth.

Dr. Richard Barth [00:53:13]: Chairman Sanders, Commissioners, distinguished staff and colleagues, thank you for inviting me, and I hope my presentation will come up on screen, because it's not as interesting as Emily's as it stands, but if it doesn't show up on the screen it becomes less so.

I have two conversations that I want to talk about, one of them is something called "birth match" and the process of matching parents who have had a termination of parental rights when they have newborn children, matching their birth data to those newborn children. And the second is about adoption and foster care.

So, let me start with the first one, and the slides will come along I'm sure. Our best predictions of harm occur when a child is highly vulnerable and the parent has clearly demonstrated inadequate or safe parenting. So, Emily presented a very broad perspective and a public health perspective and it's very important in starting to think about ways to narrow down to populations that we could really intervene with high levels of efficiency. I'm going to talk about a very narrow population. One I think is quite important, which is that we have, every day, infants born to parents who have had previous court decisions made about them, that they were inadequate parents. And yet, we very often don't know that these two things come together, and if we did, then we would be better prepared to respond.

Just as an example, in Maryland we're just beginning to look at these data. We have about 2,300 entrances to foster care every year; 22 percent of those are infants, so infants coming into foster care are a very high proportion of kids who come into foster care. And of those, about 10 percent, 10.37 percent, have had a previous termination of parental rights.

So it's not a huge group, but this is the group that just came into foster care. If we had the capacity to look at this more broadly, of all the infants who have touched the system we would have a significantly larger number than that 10 percent. It's stable over the last few years in Maryland, one of the things we hope to do is to be able to do more detailed analyses, but you can see at least that it's a significant number of children, who come into foster care, whose parents have previously had children enter into foster care and had an outcome where they were not reunited with their children. If we also included those children who had come into foster care and where the children had gone into guardianship indicating that they couldn't go back home, that number of course would be significantly larger.

So one of the things that's starting to happen around the country is that we're trying to figure out what to do about this, and there are a few "birth match" options. One of them is to do nothing, and assume that the existing system identifies these very high-risk dyads of parents who have parental incapacity and newborns that are the most vulnerable. So that's one strategy, and indeed we do see that sometimes the hospitals do identify these cases and sometimes these cases are open in child welfare services for other reasons, or child welfare identifies them, but at least a third of the time, at least from our preliminary analysis, they are not identified.

A second option is to match birth records to TPR records, and other indicators of exceptionally high-risk parenting, which I'll talk about a little bit, and conduct a timely, real-time preventive visit. So, what are some of the things then that might occur as a result of identifying, if we match in real-time, which is now going on in at least three states, maybe more, if we match in real-time and we know that a child was born to a mother who has previously been identified as having parental incapacity—what are our options in terms of how do we respond? We could have no particular pre-existing expectations about that, except that child welfare services knows about it and they decide whatever they want to do about it.

We could have visits to conduct an assessment as we do in Maryland. It's not a formal CPS investigation, but someone from the agency goes out and meets with those parents and children to see how that's going. We could require the opening of a case, which is more or less the direction that occurs in Michigan, that you're expected to open the case unless there's an administrative waiver. In some cases, in New York City for a while under John Mattingly, if this was going on there was an expectation that the child would be removed unless there was an administrative review. So there are a number of different options, that's not predetermined, what I'm really talking about here is the value of the information.

The other thing that we can do is we can add different characteristics to the matching to try to better understand what are some of the family dynamics. In Michigan, for example, they include other parent characteristics. They will include whether a parent on the birth certificate is a sex offender, for example. They even have included in some cases a parent where people indicated that she was pregnant, twice, on two occasions and children were never found, and never reported but they put her in as high risk, so if she had any other births that there would be child protection involvement.

It's a bit open, but it's an opportunity to say, "Here is information that is critical for us to have." I know that the Center for Disease Control is intrigued by this possibility. They spend a lot of money every year creating surveillance reports related to births and deaths, and they would love to be more actionable in terms of investing their money in ways that are preventive with regard to real-time matching.

It is the case, that in virtually every state that we've been able to identify, it is up to the secretary of health to determine how birth records are used and whether they can be shared

with social service agencies. As it stands, very few of them do, and when they do, they often have restrictive qualifications about how you can use those data and it often is inconsistent. You may get them for a few years and then you may not get them for a few years after that. My argument is, and I'm working with my colleague, Terry Shaw at the University of Maryland, is that this is allowable, reasonable, and achievable. We have precedent with regard to using information about families, from ASFA. We have, in that law, clarification that you must have some provisions to forego reunification if there are certain kinds of family experiences that a child has had, so unlike the Adoption Assistance and Child Welfare Act, where every child was treated uniquely, in the Adoption and Safe Families Act we do already recognize that children are in families and we need to take prior family history into account in making case decisions.

We need more analysis of the existing programs in Michigan, Minnesota, and Maryland, and I think an expansion of programs carefully as we build more knowledge about this. There are other high-risk mothers, as Emily has pointed out, who could be brought into this equation if we were really trying to improve the power of our predictive analytics. Obviously, any model that has one factor, termination of parental rights, is not going to do as well as models that have more, that are at least strongly correlated.

In one of Dr. Putnam-Hornstein's other papers, she indicates that 40 percent of children born to teen mothers who themselves were involved with child welfare services will be reported for child abuse by age 5.

There is another colleague of ours, Dr. [*inaudible*], who has looked at the death rates for children who are born following the birth of a small for gestational age child. They are three times as high, even for a second child, than general births are. So, if we really were serious about mining birth data, in a public health way, we could really start to identify children who are at very high risk of death, not all by child maltreatment. These studies don't all look at it in that way, but certainly these are premature deaths.

Another option is to match other high-risk parents. I've already mentioned that parents who have had serious other offenses, for example, are on the sex offender registry, or have been suspected but not convicted of serious crimes like homicide, that information could also be matched in, to help us to target who we go out and visit. And then there is a long history of work, for example North Carolina's Maternal and Child Coordination Project, the MCC project, which was the basis for their LONGSCAN study, where children born at University Hospital, who were born premature, low birth weight, with smoking or medically indigent mothers, went out and got home visits. That also provides a basis for improving our public health response. Whether that ends up being located under child welfare services or not is another question. But those are some of the predictives that we have, from very early on and that we could get access to in real-time if we consistently matched, say on a daily or weekly basis, birth records and child protection histories.

This is an opportunity, obviously, to use available data in real-time, to bring protective resources to those children. And I would say also to bring protective resources to those parents. The reason why Maryland has a law like this is because we had a number of deaths by parents who had had previous TPRs, and that's how we got going on this; and those parents fared very poorly. They themselves of course ended up in the criminal justice system. So it's protective for both.

The biggest challenges to overcome are reluctance to identify any false positives using the heavy hand of CPS, that's always going to be a challenge. Birth data are not medical data, they're not covered by HIPAA, birth is not a disease at least for the most part, and so we do have this option, but whether or not we can integrate this into our policy the way that I think we have reasonably well integrated the reunification bypass provisions of the Adoption and Safe Families Act, is a logical next step but it's a question about whether we really have the will to do it. The technology of it is not complicated at all.

Action items. So one of the other things I think we really need to do is we need to build on what is already a strong federal effort to get organizations to share data. Emily started out by talking about all the "siloed" data. We have the Children's Bureau on record. We have OMB on record, as having a high goal, an important goal of increasing data sharing. And that is something that we don't have to, at least, fight that concept; we have to fight the details of it. There's a lot of work to be done. But the concept is there. There's agreement about its importance, and I think that we could start with more research on this. We obviously need to know more about what happens in general to children who are born to mothers who previously had a TPR and what their involvement is in child welfare. So we need resources to look at this, but I think we have, in many ways at least, agreement that data sharing is important and that it's important not just as a resource tool but to start to use predicatively in real-time, to get preventative services to people.

So, I was asked by the Commission, and delighted to talk about a second, quite different topic.

My second conversation: and this is about preventing child abuse deaths of adopted children. We don't talk about this very much in terms of our field. I wrote a paper about this with one of my doctoral students a couple of years ago and it was very hard even to get it published, to try to write about adopted children who die. Of course we know that internationally this is an issue.

I was interviewed by a paper from Paris the other day, about that article. People are concerned all around the world about adopted children dying in the United States. I think we all need to be concerned. Unfortunately, we don't really know what those numbers are. We don't have good estimates. We could certainly do better, and here I'm going to make a very specific argument about some ways that we could do better.

First, I do want to say that I'm not making the case those children who are in foster care or adoption die more often than other children. When this came up in San Francisco many years ago, when I was at Berkley, we matched data of children who had been in foster care or were in foster care against fatalities. And the rate of fatalities for children who had left foster care was certainly much higher than they were for children who had remained in foster care. But we need better data, of course about a lot of these things.

So yes, adopted children, too. The *Child Maltreatment* report, which I hope you're all familiar with, which has become a very useful resource, reports that the proportion of child fatality cases that had prior contact with child welfare services. Well guess what, adopted children also, for the most part, if they were domestically adopted, had prior contact with child welfare services. But they're not included in that group. We count children who are in family preservation, and then go on to be killed by their parents. And we know something about that, but we don't look at those who may have ended up, whatever services they got first, in adoption.

There are tables in the *Child Maltreatment* report that include, as I mentioned family preservation, that include children who are reunited with their families within the past five years. We have a table that says child fatalities who were placed out of home in foster care and guardianship, but adoption is missing. The precedent is set for this.

So I'm an adoptive parent. I understand that when you become an adoptive parent you're inclined to say, "Okay, I'm done. I'm beyond the reach of anyone. I'm just like every other family." We have made that argument for many years; I'm not sure it was all that helpful. But I think the strength of that argument was certainly weakened with Fostering Connections to Success, when we said that parents of children who are adopted and receiving a subsidy must demonstrate that they still have that child in their custody, in order to continue to receive a subsidy. So we stopped saying, as soon as you adopt a child, you no longer should have any surveillance or be of any interest to the state. These children are still of interest to us. That was the first federal law to require any check on a child's well-being be made on an annual basis.

I think that keeping statistics on the abuse or murder by foster or adoptive parents is consistent with our responsibility to ensure long-term care of former foster children, which we're getting now, in clearer ways, by extending the length of time that former foster children can get services, that's a great thing. I think that also following up on what happens to adopted children is also consistent with that. We often now think about permanency in a broader way as including guardianship and adoption and even, although we don't talk about it so much, long-term foster care. But all of those should be monitored to see how well we're doing.

So, one of the things that could be changed is CAPTA could be revised to clarify the importance of providing information on the child level, child maltreatment fatality reporting,

on child fatalities, or children who have been adopted from foster care; and all deaths of children in foster or adoptive care should be captured so that we have a comprehensive and complete picture of them. Right now, we have a table in *Child Maltreatment*, which is kind of an odd table. I do honor the work and I don't mean to stand here and pick out one thing that I don't like, because there's so much of it that is good. But there's this table called Nonparent Perpetrators in *Child Maltreatment 2012*. I do think that foster parents, having been one of those too, are parents. I think that guardians see themselves as parents, but that said, aside from the quibble about how it should be titled, I would say, "Why aren't adoptive parents included in this analysis?"

So additional preventative steps, one of the things that we could also do, if we wanted to be more predictive, it's very challenging to predict adoption outcomes because there's so many factors that are involved, but we have had legislative possibilities about having a unified home study. So that we actually collected the same information in quantitative ways about all—and home study would be for foster care and adoption—that we had a systematic way of collecting information about foster care and adoptive families, that didn't skip any areas that were too sensitive for some adoption worker to talk about, that capture all the key predictors that we know of filicide or the killing of your children. And some of this is covered in the paper with Mary Horowitz. But there are things like, we do know if you look in the general filicide data, that people who have been involved with the criminal justice system or juvenile services are more likely to perpetrate filicide.

There are a number of other risk factors that just are never captured in our home studies in a systematic way, and that would be something that I would suggest that we start with, which is a good home study that has all these risk factors in it, and then we'll see how they play out. It's going to take time, but we could learn that if we could come up with some standardized way of collecting home study data.

Another option is to implement case reviews of serious and fatal maltreatment cases. So, this is something that is done sometimes, locally, but most of those don't include serious cases. Dr. Marian Brandon, in the U.K., is someone I hope you will talk to, she's been doing this now for five or six two-year cycles, in the U.K.. and really helping to identify some general paths of improvement that child welfare services there could take in order to reduce serious and fatal maltreatment. So those are my major points, and I'm delighted that I'll have a chance to answer some questions about them now, and certainly offer that to you at any time in the future. Thank you very much.

Dr. Sanders [01:13:41]: Thank you Dr. Barth. So we have about 40 minutes for questions from Commissioners. Commissioner Bevan?

Dr. Bevan [01:13:49]: Rick and Emily both discussed trade-offs in setting priorities in terms of identifying these kids and in terms of providing services. Is it possible, and as you know ASFA, if it was enforced, would allow bypass of reasonable efforts in these cases with TPR and

death of siblings. However, the courts are not and the states are not following ASFA, in that sense, and that has to be corrected somehow, some enforcement mechanisms. My question is, though, in California, where both of you have worked, there is this evidence-based clearinghouse, and it talks about the highest level of research, the medium level of research, the lowest level of research; is it possible to characterize research that way? So that we don't, when we talk about "best practices" for example, or promising approaches, and it has a low level of evidence, I'm uncomfortable using the term "best practices" because most policymakers would think that that is a model practice, or based on a lot of evidence, when in fact it's not. So is it possible to characterize, or to use these definitions in a meaningful way in a report, where we would talk about highest level of evidence, medium level of evidence, or low level of evidence, promising practices?

Barth [01:15:30]: So let me take a general crack at that. I'm a member of the research advisory board and we have a lot of deliberations. Is that better? I'll speak up. So we have a lot of deliberations about this. But it's important to recognize that there are two ratings for every program that is submitted by a developer, and only programs that are submitted by developers, so they're not the general child welfare practice. One rating is about the level of evidence that basically follows a standard of science framework. The other is about child welfare relevance. Most of these interventions do not have high child welfare relevance. There really are only a couple of handfuls that we can say have had good scientific testing and also have high child welfare relevance; that is, they were tested with children who were in the child welfare system. Most of them were tested in Head Start, with kids with conduct problems or something like that, so there are limitations. It's a good start, but in terms of the usual processes of intervening, and child welfare services, investigations, case management, and home services it's not a very informative, it's not that informative at this point. That would be my view. Emily?

Putnam-Hornstein [01:16:56]: I think the only thing I have to add to that is, I think there are a lot of great, small programs out there where they're not even going to show up at a place like the clearinghouse, because we haven't necessarily had the funding to do the evaluations and because historically we've approached program evaluation in such a fashion that it becomes very, very expensive. Because we're trying to intervene and track children so that's another place where I'd like to just make the plug for linked administrative data, actually provides some very good ways to, in a quasi-experimental fashion, start to evaluate some more of these smaller programs that may in fact be quite impactful but don't have the evidence base behind them, just yet.

Bevan [01:17:38]: Okay, thank you.

Dr. Sanders [01:17:42]: Commissioner Horn.

Horn [01:17:42]: I'm going to follow up on that a little bit, because I'm struck by two things. One of your slides Dr. Putnam and in the article that was submitted to this Commission, Dr.

Barth, that you were co-author of that you didn't talk about. Because it seems to me, first of all I want to thank you for your presentations, they were fabulous, they were terrific, and the amount of evidence-based and fact-based work that you've been doing is terrific. So this is not a criticism of your work by any stretch of the imagination. I'm just curious about this. So I don't have numbered slides here, but the one slide Dr. Putnam that you had shown indicates that if an infant has a substantiated report of abuse or neglect and is not placed in foster care but provided with services versus no services there's actually a higher rate of re-report for those who got services than those that didn't. And Dr. Barth, if I'm understanding one of your articles correctly, children whose parents received substance abuse treatment versus those that did not, were twice as likely to have another child abuse report. This, as a clinical child psychologist myself, this does not seem to be good news. I am familiar with David Olds' work, which suggests that there are effective interventions out there. But what do we need to do besides just sort of say, "We need more evaluation work"? What's wrong with the interventions that we're not seeing those interventions actually reducing the future risk of abuse or neglect?

Putnam-Hornstein [01:19:42]: So, I'll take that one first. In terms of the percentages that I reported, I think it's important to keep in mind that what we don't know is what the rate of re-reporting would have been for those children who did receive services had they not received it.

So let's imagine that in a counter-factual world, 100 percent of those infants would have been re-reported to child protection. The fact that only 69 percent were could actually be a good thing. So I think it's important to just be reminded of the fact that we're presenting statistics that I don't think are, what we would hope they would be, but that statistic in particular does not actually speak to the lack of efficacy for services itself.

And then I think the other thing we're seeing, this has shown up in the literature all over the place, that children who receive services have the highest rates of re-reporting and it's probably due to two dynamics; one is that we probably are doing a decent job of triaging and those are in fact the highest risk children. So it's either that we were going to place them in foster care initially or try to maintain them in the home with services, and in a lot of cases that appears to not be working as well as we would like but that's often why we see the higher rate of re-reporting.

And then there's also that issue of, is there because we're providing services there's additional levels of surveillance in the home and therefore we may have that confounder, so that's what I wanted to say about that.

Barth [01:21:14]: That's right, I think the study that we looked at, where we were determining that those who went into substance abuse treatment where they're getting tested, getting a urine analysis often, they're going to have a lot of surveillance. There may be reports back for going AWOL, those are not necessarily specific harms to the child, but

they're procedures that are put in place in order to try and manage the way that substance abuse works with child welfare.

So I think what happens is that those families that don't follow that path may be having more undetected maltreatment. We know that undetected maltreatment is massive, from the National Survey of Child and Adolescent Well-Being. If you ask parents what they do to their children, and they tell you that I burned or scalded or beat my child till they had a bruise, you'll find out that only about a third of those ever get detected. So there's a lot of detection that does not occur.

The other thing is that one of the biggest problems we have in all of this is that a child maltreatment report is not the same, every single one is not the same. So a new report could be a preventive report. It could be a referral back to the agency to make sure that things don't get worse. This mom went AWOL. This mom had a positive UA, therefore that's a problem we're going to call back to the agency; we're going to ask them to re-open this case.

That is very different than a family who hasn't received any services, and then they have a severe maltreatment incident. But the way we count them under the CFSR and for NCANDS and every other purpose, is that every child maltreatment report is the same. Well, we have to come up with a severity index. Until we do, we really shouldn't be weighing repeat child maltreatment reports.

Horn [01:22:58]: Wouldn't you agree that at least we should have a healthy skepticism about the effectiveness of the services that we're currently providing? Given that this is not overwhelming data to suggest that they're extremely effective, and the explanations you give me are somewhat conjectural. And I agree with you that we should try to do something but it seems to me we should at least have some skepticism about the effectiveness of the interventions given these kinds of data.

Barth [01:23:26]: You must have been reading my work. In substance abuse I think, as much as any place else, I think we're making a lot of progress on mental health. I think as substance abuse gets wrapped into the Affordable Care Act and becomes more science based, we're going to make more progress. But I think that we have hit a wall sort of in terms of the quality of service for these treatments.

Dr. Sanders [01:23:46]: Commissioner Martin?

Martin [01:23:48]: Thank you, and like Commissioner Horn I want to thank both of you. I have a lot of questions but I'll restrict them. First of all, when you talked about services in your presentation—I'd like to just follow up. So remember, I'm a judge, so I'm talking from what I see in the courtroom. Social workers often tell me, "Judge, you just don't understand" and I completely admit it; but telling me that you're giving my mother parenting classes and the kids not with her to observe how she's parenting is kind of problematic for me. And so

when we talk about the quality of services, I for one think that we really have to look at what services we're giving and what the purposes of those services are. I can tell you, in different parts of my city when there are methadone programs, the value, or the amount of methadone that's given in some parts is different than other parts. Now, I suspect that has something to do with the history of the abuse, and I'm not a service provider, but drastically different. Now, when I bring them in, they tell me, "that's because of funding." Well I don't know how you treat a drug problem based on funding. So I think, to reiterate, that I think there has to be some evaluation done of services. That's a statement I guess.

My question really is to you, and again I think your work is wonderful. I don't mean to be critical, but when we talk about "coke babies" in particular, and you gave some risk factors, one of the risk factors I noticed was about public funding, or how the birth was paid for. I'm from Chicago, and I don't have any "coke babies" in care that I know about and I've been the presiding judge for 14 years, that come from any hospital other than Stroger. Now Northwestern is located on the Gold Coast, right behind Saks Fifth Avenue, and all those stores, they have to have some childbearing-age women delivering babies at two in the morning, underweight and no prenatal care. When I call the social worker there, they tell me that because of private insurance they assume there are factors and supports. And so DCFS doesn't get a hotline call.

So what I'm asking you to do is take in consideration these anecdotal stories. When I get kids, re-abused in foster care, it's considered a licensing issue, not an abuse and neglect issue. So my foster mother can do the same thing to my kid that the bio-mother did, and the foster mother is not charged. It's looked at as an internal licensing issue. I would suggest that you might want to consider those things when you're looking at your data, because then I think you would have a different idea of what it means about maltreatment and evaluating maltreatment in care. And so I'm offering that to you, but I would ask you, do you have any study, any data, to show about "coke babies" coming from private hospitals?

Barth [01:27:22]: The data that we analyzed, also in California, that looked at medical indigents was the general population; we had no information in that case about drug exposure. It was a short form of the birth records. So we were just looking at whatever we could find available. I have no doubt that there is a distribution of drug-exposed child, I suspect that it is not evenly distributed across all socio-economic groups, but it's not really my specialty and I don't know whether we're getting the right distribution when they are coming to court, I suspect that there are some biases in it, but I'm not sure. I think that even if we avoid that part of the formula and use other birth indicators, we could still improve our prediction or precision quite a bit.

Dr. Sanders [01:28:15]: Commissioner Rubin.

Dr. Rubin [01:28:17]: Yeah, thanks guys. You know I'm trying to wrap my head around predictive analytics and the conflicts [*inaudible-low volume*]. When we talk about predictive

analytics, I can imagine some value when a child is reported to a child welfare system, helping to standardize the ways in which we do investigations. In some way asking ourselves, "Do we need to have the same response for every child that is reported to the system?" Privacy concerns don't seem as big there, because the kid has already been reported. I just got the report; I should know what's going on if I'm in the child welfare system.

What you're asking and suggesting is that we're going to move the dial before the kids are involved in the child welfare system. And that's the challenge here when you're dealing with the risk of serious injury or death, which is a rare outcome. And you're now sort of saying, that a child when they're born, that we're actually doing some level of surveillance, because we think there might be a response.

I'm not surprised to see the elevation of risk by some of the risk factors that we see. I think it's a little deceiving because the real question we need to ask ourselves is "What is the risk?" So if a child has this risk factor profile, is it 1 in 100,000 of a child that's going to have a near-fatal injury, or death? Is it 1 in 200? Because we have to also ask ourselves, "What is the cost of the false positive?" if we're going to move the dial, and we don't have the capacity for prevention services to reach 100,000 kids. If you have a 5-fold elevation of risk and you go from 1 in 100,000 to five in 100,000 that's a 5-fold increase at risk, but you're asking ourselves or do we have the services to provide to 100,000 families who are never going to seriously injure or kill their child. They may neglect their child, and have poor supervision; we have a lot of risk factors that we see. Dr. Barth, you actually get closer, because you're trying to pick risk factors that you think that society in some ways, we can all agree.

A family who has had their parental rights terminated, in some ways, in my mind intuitively says, yes that family deserves its own response, and we should know where those kids are, and my experience as a clinician, I've seen children die who have not properly been detected. But I would say Dr. Putnam, I'm not sure history of a CPS report rises to that level for me. And so, if thinking about the nature of what our capacity is for prevention, but also, what is the actual risk, not what is the elevation in risk.

Putnam-Hornstein [01:31:17]: I agree completely, all of the statistics that I've presented around fatalities are relative risks and so it shows that sure, these kids who are known to the system have a heightened risk relative to other children, but the absolute risk of death, following 500,000 children known to the CPS system, less than 1 percent actually died.

So I couldn't agree more and I think that we would be mistaken to think about predictive risk modeling, or predictive analytics, as a tool we would want to employ with that end outcome specifically being a near fatality or a fatality, because I don't think, I mean this is something we can answer empirically but I don't think we will ever have the data or be able to predict with an accuracy that any of us would feel comfortable with and intervene differently on that basis.

But I do think that there are some opportunities, the prediction work that I've been doing is focused on, can we screen at a population level hundreds of thousands of children, and figure out which of those children are the most likely to experience involvement with CPS, down the road, which we would like to prevent. And which we know does pick up a group of children who are at higher risk of death and other bad outcomes. So we know that involvement with CPS does mean something. Can we screen at a population level hundreds of thousands of kids, and figure out which of those kids have the highest concentration of risk factors, and not aggressively intervene, but prioritize them for service thoughts. And that's where I do think there are some interesting opportunities, and to just give you an example, I'm working with a county in California where what they have implemented, they have a maternal and child health network in their county, they initially were doing universal screenings bedside and found that it was way too costly. So they've now implemented kind of a computerized algorithm, where they flag certain births that have risk factors where they think that there may be some additional supports needed to the families. Things such as being a teen mother, and some of the other risk factors we've talked about. For those cases, a clinician comes and does a more formal bedside risk assessment. Not in a punitive or an adversarial way, but to say, "What kinds of additional supports might this family need?" And then they have a very extensive referral network, so that they can make sure that those families, right at the time of birth, are referred to services.

Now of course, we have all sorts of questions around engagement, and service adequacy, but just as kind of a framework for how we think about prevention, I do think there are opportunities to use predictive analytics for large-scale population screening.

Dr. Rubin [01:34:06]: So to follow up that as a focus, I think that's exactly, because the "Part B" of this question, because I think when you started talking about sudden unexplained infant death, and in context of your comments, which I thought were great at this point to the Secretary, but I'm not sure this is a child welfare system response. And I'm hearing that in your follow-up comments there. I think we should put sudden unexplained infant deaths on the lens. If we're going to prevent child deaths, that is such a huge problem here that we don't know, should the person at WIC know which kid needs a free crib?

Very simple interventions, the limited exposure we have to our MIECHV programs, our home visitation programs in this country, where do they dial in to who gets referred for those programs, which are voluntary programs but at least could actually start to kind of use your analytics in a way that's a non-child welfare system response. And finally a pediatrician in terms of safe sleeping like, how much should I know in my office when that newborn comes in? What some level of risk was, so that I might try to attune myself to all those community-based services.

And I think it's important to state up front, I worry about us understanding. The intention here is not to grow an unwieldy child welfare system that has responsibilities that is way beyond its capacity, even impact some of these outcomes. So you can follow up with

comments on that but I think that's sort of something I think that the Commission probably needs to think about.

Barth [01:35:49]: I just have a brief comment about that. I think it absolutely requires a public health response and that we should be thinking about, by linking high-risk children to a range of services, although it's not your role, reducing morbidity as well.

Dr. Sanders [01:36:04]: Commissioner Dreyfus.

Dreyfus [01:36:05]: Thank you first for this fabulous presentation. As I sat here as a former child welfare director, I've got to tell you, it was pretty sobering. And I thought to myself, how many deaths could we have prevented? So thank you. That was a wonderful presentation. I have two questions. One, doctor for you, and then Rick, for you.

My first question was, having had Medicaid responsibility in Washington state, my head went back to prenatal. My head didn't just go to the time of birth, but my head went back further. And I thought to myself, on the obstetrician front, do you have anything in your data that shows how many of these births had been involved with prenatal care? Had they seen an obstetrician at any point in time prior to that? Because I look at data on the Medicaid program, and I appreciate, Judge, you talking about beyond Medicaid, but I would assume that we're talking about a very high percent of the children that we're talking about having been born in the Medicaid program. It'd be interesting to see what that connection is, because I think to myself when you had your sample variables, yours were on page 17. Rick yours were on page 5. These sample variables that you created, and you provided some variables that might have these predictive elements to them prior to birth, do you see any way that we might be able to influence Medicaid policy as it relates to the kinds of requirements that are in place, prior to birth, for earlier identification. Not to swoop them into the CPS system necessarily, but to start providing earlier the kinds of services and supports and parental development that could take place prior to the birth of the child.

So my one question for you, doctor, is, in your work, did you see anything that would move us further upstream into the prenatal world of these children, prior to just looking at time of birth?

Putnam-Hornstein [01:38:06]: So it's a great question. I don't know that I have a good answer for you. I mean certainly we were able to look at the initiation of prenatal care and to your point, how many of these families did have at least one or more visits, so they were a part of that prenatal system, and the vast majority did. So certainly there were some mothers who had no prenatal care, and we would miss those. But the majority did have some contact, so I think you're right to think in terms of opportunities there.

Barth [01:38:43]: I think one of the challenges in Medicaid is the dividing of billing, where you can't get two services basically in the same visit. So, that's a challenge. If we started to

try to help some of these former foster youth, who are now teen parents, and wanted to develop a support service for them, we'd have to figure out how to add that on to what the obstetrician's visit cost and integrate those things. There are some proposals now to improve that kind of care management, but I think that's part of the challenge.

Dreyfus [01:39:18]: Right. So I have a question for you Rick, to close up on that, I just think it goes to this larger question that Secretary Carroll, I think, put beautifully on the table today.

And that is, I think, as a former child welfare director, I think to myself, we did ourselves a real disservice when we called ourselves the child welfare system. We are not the child welfare system; the community is the child welfare system. CPS is but a sliver of that pie. And we seem to have an over-fixation that that sliver of the pie is the answer to it all and it is not going to happen until we're really thinking at a cross-system level. Both at the federal level and the state, and I hope this Commission will take that on.

So Rick, I have a question for you. You talked about the foster families and adopted families, and this gets a little sensitive, but did your data in any way show a connection between the prevalence of risk or harm or children being killed, when the adopted or foster family was related kin, versus unrelated kin? Because we do have a move in our country to try to change our licensing standards, as it relates to kin versus nonkin, right? And you always worried about a pendulum swing. Did you see any connection there?

Barth [01:40:40]: No, our data unfortunately was very anecdotal, literally scrapping it off of newspaper headlines and out of state reports, because there is no systematic data. I think that's part of what a standardized home study would help us do. My sense is that in general what we see when we compared kinship foster care to conventional foster care, now there are a bunch of pretty good studies on that, is that there is less tension, less conflict in kinship homes, that kids actually seem to do pretty well in them. They don't have as much social capital but they also seem to have less conflict and challenges. Adoptive parents report more difficulty if they are not related to the children and caring for them. So I think both groups, for different reasons, have needs, but at this point, I can't say which is greater.

Dr. Sanders [01:41:36]: Commissioner Covington.

Covington [01:41:36]: Thank you both, for wonderful presentations. To me they really, both represent the clarion call for me to think beyond child welfare, and I think goes to your point, David. I didn't hear, Emily, in your presentation the call that child welfare needs to be more deeply engaged in the families. I heard that we need to identify risk for families and figure out which kind of services families can participate in, which is one reason why I think we really need to strengthen the home visiting provisions in the Affordable Care Act so home visiting is more available to more families in need. But I did have a question about, one simple question or maybe not so simple, but when you took race/ethnicity from your risk, but

earlier you had talked about African-American kids being, 20 percent over their lifetime had been involved in the system, I'm trying to figure out why you took that risk out? And that was my first question but also my second question is, can you give us some recommendations as to how you eliminate barriers to linking data sources in this country? Because I hear it all the time, when people talk about how we can't link data sources because of all kinds of regulations and prohibitions.

Putnam-Hornstein [01:42:51]: So your first question about race/ethnicity, certainly we see, and we know that there are incredible racial disparities in our child protection system. In California, African-American children are twice as likely to be reported, twice as likely as white children to enter foster care; but what we found is that when we do, what researchers like to call more of an "apples to apples" comparison, and we follow an African-American child and a white child over time, who have the same concentration of risk factors whether it's poverty or young maternal age, or whatever else, that there are no longer racial disparities that emerge. And so what's happened is when we have been able to throw in all of those variables into our predictive models, the inclusion of race/ethnicity does not actually add any power to our ability to predict later outcomes. So you're absolutely right that the disparities are very real, but the kind of disparities disappear when we do take into account all of those socio-economic factors.

In terms of data linkages, I wish I had a great answer, I think there are so many opportunities there. I think one important thing to do is to keep separate two very, very important types of data linkage, which often get conflated with one another, and therefore it's confusing and scary to people. So the record linkages that I have been doing, and others in the university setting, are just for research and evaluation. It's just to kind of look at programs and take a look at policies. There's no real-time data sharing; I'm not looking at individuals, and so it's very different. The hurdles that one has to get through to be able to access records for research and evaluation, which I think is really, really important, are very different than the hurdles that are required when we're talking about two government organizations sharing data in real time for actual service planning. And I think that both are really, really important, but I think as a country, we're still sorting out what's allowed under federal and state laws, how we feel about confidentiality, and so what often happens, I think, in States, is we kind of jump right to the data sharing for case service planning purposes. I would actually advocate for a push towards greater data sharing for policy and research and evaluation, and I think what will happen is that we will quickly realize just how many clients are overlapping our systems, just how valuable this information is, and that will actually advance discussions around real-time data sharing.

Barth [01:45:28]: But there is an exception, an important exception that separates data, which is not medical data, just vital records. It's critical. I think it can be put into real-time play. I would have argued, like Emily did for many years that it's a research tool. But it can be more than a research tool, when we match our data with the State of Maryland, we have to send our TPR records over to the health department, so that they can match. Because their

birth data is more private than our TPR data, it's crazy. So we really need to get beyond that; the CDC could make a big difference, they pay for 30 percent of all that data collection, and that's one place where I still believe that real-time data collection for real service delivery decisions can be done reasonably efficiently. But I accept Emily's other caveats.

Dr. Sanders [01:46:22]: Commissioner Petit.

Petit [01:46:22]: If we didn't have a child protection system in Florida, I think most of us would agree, there would be more child abuse deaths than there are. So when you look retrospectively, when you look at the predictive analytics going forward, and you say "look at this universe and look at what happens" in the cases that the state did intervene in, and one of the services that government provides, a specific service, is an alternate place to live, an alternate family to live with, that's called foster care, but that is a specific government service. Did you see what the difference was, or do you know, anybody want to speculate on what the difference is between those kids with those characteristics not being intervened with and those kids with those characteristics being intervened with? In other words, what was it that precipitated acting in one case versus not acting in the others? Did you take a look at retrospectively a group of deaths that would have had the exact same characteristics as what you're talking about, except that the government did intervene and a kid likely was not killed, not harmed, or whatever?

Putnam-Hornstein [01:47:31]: I did. It's nothing that's been published, although it was a part of my original dissertation research. One of the things I did is in those analyses where we were following 4.3 million children over time, we looked at whether among those children who were known to the system, a placement in foster care proved to be a protective factor, when it comes to both unintentional and intentional injuries. And even though we were forced to kind of measure it rather crudely, which is we simply said, "Was the child ever placed in foster care between birth and age 5?" because of course we know that's not a static population, children come in and out, we did find that children who had ever been placed in foster care had rates of death that were no different than socio-demographically similar children in the population who had never been reported.

Now those children still had higher risks of death relative to children who have a socio-economically different profile, but compared with other children who are living in poverty and have those same risk factors, the placement in foster care was protective.

Petit [01:48:40]: Yeah, but I'm wondering if there isn't a precipitating event that causes them to be placed in foster care. You're looking at a situation and you're saying, we need to move this child out right now. So that's not a series of predictive analytics, that's a series of, the kid is living in a dangerous household, the guy is an ex-con, something's going on, there's been prior history, and maybe that's something that the department or CPS has to respond to.

Barth [01:49:03]: That study hasn't been done for young children who are most vulnerable to death. There's a very good study done by Joseph Doyle that's published by NBER, that looks at kids 5 to 12 or 14, I can't quite remember, who are neglected in sort of a general neglect way. Not sexually abused, not physically abused, and some went into foster care and some didn't, basically by virtue of who their caseworker was, and he did some sophisticated analyses and didn't find that the kids who went into foster care had any protective effects. In fact they didn't do as well on a number of different indicators. But that was for an older general neglect population.

But we don't have any studies as far as I know for younger kids that really look at the precipitating event, how long they stayed in foster care, and really couldn't do this precisely.

Dr. Sanders [01:49:54]: We probably have time for two more questions or comments. Commissioner Rodriguez.

Rodriguez [01:49:57]: I also really appreciated both of your presentations, and I was particularly struck by the quote that was in one of your slides, about child welfare being a gatekeeper. And I was struck by that because I think if we are thinking of the child welfare system as the gatekeeper then we need to pay really close attention to how that gate is managed, and when a call does come into the hotline, things like how long it's taking to respond to that call, how many calls are dropped in that process, the training of the folks who are both answering the line and going out and doing the assessment. My sense in talking to folks across systems, is that that's all over the place. That we are not actually attending to that function, as if it is a gate-keeping function. It's sort of looked at as equal in all areas of child welfare, that that's just one other function, and so I think if we sort of reformulated our thinking to really understand how critical the gate-keeping piece is and to load our most trained and our best resources and to think carefully about hotline calls and how those calls are addressed by the agency and sort of what type of scrutiny, we'd be in a different. That's my comment.

I guess my question is actually on a different note from everyone else, who are thinking pretty expansively. I'm really curious about the specific population of teen parents who are in foster care, because I was also, the slide that you had talking about the 40 percent of those teen parents would have a child abuse report by the time their child was the age of 5. I'm curious about a couple of things: number one, in your opinion, is that because those young people are under intense surveillance, and sort of have a lot of eyes on the care of their child from the child welfare agency already?

And number two, regardless of whether it's coming from surveillance, this seems like a population that it's sort of unacceptable, that we're allowing this to happen, given that we do know they do have most of the risk factors that we're looking at, and many of those risk factors are of our own making as a system. We've actually created those risk factors for them and we have them, a good amount of them at least, a captive sort of audience to actually be

able to provide effective interventions and services and supports that don't just involve removing their child, but actually involve really nurturing them and supporting them, and helping them to become parents.

So I'm curious about, number one, your assessment of the risk and why there's such a high populous, it's such a vulnerable population. And then number two, have you seen any examples of best practices where people are really identifying that subpopulation and providing them effective supports in their parenting?

Putnam-Hornstein [01:52:59]: So, I'll let you take the second part of that, but the first part, in terms of surveillance, that statistic actually pertains to young women who had a history of substantiated victimization. But we realize that there could be a strong surveillance bias if these teen moms were actually in foster care, in terms of how their children would be treated, and that would increase the risk of being reported.

So what we did is we actually excluded from our analysis any teens who themselves were reported after becoming pregnant or were placed in foster care. So we tried to get a very, very clean measure of what is the relationship between maternal victimization and the risk to the child. When we did take a peek at children who are teen mothers who were in foster care, it was even higher. We haven't published any of those statistics yet because frankly we feel the need to go in and better understand, almost from a qualitative standpoint, what's going on with populous.

Rodriguez [01:53:56]: So it's higher than 40 percent for the population of young women in foster care?

Putnam-Hornstein [01:54:00]: In foster care, yes.

Commissioner Rodriguez [01:54:00]: And is this just mothers, or mothers and fathers?

Putnam-Hornstein [01:54:04]: Just teen mothers.

Barth [01:54:06]: So in terms of best practices, I think we do have a challenge to try to figure out how to provide better parent training to mothers and children together. I know of one program that was supposed to be doing "best practices," but they were sending the teen mother to the agency to get parent training, while the baby stayed at home with the foster parent. So we have a ways to go until we can really integrate. The parenting programs need to be with the foster parent, the baby, and the mother, and over a longer period of time. We have that opportunity now that more kids are staying to 21.

Some of Emily's data is way before that era, going back to 2006 and up to 2011. I think the future is bright in terms of opportunity to do much better work on providing parenting. Parents are still going to have a challenge if they don't have grandparents or good family

members around that they can rely on, but at least they could have better base parenting programs when they go out into the world.

Dr. Sanders [01:54:59]: Commissioner Zimmerman.

Zimmerman [01:55:01]: Let me join my colleagues in thanking you for your presentations, they were wonderful. It's a very small question. I work primarily with American Indian and Alaska Native Tribes, in rural settings. And so foster care in rural settings and tribal communities looks very much like "grandma takes over"; it's kinship placement. When you look at the outcomes, you said there was a little bit of a difference in the foster care of the risks of death. Were you able to assess, was it formal foster care, was it kinship guardianship, do you have any? And the other piece is a best practices question also, I think sometimes that when we, in tribal communities, have removed our children and placed them with grandma, that all of the services go away, because we are making the assumption that grandma is able to be able to handle it, and we're forgetting that grandmother raised mom and dad.

Putnam-Hornstein [01:56:02]: A very good point. In terms of foster care placement, it was formal, but it included both kin and nonkin, so all cases where there was some kind of court oversight and supervision.

Dr. Sanders [01:56:15]: One last very quick question.

Dreyfus [01:56:22]: I was the only Commissioner who didn't say, "thank you." So thank you, I'm so sorry [*laughter*]. I want the record to show that I said, "thank you, and I'm grateful."

Dr. Sanders: [01:56:34]: Dr. Putnam-Hornstein, I've been struck by the relationship between reporting and the later child fatality, regardless of the agency finding. Any thought about what is it about reporting that's been so effective? Was there any correlation between type of reporter, was it different if it was a hospital or law enforcement, or a neighbor?

Putnam-Hornstein [01:57:07]: What was interesting is when we looked at the rates of re-reporting we broke it out based on whether it was a mandated reporter or a nonmandated reporter. What we actually found was that reports that had initially come in from nonmandated reporters, a neighborhood, family members, etc., had a higher rate of being re-reported. And that's consistent with some other literature that would suggest that sometimes mandated reporters may be better at providing the necessary information so that an action can be taken and that there may also be differences in terms of how closely child protection, or the credibility that may lay behind the reports themselves.

Sanders [01:57:47]: Thank you. So I can join all of my colleagues in thanking both of you for an outstanding start to today, thank you.

We next are going to hear from Dr. Randell Alexander, and specifically in some ways, tying what we just heard as well as what we heard first thing in the morning from Secretary Carroll, is what we've just heard about what we've learned in Florida, and why we haven't put what we already know into action. So Dr. Alexander, and he'll have 20 minutes for presentation, and we'll have 10 minutes for Question and Answer.

Dr. Randell Alexander [01:58:26]: Thank you. And thank you for coming to Florida. I appreciate that. I'm going to make a series of comments, I'm going to sound a little bit like the Ghost of Commissions Past.

Twenty years ago I was on the U.S. Advisory Board, charged by Congress to issue a report on child fatalities. We did. We did like you, we went around the country, we had hearings, we reported to Congress and to the Administration, and I actually remember we went to the White House, and we presented our report.

Here's my concern: 20 years ago we did that, what happened? So my biggest urging to you today, and I'll talk about a couple of things, my biggest urging is do something that's actionable, that's going to get attention, and will keep happening. Because you don't want to do what I fear our report did, which is sit someplace for 20 years with a few people here in the audience paying attention to it, no doubt, but certainly wasn't a best seller. It wasn't the sort of thing that commanded public attention. And I think that's really important for you, is to do that. To that end, you can enlist the media, there's a variety of sorts of things that we talked about 20 years ago, didn't really accomplish, and I hope that you're able to take it farther than we did.

I'd also point out to you, too, that we already know the recommendations. They come out of the Child Death Review. We know, I did a book 10 years ago, Teri Covington wrote a chapter for me. We know what those recommendations are. Teri could give you the up-to-date thing, of what are all the states saying in recommendations. They'll be essentially the same recommendations next year, and the year after that.

There are not new causes of death that are going on, so if we look at all causes of death, they're the same. Even for child abuse, it's basically the same. Yes, abusive head trauma deaths seem to have gone up, both in Florida when we looked at it, and Rachel Berger formally looked at with some colleagues and showed that. But basically, we already know these sorts of things. So our problem is more of implementation. How do we take this into actually going someplace?

I'm also going to suggest to you that health is an issue. If we had a perfect CPS system, and I know you've talked about that, and you'll talk about it some more, but if you had a perfect system, let's assume that about 40 percent of the kids that come in dead—that David Rubin and I, Rachel Berger, other doctors here—about 40 percent of them will have some sort of state involvement, food stamps, maybe actual CPS involvement, something like that, 60

percent do not. How are you going to deal with those 60 percent? What are we going to do there? So I'm going to urge that we think about primary prevention or universal prevention, however you want to look at that. And I think that those are important things that need to be done.

We know that drugs, intimate partner violence, there's a variety of things that are involved, and if you look at these child abuse deaths as we do in child death review teams, and I've been on three state teams so far, these things just repeatedly come up, again and again. So I think that we need to bring in the health component, because as great as our colleagues have been for 60 to 70 years now, with law enforcement and with CPS, we haven't solved it. And we're not one program away from solving it, it's not like you'll think of the one thing everybody hasn't thought of all these years, and that'll do it somehow, magically.

But what has happened is the appreciation of adverse childhood experiences, brain changes, there's a whole health thing that's added a new dimension. Add that to what we've already been doing and we might get somewhere. And I think that's where the strongest future is going to be.

Asking, if our strategy is that people have to call in child abuse reports to a hotline, and then we process it there, that's not a strategy, asking for reports to a hotline. We need to do something that's a lot more proactive and something that is substantially better. It's not like we're going to do away with that, I'm on the receiving end, Secretary Carroll, I'm in the Department of Health with child protection teams, we deal with cases after the fact and that's important, but put us out of business. That's what we really need, we need it so that we're not actually having to deal with child abuse cases in the first place.

I want to mention about one thing that does happen here in Florida, about our child protection team system, and I'm just going to go real quickly through a couple of things about that. So one of the things we have here that's different than you would see in other states is that, if you thought about child maltreatment, and you thought about medical—getting the diagnosis right, whether it was just child abuse or if it's child deaths, you would want to do it in a safe, friendly way. And you'd want an actual system, like we do with emergency medicine. It's not just haphazard that you go to a hospital, or that ambulances show up, there's a system for that, neonatology, there's a system for that. I would suggest to you, you live in states that don't have systems for that. You have excellent doctors in a variety of states, but they're in silos, and they're not a system. And that's one of the things that we happened to do years ago in Florida. We have lots of different places, and you can find lots of places for child evaluation. These are medical evaluations, I'm talking about a medically led system that's in the Department of Health, but works with Department of Children and Families. We think it's the state's responsibility to protect its children, that child abuse is vital, but that we need to help states understand that.

In 1978, our first child protection team began, in Jacksonville. And part of it was the notion that child abuse is a health issue as well, and what we did that's different is that this is a medically led system. Multidisciplinary, community based, we have about 23 teams now, we cover every child in the state of Florida. If they have something that's "significant child abuse," we see a lot of child abuse, but if it's significant enough, we have criteria I'm going to show you in a minute, then they'll be seen by us. Not by some doctor that doesn't know what they're doing, not some ER where they may or may not know what they're doing, but they'll be seen by us. It's medically directed, each of my teams has a medical director, I'm the statewide medical director over all of them, and the idea being that we need to bring in expertise.

So yes, we're multidisciplinary, as you see other places, but we have a statewide database. We have quality assurance, many levels of quality assurance. This is in your handout, even though I'm showing you a slightly updated version. We're 24/7. Last count, we have about over 100 physicians, about 200 social workers, 50 psychologists, so we kind of have the rest of the Eastern seaboard combined.

And how is it that we do that? Well we actually pay it for them, and there's all our different teams. [*showing slides*] Every day, our child protection teams get this many reports from the hotline. We have a system whereas it turns out, not only are the 200,000 reports that we get from the hotline read by CPS, but they're read by our child protection team. A medical person looks at every child abuse report that is made and helps make a decision as to what should be done about that.

And here is our mandatory criteria, things that will come to the child protection team; if we have one of these situations, they come to us to be evaluated. And this is in state law. So this isn't just sort of like a program somewhere, this is a state law. And of course we're going to see not only physical abuse issues, sexual abuse issues, medical neglect issues, mental issues. We provide a whole variety of different kinds of services.

This is updated from your handout, but it's the same kind of notion. This shows that we, in our child protection teams system, you see about an eighth or so, of all the child abuse cases. Some because they're not going to be child abuse cases at all, and then some because they're dirty house cases that we can't help that much with but do need services.

So we see kids right away, if they need it, or soon if they don't need it right away. We monitor things in real time, continuously. I can give you QA measures on a whole variety of topics. We actually go to sites, we use telemedicine. Interestingly enough, there's some places just trying to develop telemedicine. We've been doing it since 1998 in Gainesville. So we've done thousands of cases, we've never had a court challenge, so we know about this. It's a way to deliver medicine and really get some things out there.

Some things that we can do is we can see a child in the hospital. I can go into a hospital that I don't have privileges. I can go into Tampa General today and see a child abuse case, under state law. If it's for child abuse, as a CPT Physician, I can go in there, see the child, do the evaluation, and read the records about the child abuse. That's the thing that the state of Florida cares about enough. They're saying let's do what we need to do to actually do the right thing for kids and get a good evaluation in the first place.

Now that's dealing with your spectrum of child abuse issues, of various sorts, but we're often the leaders of the death review committees. And we are on all the death review committees, and that's because that's the extreme end of things we see. We, of course, always have to keep recruiting people, but we somehow do. Legislature has been kind to us, they give us $20 million. That would be $20 million more than any other state gets. And why is that? Why isn't that done? Because basically, we haven't developed systems in other states, we need to do that.

So we know it's the right thing to do but we haven't done it. Twenty years ago, we suggested some right things to do, and didn't do it. So again, my challenge to you is let's do some things. We're counting our own electronic health record, which we'll have out this year. And primary prevention we know is real important. So that [*slide*] says questions, let me just mention one other thing. So that's tertiary prevention. Can I do a data measurement and tell you that this system is far superior to everybody else? Well I don't know if it's far superior. Number one, I do think it is that's one of the reasons I came here. I worked for 20 years in other states, before I came here. I came here specifically for this reason. But we can't do the control condition. It would be unethical for us to take away the system that we have here and see what happens. We can compare to other states, I can tell you Jacksonville sees as many kids for child abuse in our medical CPT system, as Atlanta does.

And Atlanta has fine physicians, they're really good, I know them personally, but they're certainly much bigger than we are. And why is that? It's because we sweep up the kids, because we have a system working with DCF, working with law enforcement, and our other partners. We have a cooperative system to try to do the right things, and when it comes to death cases, the same sort of thing.

So what we need to do for child abuse prevention, death prevention is we need to change the culture. CDC has something called Essential Through Parenting, I hope you've gone to their website, and you looked at it, but the concept is, what are we going to do to try to move things forward?

So let me give you an example now that we've talked about some tertiary prevention. Let me show you some examples of something that we could perhaps do. We've talked about, Secretary Carroll talked about unsafe sleep, which is a big issue around the country, and we don't count it very well.

So I do believe the death review team should count, but I think we should also prevent. Here's something that you could do that would be ambitious, that could actually make a difference, how about we look at Finland. What have they done for unsafe sleep? This is a box, it comes loaded with stuff inside it, various apparel and other sorts of things, which really are for some poor people. They've been doing this since 1938, what you're seeing is their infant mortality rate.

Now it's gone down for a lot of reasons over time, but one of the things people think is they think that this box, is very special, and everybody gets one, it's provided. This is a sleeping environment for the child, and it helps prevent unsafe sleep. You can put it in bed with you, but you won't roll over on it. So we could do that, and we actually have data from someplace else that can be universally done. What if we did that in the entire United States?

Or maybe we could do the same sort of notion called "pepi-pod" that New Zealand does. They use this more for their high-risk categories, but again, the same sort of thing. If you've ever gone to a death scene or if you've ever seen the photos of a death scene, you ever seen that crib? The child's not in it. It's loaded up with junk; they use it as another storage device. The kid is in bed where they're sleeping on them and the kid is dying that way.

So perhaps we could do something like this. If we could do this throughout the United States, and you could make a dent, they think they've dropped it by one third in New Zealand, which was already low, because remember they're the ones that invented the Back to Sleep program. If we could drop that by that much we'd have done something substantial. And that, I would suggest to you, might even be more substantial in terms of number of deaths that we save. Whether you believe it's all from neglect or some of it's from accident or somewhere along that spectrum we could be doing something there that might be as important as anything else you could do. You could fine-tune CPS all day long, and I'm a fan of it, I'm not against it, but I'm not sure you'd get as many deaths at the end of the day that you saved, as you would if you did something like this, and then we could take it big.

What else could you do? Why don't you give $50 million to CDC? That's not a lot of money. How about $50 million with a plan to advance them to $100 million, specifically. Let's follow the recommendations, particularly if you look at our report 20 years ago, let's have an NIH Institute on child abuse, and look at deaths. Why hasn't that been done? Basically it's because we already have silos with people that are already protecting their own resources. But are we going to do something? What would be unconventional enough that we could actually matter? Or do kids not care? When Congress asks us to do things, I think they mean it. Can we commit the resources and things to really do it?

I think that's something that we really need to seriously think about. We need to monitor it. How could we have a clock? How could we have something show up in the *Miami Herald* and some other place that would indicate where we are on prevention? Are we making progress or not. Yes, we think we shouldn't have as many drownings, but you know what, we have as

many drownings. What could we do to make it so that we could move that clock or some sort of visual aid to show that it's going someplace.

And I would also say, stepping on Teri Covington's toes just a little bit, that there are organizations out there that will help. Teri and I with APSAC, American Professional Society on the Abuse of Children, they're willing to help. She co-chairs the committee on child death review, I'm on it. Health for Society, David Rubin and I are in a committee there, there's other professional organizations that would be willing to help on this, and I think need to be part of the solution to this.

So, yes, please let's continue the efforts we've been doing. Let's refine the efforts we've been doing, but I think until we get to health, I think until we think about primary prevention, we don't know who the ones that are going to do this are, we really don't. And we never really will have a crystal ball on this, I think we have to target everybody; change the culture so that these things just aren't something that people think about. When people don't think about hitting their kids, when people think about sleeping in their beds with their kids in protected ways. When we start thinking about zoning, and drowning prevention, things that would really make a difference that's when I think that we'll be able to live up to your name a little bit more, which is how we're going to end, or at least seriously reduce child abuse fatalities. Thanks.

Dr. Sanders [02:15:47]: Thank you, Dr. Alexander. So, I'll open it up for questions from the Commissioners. Commissioner Dreyfus.

Dreyfus [02:15:51]: Just one quick question, and thank you very much, back to some of your earlier comments, just so I'm clear. When you showed the stack of hotline reports, and you said that CPT screens all that come in, or those that have been screened in?

Dr. Alexander [02:16:07]: All of them.

Dreyfus [02:16:09]: All of them. So if it's all of them then what role do you play in the "screen in/screen out" decision being made by CPS?

Dr. Alexander [02:16:18]: The screening part, where they are accepted by the hotline, has already been done. But for us that is 200,000 reports in Florida a year. Then the reports go two places, and we're the only state that does that, they go to DCF, our CPS in Florida, but they also come to our child protection team, and we're both looking at it; it's the safety net feature.

The idea being, we're looking at them to say which cases are mandatory for us, and I showed you some mandatory criteria, but we have one other thing in there. That CPT can see a case that we want to see, and you have to have that, because maybe you know this family, and you know that even if this doesn't quite hit mandatory criteria you're going to see it.

Bruising, we said we'd seen kid bruising, that's alleged to be abuse in any kid under 5 years of age, anywhere on their body, but head or neck if they're over 5 years old. But what if I get a kid that's horse whipped, and they're 8 years old? It's not mandatory to CPT, but DCF will call us and want us to see the case and we'll see it. And if for some reason they messed up, we would see it in the child abuse report and then we would say, we want to see it.

So it's kind of a safety-net feature. I have a colleague in Mississippi that was trying to get a similar thing going. I have a colleague in West Virginia that's trying to get a system going. The big problem is getting state legislators to actually appropriate money, because at this point they're getting adequate stuff they feel, but they're really not getting as good as they could get.

Dr. Sanders [02:18:00]: Commissioner Rubin.

Dr. Rubin [02:18:00]: Amen. First thing that I would say, I have a little bias. [*Inaudible*]

Dr. Alexander [02:18:10): Thank you. We do have that bias.

Dr. Rubin [02:18:12): I want a little more specificity in terms of, because you made some very specific recommendations, which I thought was great.

Two things I wanted you to talk a little bit more about: the value of these child protective teams in terms of preventing child abuse and neglect fatalities. I can understand the well-being issues of older children and kids who are having physical abuse or neglect, sexual abuse, etc., and have these teams work across the state. But if you're putting those teams on the table as part of federal/state strategy, where do they fit in terms of child abuse and neglect fatality prevention, in terms of what we would expect to deliver for that investment.

And the second thing is that you mentioned an investment in the CDC, you said $50 million. What would the CDC do with that appropriation?

Dr. Alexander [02:19:03]: Okay, well the CPTs are really tertiary prevention. And in fact, we've been talking about tertiary prevention this morning to some extent. About the whole concept that abuse has already happened, we're trying not to make it escalate or get worse. And so part of it is getting a good diagnosis, as you know in the first place. Is this really abuse or not, and that's one of the things we really are able to add because a number of these cases, ones we're seeing, have a lot of medical component. And DCF here, or let me call it CPS here, deserves a really good medical opinion. And they're going to get a uniform, consistent one, and the reason I know that is because we do training. Make sure that all our providers are well trained and they give good diagnosis. So it's really tertiary function, it's not a primary prevention, but it is unique in the sense that we have it here, that tertiary function. So that's the reason I wanted to mention it.

What would the CDC do with their money? Well, they would build on their Essentials for Parenting [Essentials for Childhood], they're working with health departments right now. They did a process, and I'm going to misquote them here, so just take this as a generality, and check with them please for the specifics. They worked with a number of state health departments and they put out—well, we want to work with you in terms of promoting some positive parenting issues, and they had a meeting and about mid-20s, number of states showed up, say it was 24–26 showed up, something like that. And they were only able to fund about four or five programs. A number of the other ones said, "We'll do it without the funding, we'll do the same thing," the states were that committed to it. That they would do that. We could fund them, we could fund the other states if they were unable to do that, to do projects like that. CDC is perhaps one of the main health arms, and I'm not trying to say there can't be an NIH Institute, because they do believe in that too, but they're one of the arms to sort of say, "Let's investigate more, exactly what goes on here." Let's fund those studies and also let's fund prevention programs, what works, what doesn't work.

And we know it's going to take a multiprong approach to do it, but I think we're going to have to look at cultural changes. That's one thing that they've been looking at, been working with business leaders, in terms of child abuse. You make business leaders understand the child abuse prevention approach.

When I was in New Zealand earlier this spring, the insurance commissioner, the largest insurance agency in New Zealand had a big function. He had this gleaming, beautiful glass building, he totally got it. He said, "Listen," he says, "I have to think in 90-year spans. I could write a policy today, and I may have to pay out 90 years from now. I need to be thinking about how do I keep people healthy. How do I keep them out of child abuse. How do I make them so they are good employees, and that they're healthy until maybe the day they die, or something like that." So it's that kind of mentality.

Dr. Sanders [02:22:11]: We have several other comments, and I want to make sure we get everybody in. Commissioner Martin.

Martin [02:22:16] Yes, and thank you again for your presentation, it was very informative. I have one question, as a lawyer trained, what about due process? So you look at all of the hotline cases that come in and that are actually founded or generate a report from the CPS. If in fact, and I assume that you do, have follow-up recommendations for the respondents or parents, and I fail as a mother to follow up, I fail to take my child to the therapist or to the pediatrician, what happens at that juncture?

Dr. Alexander [02:22:56]: Our Department of Children and Families can go ahead and accept it as a new report, that it's medical neglect, in the example you're using, or not. They can look at it that way, if they don't do it as a report, they could be in an active service case where there are what we call CBCs, or community-based care, and they could just be looking at services. What could they do to get people to commit to these things. And at the extreme

end is if it were to be seen as an example where it was just outright neglect, they might bring it back to our child protection team, to see if there's any advice that we would have. We do in practice, if the cases are bad enough, and a lot of times you try to work those things without being that bad.

But let's say it's a bad case, and you think we have "staff needs," and then under our law CPS or child protection teams, law enforcement, prosecutors, anybody can call a staffing and we all come, and we all meet in a room and we all talk over the case, and that's where we solve a lot of the difficult cases. We sit down and say, "Well, what's it going to take to make this work, or can it work?"

Martin [02:24:07]: So just as a follow up, technically there can be like two cases running, a CPS case and a case under your division, your office?

Dr. Alexander [02:24:17]: No, we work together with them, it's one case, we're there to assist the Department of Children and Families in their investigation. We help them with impressions and recommendations, so we're a team.

Martin [02:24:31]: Okay, I think it's great that you can provide psychiatric services in particular without going into court somewhere, so I really applaud you on that. I just envision, we have something similar in Illinois for head traumas. It's not done the same way, but it's similar and often there are conflicts between the set of doctors and DCFS, about whether or not this case warrants court intervention. So what I'm trying to find out is, where is that resolved, and how is that resolved here in Florida?

Alexander [02:25:06]: I'd say, we sometimes have differences of opinion. If professionals always agreed they must all be asleep. I mean, I don't know how we could always agree. We sometimes have differences of opinion. We actually have some conflict resolution, actual protocols on how they can do that, and basically it gets kicked upstairs and both the agencies keep talking it over and see if we can get a resolution.

Dr. Sanders [02:25:27]: Commissioner Petit.

Petit [02:25:29]: Yes, is this working? Yes, much of the conversation has been around tertiary, which is part of our mandate. And of course the safety net question and the prevention is one that I think everybody would raise a hand and say, "Yes, change the culture and make that happen." But in terms of the immediacy of an issue, where a child is in a situation, where say the father or boyfriend has been charged with some crime against the child, the case has not gone to court yet, the guy is on the street and he's in and out of that household as he wishes, he's still committing offenses—first, how does child protection here relate to child advocacy centers? Are they one and the same? And how do you cooperate with those? And the other question is, on the child protection team, what's the role of law enforcement and what kind of protocols have been entered into between emergency rooms,

law enforcement, mental health centers, child protection services, when it comes time to provide the protective mantle of the state over that child; how does that actually work out in real-case situations?

And just a last footnote, is I appreciate the fact that you can't measure the outcomes on this with a control group, but it has to be more than, "it's good." We need to see somehow, now I'm not saying it's your responsibility necessarily to establish that, we have researchers here, researchers across the state, could they be brought together. If we're going to sell something significantly different to the Congress, we've got to be able to show that it actually makes a difference.

Dr. Alexander [02:27:01]: Well, we actually do have a lot of process outcomes and I didn't mean to say that we don't have outcomes, we certainly do. We could tell you today in Tampa, the child protection team, which reports they have, and how many days it's been, they have a 10-day limit, and they have some other such things. So we could give you a lot of operational outcomes.

In this state, the CPTs basically do the forensic interviews and the medical exams; the CAC structure is the wraparound services. And most of our CPTs are CACs as well, or embedded in the CAC—not all, but many of them are. So it works out pretty well. And as far as working with the law enforcement and the ERs and everything, the ERs, by and large, call us. We go into the ICUs, we don't see kids in the ER, we either see them in our clinics or we see them in the hospital. But our biggest job is to get kids out of the ER, because I can't think of a worse place, particularly when I think of sexual abuse, I would not want to have to do anything about sexual abuse in the ER. Save their life, yes, but otherwise get them to another setting where it's controlled and quiet and away from the heart attack in the next pod.

Petit [02:28:11]: And the protocol of law enforcement looks like, what?

Dr. Alexander [02:28:14]: With law enforcement, interestingly we've got about, I think it's five counties, am I right on this? Six seems to be the answer. Six counties where the sheriff's office or law enforcement anyway holds the contracts instead of the Department of Children and Families to provide the same services essentially. It's kind of a strange thing that we do here in Florida, but in that particular case, we're working with them in that context. And here in Tampa, is one of those actual counties, Hillsborough County. Other places with law enforcement, they're at the table with us. They come to our staff meetings, they're working hand in glove with DCF, and with our child protection team.

And the protocol basically is that they will come to all our staff meetings, and they work with us, and they do. We have different memos of understanding in different areas or districts, that we have, but essentially it's the same throughout the state.

Petit [02:29:13]: Do the DAs prescribe to law enforcement whether or not they're going to...

Dr. Sanders [02:29:17]: Commissioner Petit, we probably need to wrap up, we're at a time limit. So, thank you very much Dr. Alexander, and I know you'll be around for Commissioner Petit, our later panels also include law enforcement. So hopefully you can do some more follow-up to those specific questions, and apologies to others because I know there's some more comments, but we're at our time for a break, and we will break for 20 minutes and reconvene with the predictive analytics panel discussion. Thank you, Dr. Alexander.

Morning Break [02:29:46]

Dr. Sanders [02:29:52]: If the Commissioners could join us again, we're going to get started in just a minute. [*Pause*] So I will, in advance, thank our next set of presenters, because this really flows from the earlier conversation where we'll have a chance to hear in more detail about predictive analytics and the work here in this area, in Florida and in Tampa. We will hear from presenters in two sets and then have the opportunity for questions. We'll first hear from Mike Carroll, Greg Povolny, and Lorita Shirley about some of the work going on between Eckerd, Mindshare Technology, and the Department. And then we'll hear from our final three presenters on the analysis that North Highland and SAS have done, and we'll have, after the first set of presenters we'll have about 10 minutes for questions and after the second set of presenters we'll have about 20 minutes for questions for all of the presenters. So let me turn it over for the first panel, and the panel has 20 minutes total to present, so how you divide it will be up to you, but 20 minutes, and so Secretary Carroll.

Carroll [02:31:47]: Okay, thank you again. The concept of Rapid Safety Feedback, I mentioned this morning, it really is not, and I will caveat by saying this, it's not an "evidence-based practice." It was a pragmatic response to what we considered was an urgent need.

In Hillsborough County, we had a series of child deaths that fit a very tight profile. We had nine children die over an 18-month period. We had more than that dying in Hillsborough, but these nine fit a very specific profile where we had younger parents, we had an open, active services case we were actively working with the family, and we had people in and out of the home, visiting and working with these folks. In all cases, the child was under 3, in all cases there was a substance abuse allegation, a physical abuse allegation, and a lot of times, some domestic violence allegations, in all cases there was an extended prior history with the Department, in most cases there was a paramour who was unrelated to the child who in most cases was the perp, and in all but one of these cases was in home and all but one of these cases the type of death was classified as a homicide.

To us, that was striking particularly because it was in a case that we were actively working on; we needed to stop that immediately. One of the things we had to do was look at what we were doing. And I can tell you the typical response to that in the child welfare system, and even our system would be to do a retrospective quality assurance review, we'd put some

recommendations out, those reviews would tend to be case-by-case. And almost inevitably one of the recommendations would be training.

That type of approach was not working, and would not work in the environment that we were working in. Our work environment at that time was characterized by a high level of turnover, both on the protective services side and on the case management side. So we had lots of staff that were coming and going. We also had, because of that, you had vacancies, you had higher case loads and you had a differential in experience, in terms of who was experienced we had some very inexperienced, fresh-out-of-training folks working some very high-risk cases, and you had some very much more experienced folks.

The other thing was, we did not have a way when we got cases, they tended to be assigned randomly, as they come down on a rotational basis. So you really couldn't match up the folks who were really skilled at some of the cases that they needed to be put on. So our solution really had to be atypical for what we did, and so our response was to basically look at the resources that we had dedicated to QA, and move it away from retrospective review to make it a prospective review, and begin to insert these folks into what we considered the most critical cases at the decision-making junction, to make sure that these cases were properly triaged, that all the information in these cases was considered, that our assessment in these cases was sound, and then the decision-making in these cases was sound.

As a result of our work here, and this was a concept, we worked with Eckerd Community Alternatives who came in and became the new lead agency person in Hillsborough, and they took that concept and really fleshed it out, in a case management environment. Based on their experience, we took it and modified it slightly to fit a child protective services piece, because we work in investigations that typically run its course in 60 days, where case management typically is dealing with the family for a lot longer than that. So the concept was the same but the process itself had slight variations depending on which side of the house you look at.

One of the things we did to support this, and I think it was one of the best things that we've done, that has moved our system forward tremendously, is we built a query system into our SACWIS system, which we call FSFN.

Before if I said, show me all the cases that we have open that meet this profile, where you have a young mother under 26, there is a paramour in the home, we have extended history with the family, we have multiple allegations of substance abuse, physical violence, domestic violence, we have a child under 3, it would literally take me weeks to just identify the cases, much less respond to them. Now because of the development of the query system, we're able to immediately identify those cases, and you can do it on a state basis, you can do it on an administrative level, or you can do it as unit level.

So your supervisor is sitting in your office and you want to say how many cases do I have that meet this profile, it pops right up. So it gave us for the first time the ability to really start responding to these cases differently. Because not all the cases that we deal with are created equally, right.

And so the whole idea was to take, knowing that the environment we were working in, we did not have the luxury to stabilize a workforce, enhance the skill of our workers, make systematic changes to the way we do investigations. And we were in the process of that, by the way, in deploying our new approach, which was safety methodology, we're still in the process of that, we've been in that process for several years and we think that it will take even longer. Not only to get it deployed but to have a high degree of fidelity for them all.

But the kids that we were serving today couldn't wait until all that was fixed. We needed to come up with a pragmatic solution. I can tell you while it is not an evidence-based practice, it has produced some promising results, because in Hillsborough County, since its implementation, we continue to have child deaths. In Hillsborough County, we average between 41–45 child deaths reported to the hotline per year, in this one county.

Last year was actually the first significant decline where we had about 26, which is a good thing. But more importantly, since we implemented that, we haven't had one case that has met the profile that we've put this process in place to stop. Now I would caution folks because this approach is not fool-proof, it doesn't guarantee that you won't get a bad outcome, and it's only focused really on making sure that we're triaging and making good decisions on families that we're actively working with. To get the next level we engaged SAS and North Highland to take what was inherently a small sample for us, and Eckerd did a lot of work to expand that sample. But for us, what was inherently a small sample, and increase that sample size with SAS, who looked at all child deaths over a number of years; and you'll be hearing from them a little bit later, but that really kind of corroborated what we found in the smaller sample.

The other thing that they identified, and it goes to, I think, Commissioner Petit's comment this morning, was one of the intriguing things they found was if services were put in the home, their chances of having a child fatality in their homes was significantly reduced. Now, there wasn't a lot of work done around that, in terms of what types of services or what combination of services, but the legislature's reappropriated money this year to continue our data analytic work. Our next step in that is, now that we think we have a pretty good profile, is to really look at the data analytical side of it to see what service or what combination of services both for folks that were out of home, but also for kids who were kept in their home, seem to be the most effective, so that we can begin to really focus our efforts in these cases.

The other thing, and I think this was in the earlier presentation, the beauty of this is, if you work in the child welfare system for any length of time, and you talk about high risk, all your cases fall into high risk; or it seems like all of them fall into high risk. The cases that we were

looking at, this profile of nine, and I think it's held up in the presentation that was done this morning. Not only did they have risk factors that made them high risk, they had all the risk factors. And so, by developing the query that we have now, you can use any combination of those risk factors to get at a population that you want to look at, and it has helped us tremendously to really focus our efforts, and to begin to streamline how we work with those families.

I'm going hand it off to Eckerd's Chief of Community-Based Care, Lorita Shirley. She's going to talk about how Eckerd actually implemented this.

Lorita Shirley [02:40:27]: Good morning again. I'd like to first thank Chairman Sanders and members of the Commission for allowing Eckerd an opportunity to share how we've utilized business intelligence to curtail the rate in which children were being murdered in the state of Florida.

As Mike Carroll mentioned, Eckerd was awarded the contract to oversee child welfare services in the Tampa Bay area, a little over two years ago. I think it's important to note that our mission is to share and provide solutions that promote the well-being of children and families in need of a second chance. So when we were awarded that contract, our number one priority was to address the unprecedented number of child murders that have been realized in this community while children in families were receiving protective services, under the umbrella of the child welfare system.

And so I just kind of want to walk you through the process of how we were able to accomplish that. Secretary Carroll has already highlighted the nine murders that had occurred, and I would just echo some of the comments he made. What we discovered from the reviews that had been done, the retrospective reviews of these cases was nothing new. Kids were under the age of 3, killed by a parent or a paramour, and the most common factors that were seen throughout those nine murders had to do with intergenerational abuse, substance abuse, mental health, and/or domestic violence. So we were no more equipped to figure this out after taking a look at those particular nine murders, than when we had first arrived.

So one of the things that we decided to do as an organization, Eckerd brought some funds to the table and we knew that if we were going to solve this problem, we were going to have to expand the scope and depth of the review that had been completed in the Tampa Bay area. At that time, we had a commitment to conduct a review of 100 percent of all open dependency cases in this particular area. That resulted in a review of just under 1,500 cases impacting over 3,000 children receiving services in the Tampa Bay. In addition to this review, we also consulted with some statewide child abuse death coordinators we have, I know Michelle Akins is here, and I believe she's going to be presenting later, as well as Lisa Rivera. And so equipped with this information, we started to see some common themes that were prevalent in all of these cases, all of the open dependency cases.

Some of them are highlighted here on this particular screen, I won't go through each and every one of them, but I will highlight some of the more salient points. I think one of the most significant points for that is safety plans. We did not have parents involved in the development of the safety plans, even though the children were in their care. These safety plans were often developed without their input and they were not tailored to the individual reasons why we were involved.

The other thing that we saw is that when family dynamics changed, whether it was a new boyfriend moving into the home, updated background checks weren't done timely in these cases. So we had missed opportunities there. And it didn't matter how many providers or stakeholders were involved with these families. No one was really documenting whether or not the parent had experienced a behavioral change. So it was virtually impossible for the caseworker to connect the dots, when we didn't have providers making that observation.

And then what we thought was very interesting is that when supervisors were reviewing these cases we saw two things arise, from supervisory reviews. Either (1) they missed the point entirely, they were unable to connect the dots, or (2) they were right on point with their review and they knew exactly what needed to be done to mitigate the risk to the child, but there was a lack of follow-through on behalf of the frontline worker and supervisor in ensuring that those particular issues had been addressed.

So, one of the things that we did as an organization, and Eckerd has a pretty comprehensive Quality Assurance Review team, that often operates as a research firm. They basically looked at the findings of 1,500 cases, coupled with the findings of the nine child fatalities, and it was that information that became the catalyst behind our launching of the Eckerd Rapid Safety Feedback process. We knew that historically in Florida, quality assurance was done in a way that involved a random selection of cases and it too often had in excess of 200 questions.

And we knew that we were no better off than the state of Florida keeping children safe with that method. So we wanted to develop a very focused safety review tool, that would really hone in on the particular issues that were being faced by families, and increasing the probability of a child being at risk of child fatality. On this particular screen, or slide, are the nine questions that were developed as part of this safety-focused review tool that we use as part of the Rapid Safety Feedback process.

I wanted to share, at this point in the development of Rapid Safety Feedback, what we were able to accomplish was a review of cases, we had identified some common themes, we had identified a review tool from that process, but again in Florida we were dealing with thousands of cases and we needed a mechanism to mine our SACWIS System so that it would at least return for us, those children who are at greatest probability of risk.

That led to our partnership with Mindshare, and I won't go into a lot of that because you'll hear that in just one second. But what we wanted to do is equip child welfare leaders with

the mechanism to mine their SACWIS system, to highlight these cases so that we could begin the process of applying this very focused safety review tool and start intervening in real time with families so that we can actually make a difference and not be in a situation to where we're doing a retrospective review.

Part of the partnership that Eckerd entered into with Mindshare was to kind of develop the business analytics component of their Rapid Safety Feedback process. This was our ability, this was our risk model. Mindshare had the ability to tap into Florida's SACWIS system, and pull for us, key data elements that we identified were critical as part of the multitude of reviews that were done leading up to this particular issue.

And how this particular software works, and again, I won't go into this in-depth due to our time constraints but literally, this system can be catered to pull out for any particular state what they believe are the critical factors that are impacting the likelihood of a child dying. It can mine thousands of cases, and return for them those cases that meet the set criteria selected.

And it allows a high-level manager to link to that case and understand exactly what is going on with that family that's causing the increased risk. But that was only half of the solution. We knew we wanted to have a mechanism to identify the cases, but identification alone wasn't going to solve the problem, we still needed to change the way we approached this work and how we did QA in the state of Florida.

The second part of that equation was Eckerd's development of this coaching and mentoring review process. And this is really the beauty of Rapid Safety Feedback, so we have an Eckerd QA specialist, once these cases have been identified or flagged in the SACWIS system, we assign a QA specialist who conducts a very objective review of the case. And if during that objective review, and again, they're using this nine-question tool, so we can actually hit all of the cases that have been flagged in a very timely manner. But once they complete the review, if they determine that there is a safety concern and immediate emerging danger, within one business day they're intervening a staffing between that frontline caseworker and their supervisor. Bringing them to the table in a very nonpunitive way and beginning a dialogue session around what those safety concerns are and what we can do collectively as a group to address them.

So, again, this is very inclusive, nonpunitive, and caseworkers really viewed this as an opportunity for Eckerd, serving as the lead agency, to be a part of the solution, as opposed to doing a retrospective review and pointing fingers at what didn't go right, on these particular cases. The other unique feature about the coaching and mentoring process is that our QA specialists remain assigned to these cases until those children have either reached permanency or until the youngest child has reached age 3, which is what we saw as the primary age for kids in this area who were dying.

So it didn't matter if the caseworker changed, and/or a supervisor changed, we had some continuity and consistency in the objective review that was being done, ensuring that the various individuals involved in the cases had what they needed and the information that they needed to make informed decisions. I think the other beauty on this second side of the Rapid Feedback process is that our, kind of risk modeling system, allows us to track outcomes and if you recall, part of what we realized in the review of the 1,500 cases was that, even if you were good at identifying the issues, the child welfare system failed at follow through. So we knew we needed to shore that up with our data system, and so with the partnership with Mindshare, we developed a system that sent triggers to our caseworkers …

Dr. Sanders [02:51:15]: Ms. Shirley that's two minutes for the panels.

Shirley [02:51:17]: Okay. All right, all right. Well I am going to quickly share just some information on how we better. Mike mentioned this already, but I will echo what he stated, since Eckerd rolled out Rapid Safety Feedback in January of 2013, we have actually had no child murders involving families who were under the state's supervision, receiving services.

And the last point that I would like to make is that, we believe, even though this is not an evidence-based model, it absolutely is a promising practice that has proven outcomes for this particular area. It's been rolled out across the state of Florida and we would love nothing more than to share this solution with other states across our nation. So with that I'm going to… I don't know if you have any time left.

Dr. Sanders [02:52:01]: You have less than a minute, so I'm not sure how you want to handle it.

Greg Povolny [02:52:07]: All right, I'll make this very quick, I just want to talk quickly about how we operationalized predictive analytics for daily use in the system of care in Florida.

And there's a distinction here, a lot of times we're talking about predictive analytics, we're talking about national archives, we're talking about big data; in this example, we are actually laser focused on an individual system of care. Eckerd, a specific county, a specific district, and we are looking at that domain of data to perform the predictive analytics and provide an operational view, the outputs are being used by the stakeholders in that system of care to make decisions on their active cases daily. So I just want to quickly say that we've been fortunate enough, as Lorita said, to have access to the state automated systems of data daily, we've also got daily feeds from certain school board data systems, we've got access to data feeds from the Department of Juvenile Justice, and we use complex data science to unlock all the potential that the data has in a very specific system of care.

So, we've been able to produce real-time dashboards that show the probability of high risk for children who are likely to re-enter care, children that have a high probability of being re-abused, children with the probability of leaving with no diploma, the probability of aging out,

and we're working on models right now regarding human trafficking and hope to have that operationalized within the next 18 months or so.

Dr. Sanders [02:53:38]: Mr. Povolny, we're going to have to finish and open up for questions. We have about nine minutes for questions, and I'm sure some will be directed at you, so let me open up to the Commission. Commissioner Rubin.

Dr. Rubin [02:53:52]: Yeah, I commend you guys, this is a very elegant example of, once a family is involved with the child welfare system, how we try to, you know, I think it's analogous to health care where we're thinking about population health, how you risk-segment and you try to figure out how to design sort of higher levels of care management, and quality assurance around the families that most need that level of support.

And the question in that space, the question you ultimately face is one of scale. And it has to do with the calibration of these models, and it gets down to not so what's elevated risk, but what is the absolute risk? If I started with the risk of 1 in 10,000 and I reduced because my model got me to 1 in 9,000, that means that I have to hire all these extra people for 9,000 people, and only 1,000 people were triaged out, so the question I have is one of calibration. How do you set the parameters of the inputs? It sounds like you're using more than just administrative data, you're using actual casework data to kind of do this, which is great, probably getting you closer, but how do you calibrate and how well these models—it's ultimately a question of sensitivity and specificity of these models. And so I'd like you to speak a little bit more to that and sort of ensuring that as you think about these tools; and I agree that they should be part of the discussion for the response once a family's involved in child welfare. How do you think about the calibration in these models to ensure that we can afford the scale for this care management process that you're talking about?

Carroll [2:55:22]: To me, one of the biggest factors we saw earlier on the cases was not that the whole idea of focusing on risk was to me bundling different risk factors together, because of scale. Because I had to get to something that we could actual do within the resources we had, and the ability to say not that they have a risk factor, but that they have all these risk factors, and pull those cases out, and brought it to a scale that quite frankly our resources can handle.

The other component of this was, we knew because we couldn't touch every case, that the impact of this process had to be exponential, and so when Lorita talked about the process itself and how it really is moving QA away from a retrospective, "gotcha, here's what I found was wrong with your case" into a prospective coaching, mentoring, technical assistance that not only includes the feet on the ground, the case manager doing the work, but it includes the supervisor and in many cases the operational program administrator at least on the CPI side.

And so our hope was that as we do this, we could generate transferred learning, so that even though we touched this case, we're hoping that by having all of those folks present and going through this exercise, this critical thinking exercise and we're trying to role model what things that we should be looking at in our safety assessment, and that then gets implemented in other cases they're working. I agree with you, the scale is a huge part of this.

Dr. Sanders [02:56:58]: Commissioner Dreyfus.

Dreyfus [02:56:59]: Okay, so very quickly, first of all, as I move around the country, I do have to say that I say to people something special is happening in Florida. I say it everywhere, and I do think a part of what's special in Florida is the way the partnerships between the public and the community-based organizations work out; they're not just providers of programs and services under these transactional contracts. You're giving them space for innovation, which is really the best of our sectors, so I just want to commend you with that kind of leadership Secretary Carroll. Question: Okay, this sounds wonderful, I'm in love with it, right. It's got to get funded, and I'm thinking about federal funding, I'm thinking about states and the realities of funding, I'm thinking about the flexibility that Florida has through its federal waiver. You're talking here about a contract with Mindshare, you're talking about Eckerd's internal capacity, these QA specialists that are staying connected, there's a lot of resource that goes into doing what you're saying. How are you doing it? How is this being funded?

Shirley [02:57:53]: Okay, I'll start by saying that with regard to funding, part of what we have to, I think, present to our legislators is that we can't afford not to fund it. Now in Florida, Eckerd brought resources to the table, to launch Rapid Safety Feedback, and Eckerd is committed to bringing resources to the table, to assist other states in launching this solution to child fatalities.

But it really does take a partnership. I want to speak to what Mike Carroll stated with regard to scale. The upfront investment, because it really is an upfront investment, but if it's done right, and you maintain fidelity to the model, that transferred learning, you actually have caseworkers who may have had one or two cases identified as being at high probability for child fatality but they're taking what they're learning from that coaching and mentoring activity and they're applying it across the board. So over time what you're seeing is this is an ongoing training that's occurring with frontline field staff. They are making better and more informed decisions about how we do this work.

But again, with the funding piece, my recommendation would be, we have to build a case on why it is absolutely essential to have systems like this in place in every single state, to equip not only managers but frontline staff with the tools that they need to make better decisions. And when we do that, the cost of this doesn't begin to offset the cost of one litigation involving a child death. So, it's very cost effective, and I'm not sure, Greg, if you have any other comments.

Povolny [02:59:43]: I would just add that part of the process, and coincidentally the slide on the board is showing how you get economies of scale, so as you look at aligning your case action steps with the performance, is what I'm doing having a positive impact.

Those economies of scale can get applied to the massive case load, and so we're seeing those impacts with the tools there to be able to measure that and clearly identify what's working and what's not, that broader economy of scale is realized.

Dr. Sanders [03:00:13]: Commissioner Bevan.

Dr. Bevan [03:00:15]: Yeah, I'd like to make three points. One is that Congress has spent $2.5 billion on SACWIS since 1994, and we're talking about recommendations to Congress and to the president. Currently we have only 13 states that have an operational SACWIS system, that's of January 2014. Florida including, you have a plan that's approved, but even you don't have a fully operational SACWIS system, which needs to be mined in order to get this done.

There are 14 states that don't have a SACWIS system, and will never have a SACWIS system. Those include states that have a lot of children: New York, Illinois, Pennsylvania. Without SACWIS, what do you mine?

Povolny [3:01:03]: That's a great question. We're not restricted to just SACWIS data, every SACWIS system at every state is different anyway, and so the child welfare data domain, however, is somewhat consistent across the board, and so the data tools that we have take that into consideration, so it is not a prerequisite to have the SACWIS system in place, in order to be able to use and apply predictive analytics like we're talking about, here. Keep in mind that set of very laser-focused, individualized system of care.

Dr. Sanders [03:01:34]: We have several other Commissioner questions, and I promise I will get to them right after the next panel, in the order that I identified people.

So, I'm going to turn it over to the second panel, and the three presenters will cover some of the work that's been done by North Highland and SAS, and you'll have 18 minutes total for the presentation, so again, you can structure it how you like, and I believe it's Albert Blackmon starting. Actually, we're going to start with Rick Selznick.

Rick Selznick [03:02:11]: Mr. Chairman, members of the Commission, thank you, I'm Rick Selznick, with North Highland. I'd like to begin with providing some background and context for the Commission on the work that North Highland conducted, along with our partners SAS and the Child Welfare Policy and Practice group.

The work we conducted spanned approximately a five-week time period. And the majority of the time, about three weeks, was spent identifying appropriate data elements to include in the analysis.

The analysis itself lasted roughly two weeks. So relatively short in the entire span of things. The project was considered to be a data discovery project, which is a best-practice initial step in analytics. Prior to our work we anticipated that we would see some enlightening information that would be revealed and that the many additional questions for future research would result from the work. This is the typical nature of the discovery project. Prior to identifying the data to review as part of our process, we did interview a number of representative stakeholders both internal and external to the Department.

The interviews really informed our approach and the initial set of data elements that we ended up focusing on, while we identified 24 different data sources, and those were things like Department of Juvenile Justice systems, Department of Education, a pretty broad span of state and data sources outside of the state. We focused our ultimate review on only two data sources, two significant data sources.

That was the Florida Safe Families Network, the FSFN system, which is the Florida SACWIS system, as well as the Child Death Review Database. It's important to know that the FSFN system contains a significant amount of information; however, our review really focused on a limited set of information within FSFN, and it didn't do a significant amount of data cleansing either, we didn't do a lot of that.

Out of this data, we conducted a trend analysis of alleged maltreatment deaths and that spanned a time period of 2007–2013; we also identified and analyzed an initial set of data-driven risk factors. Finally, this led to the development of a deeper road map for future initiatives, that looks at deeper dive into initial data sources and then a focus on how do you actually operationalize the work, which you've heard about a little bit.

At this point, I'd like to touch on the results of the trend analysis that we conducted, then I'll allow Albert from SAS to get a little deeper into the data-driven risk factors, then we'll segue to the Secretary and he'll talk more about operationalizing and putting this in place in the field.

The trend analysis that we did was done to really set a baseline and serve as a backdrop for the statistical analysis. To set the stage, I'll begin with the trends that we saw with regard to allegations versus verified deaths, and if you refer to the chart, the bars on the bottom show the verified deaths. The red component of that is the verified deaths with priors, meaning that there was some kind of prior contact with the Department. The green indicates that there was not a prior contact. So overall, we've seen a downward trend since 2010, roughly, with both alleged and verified. The downward trend was stronger with verified cases, as we did see a slight increase in 2013 in alleged maltreatment deaths.

One notable observation, the Secretary had mentioned this in his early comments, was that a significant number of the allegations, between 55 percent to 65 percent across this time span, were related to children who had no prior agency involvement.

Next I'd like to walk through, a little bit of a deeper dive on some of the trends related to specific causes of death—abuse, drowning, and asphyxiation—and those three combined account for roughly 50 percent of the total deaths that were observed. This chart shows the maltreatment trend deaths related to abuse; we do see a similar downward trend over the last four or five years. One thing to note, here too, is that the percent of verified of total allegations is relatively high. And you'll see on the next couple of charts where there's a bit of a bigger delta between verified and allegations, and that's in drowning and asphyxiation.

With regard to drowning, you'll see that it's a relatively flat trend—a lot of up and down over the time period, but relatively consistent over this time period of 2007 to 2013.

Asphyxiations, we did note a downward trend here with the flattening in recent years, and again, here you see that there's a relatively big delta between the maltreatment allegations and those that were actually verified.

Another one of the notable observations was that age is a significant risk factor in verified deaths, particularly with regard to asphyxiation. So this chart takes a look at the bars on the left-hand side represent months, and then the five bars on the right-hand side represent years. So you can really see that there's a significant skewing towards younger children with regard to asphyxiation deaths, based on this time period that we looked at.

Finally, while we didn't include a chart here, we did observe another interesting trend, which showed that the majority of asphyxiations, those deaths occurred during the months of January to March; and you can think about that and come up with a number of theories related to that, but this is really a good example of what happens when you go through a data discovery project as it really leads to additional questions, and then ultimately should lead to changes in policy and practice based upon those observations.

With that, I'll go ahead and hand it over to Albert, and he's going to talk through some of the data-driven risk factors.

Albert Blackmon [03:08:21]: Thank you Greg. This slide is an excellent segue, what you've got here is a univaried analysis of age and as it relates to asphyxiation deaths.

Seventy-six percent of all deaths that we looked at, which is about 3,300 over a 5 ½ year period, 76 percent of those deaths took place between the ages of 0 to 2 years. So consistent with what you would expect, especially in the academic literature; younger children are at far more risk.

From that and from the FSFN system, we developed a very basic, logistic regression model. It's very industry standard, very standard across literatures as well, and included a number of data elements. From FSFN, and both the Child Death Review data sets that were mentioned earlier, one of the things that I will mention in looking at this, is this is a unit scale on the chart, the effect is actually exponential, and I'll explain what that means momentarily.

You see the note there that 75 percent of all child deaths occur between 0 and 2; it was observed across the board strongest in the asphyxiation category, meaning that the strongest effect of actually reducing the odds of the child dying was in the asphyxiation category. So the older a child is, they're far less likely to die from asphyxiation, again very common sense, very straightforward.

This baseline risk model you'll notice, all of the variables listed there, we included a large universe of variables to include in the model, and basically the modeling technique we used with SAS, was to take all of those variables into account and then slowly back away the ones that were not statistically significant, and we can have a discussion about that in a moment, I want to highlight a few things, make sure we get that in time.

The most interesting one, and again, per earlier discussions today, prior in-home services reduced the child's odds of death by 90 percent. Obviously, this is very good news, and this is some of the special things that are happening in Florida. Unfortunately, with the time period that we had, we could not go more granular than the fact that a child received a certain number of in-home services. One of the things that we would love to do, going forward, is to obviously take a much more granular view of this, of what types of services are being administered and what effect they're actually having, that's one of the next steps in the modeling we certainly recommend.

Something we want to point out on kind of the risk factor sides, that elevates a child's odds of death by 14 times, is if there is a prior removal from the home due to physical abuse. Again, very straightforward, it makes a whole lot of sense; if there's a pattern of abuse in the home, this child is going to be much more likely to experience a fatality. What's interesting is it was not statistically significant in the asphyxiation and drowning categories. So really just kind of your baseline death category that we looked at was really where it appeared, statistically significant.

Prior model, parents who had some sort of drug or alcohol abuse, this was very interesting; it was actually strongest in the asphyxiation category, followed by drowning. What's interesting here again is with the limited scope of data that we did have with those two sources, it would be very interesting going forward to take a look at a larger data set, with some of those substance abuse and mental health data points.

One of the main discussions that took place on our team, especially around some of the things that have been highlighted by the *Miami Herald*, was the physical disability and mental disability that a child may have—and again it did show up in our model, showing a multiple of 17, so increasing a child's odds of death by 17, which again is very straightforward, and makes a lot of sense; that if a child does have some sort of physical disability it will be very difficult for them to take some action to mitigate that risk.

So the road ahead, I recognize that this panel is about analytics, and you've heard some of the major recommendations from some of the good researchers that spoke earlier. A heightened risk profile or some sort of predictive model I think is absolutely essential and by that I mean, something that can help provide us some sort of measure against what certain risk factors provide in the life of a child. Whether that's death, obviously securing children from death and just general welfare is absolutely critical. But I would argue that there is a greater longitudinal study that should be done with positive outcomes, both in services being provided, but also in the longitudinal aspect of a child from birth getting that child to graduate high school, get a technical degree, get a 4-year degree, go on and do bigger and better things. And understanding, if you'll excuse the mathematical expression, the trajectory of that child from birth all the way through the point where they become a, often referred to very simply as a tax-paying citizen.

With that, I'll turn it over to the Secretary.

Carroll [03:12:46]: Thanks and I just want to follow up in terms of the road ahead. In the coming year we hope to take our use of data analytics, and merge it with science, and take us to a new level. I think what data analytics has provided us now is a vehicle, and I agree that scope continues to be an issue, but it provides us a vehicle to begin to look at cases differently based on level of risk, and to have them work differently. Have the surveillance in those cases different.

And so I think the more we use these profiles to hone in on those cases most at risk, I think we can have an immediate impact for those kids that are currently in the system, but I think to have a longer term impact when they leave the system, I think exactly what was suggested, and what we plan to do this year with our data analytics project, is to begin to look from a positive side, for those children who didn't die, what sets of services or combination of services were in place that had the biggest impact. Because not only do we want to make it safe for kids we're actively involved in, but there's an expectation that if the child welfare system is involved with a child and when we leave that family that that child's going to be relatively safe, and we're not going to be back with that family in the next two or three years because the child has been killed or died due to an act of neglect.

So we're going to make a big investment in that in the state of Florida this year to see what we can do in terms of our information around services, and quite frankly we would like to push toward evidence-based practice in these cases. Now, one of the things that was said

later, in the caveat to all this because again this goes to scope and scale, all of this is great in a perfect environment. It doesn't work if you're in an environment with high case loads and you don't have enough services to refer folks to.

I am buoyed by the fact that we did get an infusion of resources this year, from the legislature, that greatly increases our capacity in terms of feet on the ground. Both in terms of the investigative side of it but also on the case management side, and some influx in terms of services. But we have lots of work left to do around demonstrating the effectiveness of services before we're in a position to go back to legislature and say, "Hey, I want to fund more services." We need evidence to show that these services are really making an impact.

Dr. Sanders [03:15:24]: Great, so let me start with those that I had earlier. Commissioner Martin.

Martin [03:15:31]: Thank you so much for the presentation, this is really creative and innovative work and it's very effective, or at least it's very interesting to me.

My question is what happens after Eckerd and all the contractors leave? And if I understand correctly, what you're trying to do is build this internally, so these staffings that are done with your contractors and workers will be taken on and they will be train-the-trainers kind of thing, your internal staff will start doing this work with the case providers or the caseworkers on the troubled cases. Is there going to be an opportunity to test that system before all the contractors leave? And the reason I ask the question, from a judge's perspective, often times when the agency is doing statewide training for their workers, and retraining their workers, on any element, I ask the worker in the courtroom, and two years later; "Judge, I don't know what you're talking about." So, I'm concerned about this work is really great while everybody's in place, when they leave and go home, how is this going to be continued? And whether or not you're going to be able to test it before they all walk out of Florida?

Carroll [3:16:51]: Just to clarify ma'am, we do have folks that are providing technical assistance for us in our deployment of the safety methodology, because we are shifting away from how we typically conduct an investigation to a new way of doing it. And quite frankly, it has the same impact in case services, and we do have contracts with folks that are providing us the technical assistance and working with us to make sure, not only the folks get trained, and that the proper process gets deployed, but that there's a high degree of fidelity to the model. And that's an ongoing process and will be forever an ongoing process, and we're going to have to continue to monitor that and survey it.

But in terms of Rapid Safety Feedback, that's totally an internal process, the Department, at least on the CPS side, uses no outside contractors to do this. The data inquiries that we created are within our SACWIS system. On the Eckerd side, the work that they do around Rapid Safety Feedback is all an internal process to Eckerd, their contract with Mindshare provides some of the data-mining capability to them that others might not have, and that's a

piece we need to figure out because if Mindshare was to go away, how do we build that capacity into the SACWIS system for instance. Because every CBC in the state should have the same type of capacity to do that, so that's an issue that we need to look at, but as far as the process goes, that is internal and we're not relying on contractors to do it.

Dr. Sanders [03:18:28]: Commissioner Horn.

Dr. Horn [03:18:32]: Mr. Secretary first, congratulations on your relatively recent appointment to your position, it's really nice to see someone with such a deep background in child welfare and other human services at the helm, and the Governor's chosen well, and the citizens of Florida are clearly well served with your being there.

You undoubtedly know, well first of all, back in San Antonio in our last hearing, the person in a similar position as yours in Texas made an impassioned plea for flexible funding in title IV-E. And I know that the state here in Florida has been operating under a flexible funding waiver for quite some time—full disclosure, I was the assistant secretary that negotiated that with the state [*laughter*]—and part of the rationale for that was to provide the opportunity for a state to use some of its IV-E funds, which otherwise would go just for foster care, for preventative services.

So my question to you is, how's that working out for you? [*laughter*]

Carroll [03:19:44]: Now I understand where all the compliments pre-caveat are for. Listen, and I was told last night that Florida has the "mother lode" of IV-E waivers, and I believe that to be true. I absolutely think that that should be the funding mechanism for the entire country.

You have got to have flexibility in your funding and I think we have to, even at a local level, provide flexibility in our funding to our CBCs because I'm one of those folks that think if you're going to combat child abuse, it's a community-by-community fight; it's not a one size fits all, there's not a national fix to it, there's not even a state fix to it. It's going to be community by community. Now we can do a lot of the work as state and federal government in terms of giving folks the tools and the money to do it, but in the end, you really have to tailor it to meet that community's needs, so the more flexibility the better.

Here, I mean if I was to make an argument, we'd like even more flexibility. I wouldn't mind more funding either from the federal government, but I appreciate the flexibility. Substance abuse, mental health world in SAMHSA, we argue for the same thing quite frankly, and I know with the Affordable Care Act, and the potential integration with substance abuse and behavioral health services into that, down the road it might be different, but right now, quite frankly, Florida is not a state that has expanded the Medicaid rules and I think we need equally a level of flexibility in terms of how we deal with our substance abuse/mental health funding.

Lots of folks have told me in the past, "Don't worry, we didn't cut child welfare, but we cut substance abuse in half." Well, that's a cut to child welfare because the primary issues that we deal with when we deal with family are mental health and substance abuse-related and so we do have to have those. I would agree that we need to get to an evidence-based practice level in some of the services we do, but the more flexibility the better. I can't see life without the IV-E waiver, we've been in it a short period of time, please don't send us back would be my plea to the Feds.

Dr. Sanders [03:21:55]: Commissioner Ayoub.

Ayoub [3:21:57]: I have two questions for Mr. Povolny. On one of your slides, on one of the handouts on predictive analysis, and how do we apply it, I'm trying to get clarity on predictive analysis, so I need your help. What I have heard, is that some of those were demographics and somebody in the system before, things like that would help predict. But if I'm reading your slide right, you're saying that's not predictive analysis, it's more the who, when, and why of re-entering. Is that correct?

Povolny [03:22:34]: I'm not sure which slide you're referring to.

Ayoub [03:22:36]: It's titled, "Predictive Analysis and How Do We Apply It."

Povolny [3:22:41]: The one with the boxes? Okay, well the point is, there's a tremendous amount of reporting and statistical analysis that's done on the data that gives you the trends and so forth. What we're doing is looking at the operational data in the system, all of the data that is available to us, so if you consider what's in the automated system, you know the entire case record, all the history, we're using all of that to generate the prediction, and so that then the way it's applied is it's handed off and Eckerd's example or Eckerd's story where they take that information and they apply the Rapid Safety Feedback.

And then from that perspective, you can re-run your model and you can look at the changes in the probability, you can look at the percentage differential and the risk as it drops or increases, and you can align that with your case practice and what you've injected or the changes you've made and make a determination if what you're doing is having an impact on those risk factors, as it relates to the data that we're using to predict.

Ayoub [03:23:43]: Okay, thank you very much. And I'm sorry, I don't know your name, for you. Your maltreatment trends, I think it was on abuse, you said that there was a downward trend, and I was discouraged earlier when I heard Dr. Putnam-Hornstein say that the SIDS was also on a decline, but that it wasn't necessarily factual, but a coding. And when we've heard in some other hearings that what's reported as a decrease in fatalities, has really been a data-input coding difference

Female Speaker [03:24:13]: …a definition

Ayoub [03:24:15]: A definition, yes; so is your slide real? [*laughter*] Can I quote that one?

Blackmon [03:24:26]: Let me just start and I think I can probably pass it to Geir, as well. The data, obviously, that we pulled was out of the system, now the interpretation of how that was coded into the system, certainly has changed over time and some of the interpretation of how that gets put in, so there is a caveat to that, but I'll let Geir talk a little bit more.

Geir Kjellevold [3:24:49]: I'm Geir Kjellevold, and what I'll add to that is that for that reason, for the statistical analysis, we actually chose to use allegations instead of verified. So that we wouldn't have any of those concerns.

Ayoub [03:25:01]: Okay, thank you.

Dr. Sanders [03:25:02]: Commissioner Covington, then Commissioner Petit.

Covington [03:25:05]: [*Inaudible, low volume*] Coming from a point of public health myself, I have two thoughts. Have you thought about applying this model to looking at populations at risk in general for preventative services, rather than waiting until they're actually in the child welfare system, have you done any work in Florida on that?

My second one, is why are you just looking at fatalities that came in as verified or reported rather than all fatalities to see what you have in that mix? Because my own experience with child death review is that populations of kids who haven't been reported into CPS who die or haven't been verified as maltreatment deaths often look similar when you start looking at some other fatality patterns. And I guess I would encourage you, as we move though this, that we start taking broader looks at kids beyond just those kids who have made it into the CPS system at some level.

Dr. Rubin [03:25:57]: Add near fatal injuries because they're basically a death that a kid's been kept alive with traumatic brain injuries.

Covington [03:26:07]: I guess I'd like a response really to both of those thoughts or questions.

Kjellevold [03:26:11]: So the choice of using verified deaths was just due to the, quite frankly, the time frame of five weeks and just making a clear decision on, okay these are the deaths we're going to look at. Again, very clean cut from a modeling standpoint.

To address, I believe what you said about preventative measures and looking at what I described as the trajectory; that's exactly right, there's a larger picture here beyond just

deaths. The preventative measures around the child, so SAS has a statistical type known as Social Network Analysis, that looks at the holistic view of the child and the external factors and how they play into that child's life. We're doing some work in some other states using that particular method. Here in Florida, we specifically looked at fatalities, because quite frankly, that was the project, was to do specifically that.

But you're exactly right, in the fact of a larger, grander vision would certainly be to compare all of these different risk factors with the general welfare of the child, and to quote the good doctor from Maryland, "some sort of severity index" or we're using in other states CAN surveys or child needs assessment surveys to track more of the welfare in general; more than just a death event of some sort. Absolutely, and I'll throw in one more thing, one of the things that a lot of health care companies are doing right now is obviously episodes of care, following the whole life cycle of an individual. Same method could apply here as well.

Covington [03:27:26]: Thank you.

Dr. Sanders [03:27:27]: Commissioner Petit.

Petit [03:27:29]: This is a question for the secretary. A couple of times you noted, in some of the reporting we've seen on the screen says 55 percent or 65 percent of the kids weren't known to us. That's unfortunate for the kids, it seems to me that that number should read 0 percent. You should know all of the kids in one capacity, not necessarily that you've provided services or treatment to them, but in terms of a central point of entry into the state where you have live, online kind of ability to gather information, seems to me that we ought to know all of these children, and then make an appropriate decision as to where the case belongs.

But to that 55 to 65 percent, I have no doubt that had you intervened in all of those, some of those kids would still be alive today.

Carroll [03:28:12]: And I agree with that, it's just the way we do surveillance now, we only see the child when somebody calls in an abuse report, and there are differences in communities. Some communities have a much greater, much higher rate of reporting than others. So what would be reported in one community may not be reported in another community.

But that's why I say this fight needs to take place community by community, because you have got to make those connections at a community level, and at a state level we might not know all those kids, or at a community level the stronger that quilt is knitted together with all the stakeholders involved in serving these families, the better off we'll be. But we just don't have that surveillance capability right now, to get at those kids.

Dr. Sanders [03:29:01]: I have a couple of questions, and Commissioner Rodriguez.

For Greg Povolny, can you say a little about how long did it take from initial concept to implementation, how long was the development? How much it cost? And some idea about ability to replicate what you've done.

Povolny [03:29:23]: Sure, fortunately in Florida, we've been working here since 2005 and have had a lot of experience with the data. And it wasn't until the most recent two years that we started to focus on predictive analytics, so it's a little hard to size up, in terms of the timeline in Florida with the lead agencies in Florida.

But we've since started to work with other data sets, national archives, and other states' information from their SACWIS, and from the minute we get the data. So there's a lot of stuff that has to happen with data sharing agreements, and the things that go wrong with that, but once we have access to the data, we can start to produce output within about six weeks. And that is a given model, part of what we do, is we produce the models that can be re-used.

So to your second part of the question, about being able to pick this up and re-use it elsewhere, the models are trained, the models are tuned and they are re-usable, we just need to work with the given data source to get the model populated with the respective data and then the outputs can be used accordingly.

In terms of the cost, we really have tried to set a guideline in Florida, as a start where we look at the number of children. Because each child has some number of data elements associated with it and all of our technology is based on data processing and so forth. We have averaged somewhere between 5 cents to 8 cents a kid per day, in terms of turning. Now remember, we're looking at predictive analytics in a daily use environment, so we're running models, and we're analyzing data every single day, to produce outputs for decision support. So, that's about the guide that we use.

Dr. Sanders [03:31:08]: Thank you. Mr. Selznick, you mentioned using SACWIS and child death review as data sources, and the work obviously is critical and I think taking off of Commissioner Ayoub's question, the *Miami Herald* has been particularly critical about an undercount, as well as about the trend line, and they identified using additional data sources in their review. Can you speak a little to that? And I think it's consistent with the Commissioner's question because we're really left with the task of trying to sort out what the scope is and what the implications are from using different data sources, can you say a little about your perspective on that?

Selznick [3:31:54]: Sure, I'll start off and probably hand it to Geir again, but obviously, the more perspective you get as you're looking at the CPI data, hotline data, FSFN data, and then you start to kind of stretch that across different data sets, kind of a more overall better picture, more fuller picture you're going to get of truly what's happening. So expanding to those additional data sources helps to give you a better picture.

Kjellevold [03:32:01]: And again, one of the key ways that we dealt with that, we knew that one of the primary issues was the definition of "verified." There have been changes with that definition over time, and that's why we chose to use "allegations" as the primary, we show both but for the feeding into the statistical models, we chose to use allegations.

Beyond that, just as far as the overall recommendations we identified 24 data sources, and that's probably scratching the surface, and the biggest challenge there is going to be getting data-sharing agreements, and be able to link the data. That's really what's going to be needed to take it further.

Povolony [03:32:58]: If I may, I'm sorry. With modeling your estimates become better, you get a much fuller picture of what those risk factors are and again, what I think you're looking for is actual insight. You get a very quantitative look at how truancy may play into the welfare of a child as you bring those data sources together.

Carroll [03:33:20]: I just want to respond to that as well. In terms of the discrepancy in the numbers reported, a lot of that discrepancy comes around the decision whether to verify or not verify. And because, up until this fiscal year, our child abuse death review team statewide team only looked at and reported on verified child deaths. That was changed this year, where they're going to be looking at all child deaths coming into the hotline. And our website that we put out is also going to look at all child deaths, so some of that issue, at least the controversy around whether the child welfare agency is underreporting child deaths, I hope has been resolved.

But your point about deaths that are unreported to the child welfare system, I think that that's the next step. Because one of the things that we want to do this year, obviously it's taken us time to load the historical data into the current website that we have, but our next step is we want to actually audit our data and put it up with the health data, and see who we're missing and what type of information we can glean from the kids that are missing. So that's going to take time, and we're early in this process, but that's the direction that we want to go so that we have a full scope of the children who are dying in our community and we have some of the causal factors.

Dr. Sanders [03:34:38]: Thank you. Commissioner Rodriguez.

Rodriguez [03:34:40:]: I have a question that's really a practice question. Thinking about the researchers' presentation earlier and then combined with your comments about the exponential value of what you are doing, and then also thinking through the coaching and mentoring piece, I'm curious. The researchers' highlighted about how important that initial point of contact, for the child abuse referral coming in was, and then also the high rates of re-reports from folks who aren't mandated reporters, and I'm wondering if you've made any efforts to sort of coach folks who make calls to the child abuse hotlines, on what type of

information is helpful to gather, what might happen with cases, because it sounded like one theory for some of the reason there were re-reports is that people weren't gathering information. My sense is, just from having lots of conversations about child welfare and when people suspect abuse, the community at large is rather mysterious about what you actually say when you call a child abuse hotline, what the next steps are, what will happen; and so if it is a community-by-community issue—and actually I don't think this just applies to nonmandated reporters, I think that many mandated reporters could also probably use coaching and support on how to make an effective complaint. And how to use the child abuse hotline, so that maybe many of those children who are not known to this system really should be if we were doing a better job of not just telling people to call, but, "when you call this is how you call," so that we have the information that we need as a system to respond. And so I'm just curious if you've made any efforts in that area?

Shirley [03:36:32]: I would just say, as it relates to our primary stakeholders and individuals who are involved within a formal child welfare system, "yes" that's an ongoing training that's provided in terms of the information that needs to be gathered and how to make an effective report to the hotline, and what to do should the hotline not accept a report. In recent months, we've actually gone out, because within the state of Florida we're actually rolling out a new methodology, so we've expanded that training to the general community so we invite individuals, we've had trainings at community alliances, we actually host community forums where constituents have opportunities to bring up areas of concern and we have an opportunity at that point to make them aware of how to report abuse, how to help prevent child abuse in their particular communities.

So, not as much in the past with our general population but we're seeing more and more of that as the state is moving to a new way of reviewing child abuse reports.

Rodriguez [03:37:40]: Thank you.

Dr. Sanders [03:37:43]: With that, I want to thank both panels for an incredible amount of information and will help us in our deliberations, and certainly I believe most of you are going to be here for the remainder of the day, so if we have questions informally we'll be able to ask you. But thank you very much.

Everybody, we have one more presenter this morning, and that is Kristi Hill, and Ms. Hill is with the Family Services Department with the Seminole Tribe of Florida, and will be giving an overview of the some of the unique issues faced by tribal members in Florida, related to the issues of child abuse and neglect fatality. Thank you, Ms. Hill.

Kristi Hill [03:38:34]: Good afternoon everybody, I first want to say thank you for inviting a tribal representative to speak, it's great to have that opportunity.

I will be speaking primarily for the Seminole Tribe of Florida. So I don't want you to think I'm speaking on all tribes, because all tribes are different. I'm also going to move a little bit away from where everybody else has been, I'm going to talk rather than about data. I'm going to talk more about practice. And what the Seminole tribe has done to address child abuse and neglect.

I think it's highly important to always start with the Indian Child Welfare Act, it is a very important issue as to why I do what I do, in addition to protecting children, the Indian Child Welfare Act is highly important. This is why it is important, this is the Carlisle Indian Industrial School, one of the boarding schools that was in effect up until probably even in the 1980s.

At one time, the United States government thought it was a good idea to send Native children to boarding schools, and also the American Indian Adoption Project, where children were adopted out to non-Native homes, thought all of those were good ideas; luckily in 1978 they decided differently and enacted the Indian Child Welfare Act.

To get to the Family Services Department for the Seminole tribe, this is to give you an idea of how the tribe works. The Seminole tribe has approximately, close to about 4,000 tribal members right now. And we started to see probably, six or seven years ago, a significant increase in the amount of child abuse and neglect reports that were coming in, so we put a lot of things and really have progressed in our department in how we address those issues. And I think why we saw the increase is due to a lot of education on reporting.

I don't necessarily think that it was a huge increase in abuse and neglect issues or problems; it was more along the lines of reporting it, so we saw a significant increase in the reporting. Now, the Seminole tribe has a brand new tribal court; however, they're still training everybody to be prepared for the cases. So up until whenever we start that, we have been working with the state of Florida, the Department of Children and Families, and all of our cases have been held within the Department of Children and Families. That's where all the abuse reports go; the investigators come and do the investigations.

We have really worked hard, the Seminole tribe has, in improving the relationship with the Department of Children and Families, so that we're able to be present and to offer all the services that the tribe has to offer. The Seminole tribe does have a lot of resources, it is a gaming tribe; so luckily there's not a significant amount of funding problems so they do have a lot of resources, and we want to make sure that the tribal members are able to use them.

This map shows you there's six tribal reservations, in six different counties, which makes our life difficult simply because when talking about Department of Children and Families, you're dealing with six different counties in addition to the outlying counties; so we kind of have to try to keep our system uniform, in the way we do things on all of our sites but also responding to the county, which may do things differently than in other counties.

As I'm going through this, I'll kind of touch on a little bit of the things that we've seen that didn't work necessarily, in our relationship with DCF, and so things that we've put in place because we thought that perhaps we could respond to the tribal members better in that way.

Keeping our system uniform across all sites has been highly important to us, we have a lot of tribal members who travel all over the place, all different reservations, and we want to make sure that the services that they get at one, are going to be the same at another. Six different programs within our Family Services Department: clinical, family preservation (clinical is mental health and substance abuse services), prevention and after care (again having a lot to do with substance abuse), psychological and psychiatric (we do have a psychologist and a psychiatrist), utilization program (the tribe is self-insured so this program helps to make sure that we have the appropriate services on our network), and then our guardianship program.

So, specifically, the family preservation program is our child welfare program for the tribe. These are just some of the services that we offer, again we work very closely with the Department of Children and Families. We've worked it out that they don't wait until a case is in court. They are calling us when a case is under an investigation, so hopefully we're there at the very beginning, which has made a huge difference because if we have all of these resources it doesn't make sense to put them through a system that they're unfamiliar with; we can offer it to them. We've been pretty successful at making sure that we're there at the initial investigation.

Going down the list, I have mutual development of safety plans, so everything that DCF does, all of their legal sufficiency staffing, we're present, we're there. Safety plans was one of those things we saw that was not working some years ago, and I know that right now DCF is addressing that safety plan issue themselves but we saw it a long time ago. What was happening was that we'd go out on investigations, they'd see that they probably needed some services, and they just kind of a verbal agreement, "Will you do this and this?" and the family says, "sure." Our staff are the ones who go back out. So we're out there to make sure that they are getting those services that they agreed to do. However it's hard to say, you verbally agreed to do this. So we came up with our own form that we wrote everything down that was said at the investigation, had the parents sign it, "This is your agreement that you're going to do these things." That made a huge difference because we could take that paper back out to the parent and repeatedly keep telling them, now of course safety plans are voluntary so we can't force them to do it, but we can keep reminding them, and telling them where the services are. Perhaps it's a service we can put in the home. And that made a big difference in making sure that, (1) that things are written down, and (2) that somebody is coming out on a regular basis to follow up with the family.

Because that was another problem that we often had, investigators had a lot of cases and they just weren't able to follow up. So you might hear from them when the case was about to

close, but it was difficult to get the investigator to come back out with us to press the family to do what they needed to do. So, that's helped with the safety plan compliance.

Of course, we locate placements, we do home studies, develop case plans with DCF, we go to all court hearings, we do offer our own tribal parenting course, so you can see we do offer a huge array of services; pretty much anything that's on a case plan we through the Seminole tribe can offer it. Now parents can also decide to go outside of the tribe if they choose to, so they have that choice, but it's often if they do, you see them come back because it's easier to do it with us. They know where we are and they're familiar with us.

This is just another list of some of the services that our Family Services Department offers to families. We often see that there's a need in the community, so we try to find a program to meet that need. So, we have a lot of things, the newest thing coming is a youth home, group home setting for children, that maybe needed some kind of a step-down type of program for maybe a residential treatment.

We do use a system of care, and these are the guiding principles from that. This has been key, and the key in that is that we really wrap around the family and all the services come from one place. I'll show you some of the products that we've come up with, I call them products. The first one is our treatment team meeting, this happens within our Family Services Department; so it means all of these people sit down at the table, so the mental health counselor, maybe the family preservation counselor, if we have an aftercare counselor, everybody sits down at the table and talks about this case because we're all dealing with the same families and it doesn't make sense to not be talking to each other.

So again, that makes a big difference in talking about what these families need, so they're not getting one message from one counselor and another message from another, which is confusing. They're getting the same message from everybody.

This has been our highly important thing, we've started doing in the past three or four years now. Our child protection team, which is different from the state of Florida's child protection team, ours is more of a staffing mechanism. All of our child abuse and neglect cases are brought to this team, you can see it's made up of a number of services. These are tribal departments, education, health department, law enforcement, all of these people sit down at the table and we staff these cases because once you know there's an abuse investigation there's probably some other area that this family needs help in. So this has been extremely important in making sure that we are all talking to each other and that the family is getting what they need.

Dr. Sanders [03:50:12]: Ms. Hill, I'm going to have to ask you to wrap up so we can get a chance for some questions.

Hill [03:50:19]: The other team worked so well that another group, I'm helping them to put together another team; this is for educational purposes. So that's it, I think the next one is questions, and I just want to finish up, the key for us and what's made a huge difference is communication. I think I heard somebody on the panel say something about the community level. Of course, within the tribal community that it's very evident, but it's talking to each other, so that you don't have people duplicating services, you don't have parents getting mixed messages. So communication has been the key.

Dr. Sanders [03:50:58]: Thank you. Open up for questions, Commissioner Zimmerman, and then Commissioner Horn.

Zimmerman [03:51:05]: Ms. Hill, I'm so glad to see you. First of all, I want to qualify my statements, and finally my question. To make sure that, I appreciate the first slide when you described the boarding school experience which for American Indian tribes, it seems to be the most devastating historical event that has occurred for our people. It's a place, and a time, and an era that lasted a long time, it was a federal policy that was meant to assimilate us into the Western world view. It didn't work very well; instead it undermined and destroyed our traditional family parenting practices, which was really unfortunate and leads us here today.

I want to make very clear also that you're very blessed to be able to be in the state of Florida and be a gaming tribe. Most tribal communities don't have those sorts of resources, and I also want to make clear that the "rural and isolated" issue is really imperative in the discussion about how we practice child welfare and how we reduce child fatalities.

In North Dakota, Montana, South Dakota, and Alaska the American Indian population is only somewhere between 3 percent and 8 percent. But for child welfare, they make up between 30 to 60 percent of the state child welfare cases. There's a huge difference in, what do they call it in juvenile justice, the "disproportionality of representation," so the other one, I'm really nervous for some reason, I apologize.

Also, child welfare in most rural reservation communities is made up of sort of this puzzle of different sorts, BIA, social services can be involved, state child welfare can be involved, Indian Health Services may have some sort of family preservation programs that they do, tribal consortiums like, or feels like you guys do, here in Florida, can be involved and so sometimes children get lost and get counted differently. And they receive different levels of care and their families receive different levels of care.

I want to ask, so knowing those jurisdictions, we also work in communities where there isn't a database, it's paper based, still. And we work in communities where there is during sequestration there was one law enforcement officer and one MSW that covered 2 million acres. And when they're fully staffed, there's only four. So there's this huge difference in

how tribes are—566 federally recognized tribes, over 300 state-recognized tribes that are all unique, but their systems are all unique too.

And because they are unique they have unique ways of counting, and collecting data, and most of the time, as I said, many are still paper based. In NCANDS only about 61 percent of American Indian/Alaska Native children are counted, because tribes don't have to cooperate with states, and they don't have to put into that database. Okay, finally the question.

How do you count a fatality? Because of the jurisdictions, if it's a homicide the feds are going to get involved, not the state, and not the county. It'll be an investigation by the Federal Bureau of Investigation. So how do you count, and how do you know?

Hill [03:54:53]: The Seminole tribe works, again even in law enforcement, with the state of Florida, closely. And we just talked about the feds coming in and they said that they can't remember when that's happened. So the feds don't usually come to the Seminole tribe for whatever reason, but the law enforcement, they do work closely with the state of Florida, so that's how something would be. Now child fatalities, this was when I was coming to talk about this, I thought, "Well geez, we don't really talk about child fatalities." And you know any fatalities that have happened, I don't know that there's, of course there's been an investigation, however I think they've all been ruled as an accident.

Zimmerman [03:55:46]: Do you think that has to do with the culture?

Hill [03:55:51]: Well when the investigation is done, usually by, well, DCF does the abuse and neglect investigation, and there may be some that had some indicators of probably neglect. I would say that neglect is the biggest issue, you don't see a lot of actual physical abuse, it's mostly neglect.

I could probably, in the past nine years that I've been there, there are probably that I'm aware of maybe six or seven child fatalities over that time. A couple of them have been for medical reasons, so there was really no finding of any type neglect or abuse, probably most of them have been drowning, which there probably could have been some form of neglect found. Part of it probably is cultural, now that I'm thinking about it, because there are some issues with surrounding death in the Seminole tribe, and access to people to be able to investigate, so I think that does affect how intense the investigation actually is.

Dr. Sanders [03:57:07]: I think we have one more question that we'll be able to get in. Commissioner Horn.

Horn [03:57:11]: First of all, I want to thank you also for sharing this perspective, it's often overlooked, unfortunately, in child welfare. You describe a situation where it sounds like you have a very good working relationship with the child welfare system and the agencies here in Florida.

Unfortunately, that's not universally the case across the country with federally recognized tribes, and as I understand it under the law, federally recognized tribes are supposed to be treated as sovereign nations. So I have two legal questions I just don't know the answers to. If a child is a member of a federally recognized tribe and there's a report of abuse or neglect, who owns the case? Who has jurisdiction? Is it the state, or is it the tribe? And then the second question has to do with information sharing. To what extent are you able to share information with child welfare agencies? And is that dictated by federal law or is that dictated by each tribe's own policies and the way that it administers itself?

Hill [03:58:19]: First question, as to jurisdiction, it depends on where the child lives. If the child lives on a reservation the tribe has jurisdiction over that case, that child. If the child lives off the reservation, jurisdiction would fall within the state. Once a case goes into court, if there's going to be an open child neglect case or something in the court, a tribe can then transfer jurisdiction, but initial jurisdiction falls within the state.

Now, for the Seminole tribe, because the tribe did not have a tribal court set up, they allowed the state or DCF to come on and to have jurisdiction over any type of child abuse or neglect investigation. That will change once the court is fully up and running.

The second question, we do have a good relationship with DCF; that has not always been the case. I will say that because the tribe has a lot of resources it allows, particularly me, to do a lot of advocacy. It takes a lot of work to keep that relationship. And that's because there's always changes going on, there's changes in staff, there's changes in administration, and you kind of have to start over again, with training about the tribe, about how we work together, so it's a nonstop job basically to keep that relationship going.

We've had no written agreement with the state of Florida, for a very long time it's been an informal agreement. We did actually just draft an agreement, actually it was probably about a year ago, unfortunately it's kind of at a standstill right now, but within that we do talk about information sharing. Because it was a concern on both sides about being able to share information, and we both agree that, looking at each other as government-to-government or like you would a state-to-state, that you are able to share information with each other about child abuse and neglect issues. So, that's part of that agreement, and that's because that has been a problem for some. Within the tribe, sharing information is a challenge even within the tribe, between our departments. We don't follow HIPAA to a "T"; tribes are able to come up with their own type of HIPAA, what it does is it mirrors it and it has to be approved.

The Seminole tribe has that, but it pretty much follows what HIPAA is, so it's always a problem that we're running into and that is a problem, I would say in these cases, being able to share information. I talked about our child protection team, our staffing, we're having that problem right now with people starting to question, "Well can we really share this

information that we're talking about in here." Although we have all signed confidentiality agreements.

Dr. Sanders [04:01:36]: Ms. Hill, I'm going to ask you to finish up because we're a little over our time. So thank you very much for the presentation, it was very informative.

Hill [04:01:45]: Thank you.

Dr. Sanders [04:01:47]: And we're at a time for a break and we will break until 12:55 and reconvene with a couple of hours on confidentiality. Thanks.

Lunch Break [04:02:00]

Sanders: [04:02:05] If Commissioners could take their seats, we are going to get ready and get started again for this afternoon. So we're going to start with this afternoon's initial presentation and the first half of this afternoon is really dedicated to a conversation. Opportunities for us to learn more about confidentiality. This is one of the issues that the Commission has decided to take on and we had some initial conversations in the last meeting but are devoting more time to it today. So we'll have our first presentation by Howard Davidson from the American Bar Association Center on Children and the Law, and he'll present on some of the legal issues. He'll present about 30 minutes, with 15 minutes of questions and answers. And then we'll have a panel on confidentiality, transparency, accountability in the media that will follow. So Howard?

Howard Davidson: [04:03:34] Thank you, Chairman Sanders and distinguished Commissioners. Thank you for the invitation to make this presentation. As you can tell from my bio for those who don't know me, I've been interested in the child fatality issue for a long, long time and have been privileged to have received funding to work in the area of child fatalities, actually decades ago now. I need to start with a disclaimer because I have a lot of recommendations and the views and the recommendations are my own and they don't reflect any official policies of the American Bar Association or any other organization that I may have been affiliated with. I believe you asked for this presentation because abused and neglected children may die if agencies and individuals don't promptly and thoroughly share information relevant to child safety. But also because after children die due to abuse and neglect, critical system improvement may not occur without meaningful public access to the child protective system's past involvement with the dead child's family.

Doctors Putnam and Barth talked this morning about sharing data, and I think that's very critical. I'm going to talk, as the title slide indicates, about sharing of information. That will be the focus. Although I will talk about both after children die as well as before children die. I am not going to go through this right now. First of all, this is a very complex issue and I have

to go through this very, very quickly and for those who know me are aware of what a challenge it is to go through this kind of material very quickly, but I will do my best. This is a timeline of events. Key milestones on the issue of child protection information-sharing, and I will be talking about each of these in the next 30 minutes. What this shows is a pendulum that swings back and forth between privacy and information access. Again, all this will be covered.

I want to start the presentation with the issue of release of records and information after a fatality or near fatality. As you probably know, in 1996, CAPTA was amended to address this issue of post-death public release. Public access to CPS records has been a focus of investigative journalism prior to 1996; for example, Jane Hansen of the *Atlanta Journal-Constitution* was a Pulitzer finalist in 1990 for a series of stories on child abuse and neglect deaths in Georgia. In that tradition is Carol [Marbin] Miller and her colleagues for the *Miami Herald*. But 1995/96 was an interesting period because in 1995 there was a very well-publicized death of a child in New York City by the name of Elisa Izquierdo. It led to the mayor completely revamping the child welfare system in New York City, but it also brought national attention to the secrecy of CPS records, and in early 1996, to my knowledge, the first major state law addressing public access to child protective information occurred. I will talk a little more about that.

So in 1996 CAPTA was amended by Congress to authorize release, allowing for public disclosure of findings or information held by child protective services. It's notable that Congress didn't say, "you are required to release." It left open whether releases were only to be done upon a request. It didn't specify what was meant by "findings." What was meant by "information." What the use of the word "or" meant. Interestingly enough, there were CAPTA confidentiality regulations. They were actually issued when CAPTA was first enacted in 1974. So it preceded the 1996 amendments, but the regulations were never changed after this 1996 amendment to CAPTA, because HHS in its wisdom decided after 1990 to my knowledge on CAPTA not to do regulations but to do something called "Policy Interpretation Questions" or PIQs. To address policy in a series of questions and answers that form something called the Child Welfare Policy Manual. So the regulations are still out there. They are codified in the Code of Federal Regulations, but what essentially now has followed them is this Child Welfare Policy Manual with a series of questions and answers.

So the most important policy interpretation question was in September of 2012, and I'll get to that in a moment. But before then the policy interpretation questions from the Children's Bureau had clarified what is meant by a "near fatality" and you see the list, I won't go through it. But one of the things that wasn't really adequately addressed was, what information must a child welfare agency release upon a request by the media or others after a fatality or near fatality. So, significantly, here's what HHS said in September 2012 has to be released. I'll comment on this list of 1-6 by saying it's very interesting to me that it talks about releasing information pertinent to the abuse and neglect that led to the fatality or near fatality and they can release information about services on behalf of the child who died or near fatality, doesn't seem to cover any past involvement with other children in the family.

Now I don't know how states are interpreting this. How much this policy in the Child Welfare Policy Manual is being followed.

It's notable that in 2010, in what is the last of reauthorization of CAPTA there—it's the last bulletin in the case, the authorized committee stated they were aware that not all states were in compliance with the disclosure requirement. So it called upon the Department of Health and Human Services to "develop clear guidelines in the form of regulations" instructing states of their responsibilities to release so that they could provide technical assistance based on full disclosure procedures. I'm not aware of any regulations that have been promulgated since that set of report language. Nor am I aware of any specific technical assistance program from the Children's Bureau on helping states with the disclosure. I certainly want to mention, as the Secretary indicated, there's a new Florida law in 2014, Chapter 2014-224, which has a provision specifying five things that must be disclosed after a child dies and requiring child death information to be posted on the child welfare agency's website. So that is a good advance on that issue.

I'm not going to get into this because there isn't time. I assume you know about the Government Accountability Office report, "Child Maltreatment: Strengthening National Data on Child Fatalities [Could Aid in] Prevention," and you'll note at the bottom of the slide the congressional response, which is just now beginning to have an impact, hopefully, because as of 2012 all state child welfare state plans must describe the sources that they are using to compile accurate data on child maltreatment deaths. And to the extent that they are not using vital statistics, review team, law enforcement, medical examiner—not using that data, they have to describe why they are not using that data and how they're going to later incorporate it. So hopefully there will be effective implementation and oversight over that important state plan requirement.

Now in 2008 and then again in 2012 the Children's Advocacy Institute of the University of San Diego School of Law issued the report, which I'm assuming most of the Commissioners are aware, called "State Secrecy and Child Deaths in the U.S." The subtitle is, "An Evaluation of CAPTA-Mandated Public Disclosure Policies About Child Abuse and Neglect Fatalities or Near Fatalities, with State Rankings." So this is in a sense a report card on how the states have been doing on public disclosure, and as the slide indicates, for the most recent report 10 states got A grades, that's up from six in 2008. Four states got D or F grades, that's down from 12 in 2008. It's a really informative report about public release of information.

Many of the states have in their sections something called "illuminating information," on details about state compliance with disclosure. But I want to mention that there are some things that were not grading criteria. I find these additional elements, things that I think would be in a good state law related to disclosure. This is in the bottom of the slide. Requiring publication/dissemination of recommendations made in the child death review process. Mandating that states collect and report on aggregate fatality data and related CPS information—Michigan did that in 2011 law—and finally, assuring us that a state summary of

fatality reports would be posted on the Internet. Again, I am very impressed with what Florida has done so far in its implementation of this child fatality website.

I now want to shift focus from post-death secrecy to post-abuse and neglect report information-sharing to prevent future harm to children. The original Child Abuse Prevention and Treatment Act of 1974 had a very clear focus on keeping records private. To preserve the confidentiality of all records in order to protect the rights of the child and the child's parents. Obviously it's an incredible stigma to have public disclosure. To have any kind of disclosure outside of the agency that you've been the subject of an abuse and neglect report. So I certainly understand that but, there was concern over the years that that strict confidentiality, I'll say more about that, that that could endanger kids. So in 2003, CAPTA was amended to require that states have provisions mandating disclosure of confidential information to any government entity with "a need for such information in order to carry out its responsibilities under the law to protect children from child abuse and neglect."

Some states go further. There's a Kansas law cited which calls for freely exchanging information. It is interesting to me on this "let's share information to protect children" that in the HHS policy interpretation questions on CAPTA, confidentiality interpretations, none address this 2003 requirement which, I think, really challenges states about when we can share, how can we share. And moreover the old regulations are still out there. The 45 CFR regulations, which also have a provision that says that states have to criminalize disclosures that lack state law authority. And I believe that may have inhibited full implementation of the 2003 mandatory disclosure provision, because there's this regulation that says if there is no state law that clearly authorizes the release of the information, you have to make it a criminal offense to release that information.

So, I believe we need to improve state laws on both permissible and mandatory disclosures. The CFR, the regulations have a list way back prior to 1990 of permissible, of disclosures if authorized by state law, but that was last amended in 1990. A lot of things have happened in this field since 1990. For example, the regulations on what is a permissible disclosure don't say anything about licensing agencies, children's advocacy centers, cross-reporting on animal criminal cruelty cases, which I've done some work on. Reporting to protective agencies for persons with disabilities or older adults. Reporting to the military or the tribes. Reporting of domestic violence to appropriate authorities and checking records for civil orders of protection. None of this is covered in the regulation. None of this is covered in the policy interpretation questions.

Now CPS information can be disclosed, according to CAPTA and the regulations, if there is a relevant state law that you can release information to "properly constituted authorities" and their designated multidisciplinary case consultation teams. Thank goodness for that language because of the wonderful stuff that Florida is doing. But those terms unfortunately have never been defined in either the Code of Federal Regulations or in the PIQs. The same is true with release to physicians. The law says that information can be released to physicians if they have a suspected victim before them. What if instead of diagnosing abuse of a child before

them, they are after substantiation or doing diagnostic or treatment work with the child? What about CPS disclosures and mental health professionals and school personnel doing therapeutic interventions with a child? What about disclosure to probation officers supervising offenders? There is no clarity on these disclosures.

Here are some other vague areas. Although it is permissible to release CPS information assuming state law so specifies, to properly constituted agencies authorized to diagnose, care for, treat, or supervise a child, this hasn't been clarified. It doesn't include schools. It doesn't include private agencies providing foster and group care. It doesn't apply to CASA programs, medical examiners, juvenile justice agencies … there is need for more clarification. The same thing with the language about who: released to people "legally authorized to place a child in protective custody." That's vague. The regulations are not being revised since the federal law under CAPTA. The CAPTA amendment that mandated that CPS information-release for employment and licensing, screening, and the regulations haven't changed since CAPTA was changed to mandate release of CPS information to review panels. So again, I'm calling for, suggesting the need for more clarification and helping the states by HHS and other oversight mechanisms.

I believe it's critical that state laws mandate feedback to reporters. It's especially important for doctors, teachers, police, and other professionals. Sharing information across states is critical. There are a bunch of states that actually have laws that permit CPS information disclosures other than in a fatality or near fatality case. The motivator of this was actually Elisa's Law in New York, which permits disclosure as long as the Commissioner finds that disclosure is not contrary to the best interest of the child, the child's siblings, or other children in the home. Disclosures to the public before a child dies is very important to help the public understand how the child protective system operates. It's shouldn't just be limited to after a child dies. I like those statutes, which is why I listed the states on the slide.

There should also be an explicit legal authority for public release of information about children missing from foster care. Florida has been a leader on this. It shouldn't just be when children are missing from foster care. If you're missing from foster care, group care, or even missing in homes where they are under protective supervision. The worker goes to a home and the child is not there and you can't get information about the child. There should be a mandate for this kind of sharing information. Some of this is actually going to be covered in a bill that's getting through Congress and will be signed into law, hopefully soon.

Improving immunity protection. We were privileged to write a report for HHS, a congressionally mandated report on the issue of immunity and liability for professionals who assist child protective service agencies. The question is, if there's fear of liability does that inhibit professional cooperation with child protective services. So you should have this broad protection for doctors, pediatricians, and others who are working with child protection beyond the reporting, which has always been protected.

Consent forms. There needs to be clearly understandable consent/release of information forms that permit release. One way you can assure that information is shared adequately, is if the parents consent to release for that information. So that needs to be addressed. The use of unsubstantiated reports. This is an issue that was talked about this morning. Reports come in but they are not substantiated but you want to be able to use and access that information. Well unfortunately, some states I believe are misapplying what CAPTA says, to limit the use of unsubstantiated reports of abuse and neglect. Cross-reporting, police/CPS, CPS/police, that is critical and allowing information to be released at family team meetings, which New Jersey permits.

I want to say something about the Adam Walsh Child Protection and Safety Act of 2006, which has a lot of provisions related to child protection and criminal background screenings. But it has a very important provision that has been implemented. Florida was the first state to implement it actually, in which record checks on adults in the home can be made during an investigation, especially important after substantiation or prior to reunifying a child in the home, so workers will be aware of adults with violent criminal histories that may endanger children. Well this is really important because Adam Walsh gave authority to child welfare agencies to have FBI terminals in the child welfare agency office to do instant background checks on adults. Florida—and I checked with the Secretary that this is still going on in Florida—Florida was the first state to get authority. There are a number of other states that got authority to do this. I think this is a very important thing. Philadelphia, the Department of Human Services in Philadelphia has been doing this for a couple of years. How can you address child safety after a child has been substantiated for abuse and neglect and even before, how can you fully address child safety without knowing about the criminal histories of adults who are frequenting the home? I'm not for violating anyone's civil rights here. This is just important child protection-related information.

I don't have time to get into HIPAA and FERPA and the confidentiality of substance abuse treatment records. I'm surprised there isn't more out there from HHS on the connection between HIPAA and child protection. I wrote a short paper in 2003. Everybody asked for that paper because there's nothing much out there on the application of HIPAA to child protection, and I can make that paper available to the team.

FERPA, what's really interesting to me is the middle bullet. We were involved in this Uninterrupted Scholars Act, which is very important in terms of accessing school records. Abused and neglected children, one of the things you should be looking at to know they are safe is, are they going to school? Are they in school? Are they absent from school? It's important to know that FERPA has always allowed release of what is called directory information. Dates of a student's attendance, so CPS can check without any violation of FERPA whether a child known to them has been chronically truant or absent. But as the slide says, what about a home schooled child? Well, some of you from D.C. know that there was a horrible child death case in 2000, Brianna Blackmond, that involved a parent with past and present CPS involvement who said their child was being home schooled. The agency couldn't get access to the child and the child was found dead and I should note that Sari Horwitz and

her colleagues from the *Washington Post* won the first Pulitzer Prize actually awarded for coverage of child death issues in 1992 for reporting on this case and over 200 other child death cases. So I think we need to do something to make sure that child protective services is getting school information about whether kids are in school and if they're not in school, if they're being home schooled some sort of check that that child is okay.

This is a very complex issue, access to alcohol and drug treatment records. If a drug and alcohol treatment program receives federal assistance there are very strict confidentiality requirements that can inhibit child protection from getting those records.

And to wrap up, I want to make six additional recommendations. The first, Teri Covington does great work in this, but I think the Department of Health and Human Services should be adequately funded to take all the child fatality and near fatality review information and consolidate it, organize it by topic, report on it for national dissemination, and then follow up on adequacy of implementation on those recommendations. That should be a federal law.

Secondly, that the Children's Bureau should work with their counterparts in HHS to address privacy and record access issues, to produce and disseminate materials and models for informed parental consent form language. For interagency data sharing and agreements. There's some innovative stuff that's in the GAO reports about Allegheny County in Pennsylvania and data sharing. There needs to be HHS active involvement in promoting innovative information sharing for child protective purposes including data exchange, warehouse processes to make that information available right out of that 2013 GAO report.

Finally for suggested changes to CAPTA. The Child Abuse Prevention and Treatment Act is up for reauthorization in 2015. So during the life of this Commission, this important federal law will be up for renewal. Now, you may know that the amount of money under CAPTA that goes to the states is about $26 million divided up among the states. Some big states like California get millions, others less. It's a tiny amount of money. Compare that to the federal money per year for foster care and adoption and guardianship assistance, which is $4 to $6 billion a year in federal money. There has been some discussion here about the underfunding of the front-end of the child protection system. The lack of adequate federal funding to support states in doing appropriate investigations and safety assessments, so somehow we are out of whack. We are out of balance. This is more than a finance reform issue. When they talk about finance reform it's title IV-B and IV-E and kind of adjusting that balance. But this is this tiny amount of money for the upfront child protection system. The basic system of child safety that we have, and it's so drastically underfunded.

So the number three recommendation is amend [CAPTA] and provide and have new state laws, and also do this targeted financial support for maintaining effective state and local multidisciplinary child protection teams that address child abuse and neglect, including child death review teams. Possibly have the federal money be a match for state dollars. So the state would invest in doing what Florida has done with the child protection teams.

Number four: CAPTA, I suggest, should be amended to tie states receiving CAPTA title II, which is the prevention part of CAPTA, tie that money to an independent careful review and implementation of the findings and recommendations of fatality and near-fatality review teams.

Number five, CAPTA and state child abuse and neglect laws should be amended to give explicit authority to CPS to subpoena the production of documents, records, and other materials deemed relevant to an investigation of child abuse and neglect. To give CPS clear authority to get the information it needs to protect children.

And finally, CAPTA, HHS, and state laws should provide a mandate to promptly share an agency's, organization's, or even an individual's information with other agencies and professionals that are engaged in work to protect children. There is no legitimate reason for keeping information away from those who have a legal responsibility under the law to protect children. That involves both child protective services and law enforcement. It is the failure, as my opening slide indicated, of sharing adequate information in a timely way that can contribute to the fatalities and near fatalities of children. Thank you.

Dr. Sanders: [04:33:37] Thank you, Howard. We have about 10 or 15 minutes for questions. Commissioner Petit, Commissioner Rubin.

Petit: **[04:34:43]** One question that I have. You didn't seem to mention legislatures. Like a legislative panel that's looking into the laws of governing child abuse and neglect. And also, the press? In terms of when to release information to the press. I don't think you covered those two.

Davidson: **[04:34:04]** Well, I started with talking about the 1996 law about release of information after a child dies and how there has been insufficient guidance in my view, and the guidance that was issued by the Department of Health and Human Services in 2012 was very limited in terms of saying, "here is what you have to release." At least the Children's Bureau said, "Here is what you have to release." At least they finally did that. It took six years after the CAPTA amendment for the Children's Bureau to clearly say here is what you have to release. But if you read the state secrecy report, you will see that states, and certainly as of 2012, are all over the map in the ability of the media and others to get information after a child dies.

Petit: **[04:34:55]** Follow-up question. Is the ability for the legislature that you received this information.

Davidson: **[04:35:05]** Oh, for the legislature?

Petit: **[04:35:07]** Yeah, for a legislative committee. Someone was complaining about a kid and the lawmaker would come in and we'd say, "We can't share the information." So has the press been suing states on this and has anybody brought -

Davidson: **[04:35:19]** The states have, but I have not been following that litigation. It's very possible that somebody on the panel will know of that litigation. I seem to recall that litigation in a number of states, for the media suing to get access.

Petit: **[04:35:34]** It sounds like there isn't much enforcement on the federal side of the laws and regulations. They are out there, but they are not being necessarily enforced?

Davidson: **[04:35:44]** I'm not aware of enforcement in a way that would be helpful to the states. Other than that 2012 policy interpretation question answer that says, "Here, at a minimum, is what you have to release when a child dies."

Dr. Sanders: [04:36:01] Commissioner Rubin.

Dr. Rubin: **[04:36:03]** Thank you. I guess the question, we had a focus this morning on predictive analytics about earlier intervention. I think if you think on the public health side, there is a huge focus right now on adverse childhood experiences. If we could measure them in primary care, then we could potentially respond and actually provide more holistic care to a family of a child at risk. Theoretically, in a world where we could have that information shared sensitively, particularly CPS, the history of a parent and/or their child so we understand the nature of the risk that we're dealing with as providers. If the health commissioner was going to get that on all new births, what would it take? What would it take for a primary care provider to have that information available to them just like they have through the immunization registry?

Davidson: **[04:36:57]** I am not prepared to give you a good answer on this predictive stuff.

Dr. Rubin: **[04:37:02]** It's not the predictive stuff. I'm asking what would it take from a legal perspective to share the information with the health commissioner, the public health department, or an individual primary care provider who's assigned through the Medicaid program for a child to be able to know when that child comes in, not that I'm going to report them, but to know that this child's family has had a few CPS reports.

Davidson: **[04:37:23]** Obviously state legislatures can clarify what's permissible or what's mandatory in terms of providing that information.

Dr. Rubin: **[04:37:31]** So it's a state versus a federal? Do you think this is more of a state strategy?

Davidson: **[04:37:35]** I think it's a state strategy, but I think CAPTA has to be clearer about what's mandated and what states have the authority to do, because I don't think states want to lose their CAPTA funding. That being said, there is certainly, I believe that there is a lot of noncompliance with CAPTA. The money is so small, I'm not aware of any state in recent years that have been held to be out of compliance with CAPTA. A few years ago there was a couple of states, including Pennsylvania, that lost CAPTA money because of language and state law and so forth. I know no state on this issue that's lost CAPTA funding for either something that they have or haven't done in terms of disclosures.

Dr. Rubin: **[04:38:15]** The amendment to the HIPAA law? It's not HIPAA because it's child protective services.

Davidson : **[04:38:21]** It's child protective services information; it is not protected health information. But coming the other way, obviously, it is protected health information. And one of the reasons I talked about the importance of having adequate model release of information forms, consent forms, informed consents for parents, because parents could give consent to the release of their health information. They just shouldn't be coerced into doing that. It should be a freely, voluntarily given consent.

Dr. Sanders: [04:41:07] Commissioner Covington.

Covington: **[04:38:55]** What is your humble opinion because to me the elephant in the room—I get a phone a call a week from either the public, the press, or an agency about my own opinion about what should be shared to the public through the press or directly to the public in the event of a child's death from agency records. What do you think should be shared and what shouldn't be shared, and what are the reasons for or not?

Davidson: **[04:39:23]** I wish I had a good answer. When I looked at what the Children's Bureau said in 2012 you have to release, it struck me that it didn't include history with a family that involved other children. And I thought, "well that doesn't make sense." You want to know the full history of child protective services involvement with that family, not just things that are relevant to the child who died. But as I read that language and I don't know if you would give it the same interpretation, but as I read that language it can restrict states from giving out more information. Although it does say at a minimum, "Give out this." But I think the states will take that 2012 policy from the Child Welfare Policy Manual, they will take that and that will be what they say they will release because HHS said that's what you have to release.

Covington: **[04:40:19]** But if you look at the 2012 information, it's really hard to decipher to whether they are talking about identifiable information or information that can't be tied to a specific child in that family.

Davidson: **[04:40:31]** Clearly the states are hungry for more information and guidance, and that's what the U.S. Senate said in the 2010 reauthorization. I think one response to what the Senate did in 2010 was the release of that policy interpretation in 2012, but I don't think it went far enough to help CPS agencies and the media clearly understand what can be released without violating federal law.

Dr. Sanders: [04:41:07] Commissioner Martin.

Martin: **[04:41:09]** My question is politically incorrect and I confess that upfront, but people are often talking with me about opening, our courts are confidential in Illinois, and they constantly have this issue with me about opening my courts. They always say because giving more transparency will protect kids. So tell me and explain to me how opening the court and

giving everybody access to the identity of my kids and my families are going to protect the kid I have in care?

Davidson: **[04:41:47]** That's a really good point. It's why I personally I have had very mixed feelings about open court. And as you know there are judges who are very passionate about this issue about having their court be open and they have even found themselves in litigation over opening the court. CAPTA was amended a few years ago, and title IV-B, title IV-E was amended to specifically say that you are not violating CAPTA or IV-B or IV-E if the dependency courts are open. It always should be an option to close them, even if they are presumptively open. Any attorney should be able to object to that. In particular, the child's attorney or guardian. And this is my chance to say we are in a state that I've said wonderful things about Florida, it's doing great stuff. I heard great stuff this morning. This is the state with the largest number of foster children in the United States who never see an attorney throughout their stay in foster care because there is no statutory right to an attorney for children in the foster care system in Florida. It's a wonderful guardian program in Florida, but most kids never see a lawyer to protect their legal rights and legal interests in Florida. I have no solution to this problem if you're open or not. It can be misused and it could result in nothing happening at all.

Martin: **[04:43:16]** But how does that protect the child I have and take into … this morning. If in fact my court is open, if in fact anyone and everyone can get information from my court and can review health records.

Davidson: **[04:43:30]** That's a different issue, reviewing the records. You may have the right to sit there and listen to the proceedings but to actually see court records I think is a very much a separate issue. I don't think anybody has the right to do that. Your court records are very, very private. I believe. Just pick a system where the judge feels this case should be open. I'm sure he doesn't allow the media to go through case files from the court.

Martin: **[04:44:02]** And I'm just the opposite. So my court is presumptively closed, but the media, once they come and have a conversation with me, which is basically through a form, and they agree not to report the identity of my kid and my family, I will allow them to go through the court record accept the impounded part, which is typically the medical health stuff.

Davidson: **[04:44:23]** And an agreement not to disclose the identity of the child or the child's siblings, or even the name of the parents.

Sanders: [04:44:31] Commissioner Martin, I think this next panel is the very issue that is going to be debated and it seems like there will be people with positions on both sides of this issue. The next panel might be a question to also ask them.

Martin: **[04:44:46]** Thank you.

Dr. Sanders: [04:44:49] Commissioner Bevan then Commissioner Horn. Those are the last two comments we'll take.

Dr. Bevan: **[04:44:53]** I was just looking at the Gateway information service. As of 2013, only four states allowed parents to get information on a babysitter they want to hire. In terms of background information. Child abuse and neglect information.

Davidson: **[04:45:13]** I'm not prepared to address that.

Dr. Bevan: **[04:45:15]** My question is, who are we protecting? It's the child protection system. Who's the client? The client is the child. Correct? So if the child is the client and the child dies, where is the confidentiality?

Davidson: **[04:45:31]** I understand. There are still interests clearly in the surviving siblings and their privacy. The privacy of nonperpetrating parents. I mean, there are privacy interests that should survive the dead child, but there is also a public interest. A public purpose into disclosure of information. I mean that's why Congress in 1996 added that provision. They didn't make it clear enough, and it's resulted in states being all over the map, but it clearly, there is a legitimate media interest in having information. I've been asked this question: Does that mean we have to open our entire CPS and child welfare agency case file? And I have said there is nothing in the law that says that. And I don't see anybody proposing that when a child dies it's open season on anything in the child welfare agency case file.

Dr. Sanders: [04:46:37] Last comment from Commissioner Horn.

Dr. Horn: **[04:46:40]** Good to see you again, Howard. So you made brief mention of the fact that the CAPTA statute requires states to criminalize disclosure.

Davidson: **[04:46:50]** It's in the regulations.

Dr. Horn: **[04:46:52]** It's in the regulations. So, it would still exist and has not been superseded?

Davidson: **[04:46:58]** To my knowledge it's still in the CFRs. It's still there.

Dr. Horn: **[04:47:02]** So it seems to me that there may be good reasons for that. But the down side to criminalizing disclosure is that if I'm a caseworker and I start out my career, the last thing I want to do is go to jail for my job. So I'm going to just shut down in sharing information if any disclosure is actually a violation of a criminal statute.

Davidson: **[04:47:27]** I understand and I want to be clear. It's disclosures that are not specifically authorized by law, which is very tricky language because what does a social worker know about what's authorized by law and what's not authorized by law. But having that revision I would probably put in there so that social workers don't talk at cocktail parties about their cases.

Dr. Horn [04:47:50] But you've also said about the PIQs are fussy about what you can disclose and what you can't disclose, and so in the absence of clarity with a criminal statute facing someone, staring someone in the face, you just don't disclose anything.

Davidson: **[04:48:08]** I think so. I have no empirical evidence on what impact any of these regs or policy interpretation questions are, if the statutory language in CAPTA, there is no empirical evidence because nobody studied this on what impact it really has.

Dr. Horn: **[04:48:26]** Knowing all of that, and all those caveats, knowing that, would you recommend that HHS revisit the idea of criminalizing disclosures? And maybe having a lesser standard for lesser consequences.

Davidson: **[04:48:42]** I'm not sure I would do away entirely with criminalizing disclosures. This is very sensitive stuff for things that have nothing to do with protecting children. I mean, there's a really good reason to keep this information private except for those with a need to know. And those with a need to know should be able to get that information.

Dr. Horn: **[04:49:04]** In the regulations is there any caveats to that? Does it have to be malicious?

Davidson: **[04:49:10]** I don't think so. I have the regulations. Let me look real quick.

Dr. Horn: **[04:49:19]** I'm just telling you as a former frontline caseworker. I just shut down. In the absence of clarity, you don't share anything.

Davidson: **[04:49:28]** So the language is "the state must provide by statute that all records concerning reports and reports of child abuse and neglect are confidential and unauthorized disclosure are a criminal offense." But then it says, "if the state chooses, it may be authorized by statute disclosure," and then it gives a list. A very short list that doesn't include things like children's advocacy centers and the things I talked about.

Dr. Sanders: [04:49:53] Howard, we're going to have to finish.

Davidson: **[04:50:01]** I'm giving you the lawyer's response to this question.

Dr. Sanders: [04:50:06] Thank you very much. That really is a great overview and leads us into a good panel discussion. I think you'll be available for questions.

Davidson: **[04:50:16]** I certainly am available. I'm not going anywhere. If I can be helpful in anything that comes up with the panel.

Sanders: [04:50:24] Thank you. So we have Representative Gayle Harrell, Judge Katherine Essrig, John Jackson, Carol Marbin Miller. John Jackson is from the Department. Carol Marbin Miller of the *Miami Herald*, who did the series that many of us have read, and Curtis Krueger from the *Tampa Bay Times*. They are going to each present about 10 minutes. We'll have about 20 minutes for questions on Confidentiality, Transparency, Accountability, and the

Media. Do we have somebody going first? Okay, we'll start with Representative Harrell and you have about 10 minutes. Thank you very much.

Rep. Gayle Harrell: **[04:51:15]** Thank you very much and first of all I want to thank you for coming to Florida. We are delighted to have you here in the Sunshine State, and I hope you go shopping while you're here because we are a sales tax state with no state income tax. So go shopping. Enjoy our beaches and have a wonderful time while you are here. I am really very thrilled to be with you today. I am Chairman of the Healthy Families Committee in the state of Florida and we passed some major legislation this year that really is going to shine the beautiful sunshine of Florida even more and provide even more transparency for what is going on within our child welfare system. It's not without some really in-depth thought of being the balance between transparency and confidentiality. You have a major conflict here, and for me you always have to put the child at the center of that. As you look at what is the appropriate balance between total transparency, where your courtroom is open, anyone can come in and read any record they want, versus total confidentiality, where at what point do you protect the child's interest.

We are talking about child deaths here, but we also have many cases that don't involve child deaths that also come to the media's attention, come to us, as legislatures, come to our attention, and we are balancing that act between the rights of the child, the rights of other children in that family to their privacy, their confidentiality, and these are constitutional rights versus the need to know, and the balance of the media and the elected officials to know. So we are walking a tightrope, there is no doubt about it, and you have CAPTA out there that puts very specific requirements on states. I have to say I think Florida has been in the forefront of really providing a great deal of transparency. I just saw the report today for the first time, and Florida got a B+ on the report. As an old-school teacher I've got to say, I am in it for the A. We're going to make an A out of this. I think we've taken some significant steps this year in moving us to the A grade, and that's the goal. We established child death review teams years ago, and this year we broadened that to make sure that all child deaths are reported. Part of the confusion you've heard, and you'll hear from the wonderful work that the *Miami Herald* has done in their investigative reporting, and I have to thank them for the job that they did do on that, that various things come to light. That is the sunshine that is really the goal, is to make sure people know what's going on is transformative. It helps move things along.

We made sure that all deaths that come through the hotline are part of that child death review committee process. And that looks at things from more of an epidemiological point of view. To really decide what is happening across the state, and it involves any death now that is going to be there. Part of the problem has been confusion down on the ground level as to, is it verified before, is it not verified, how do you put that in the system … and there's been some systemic problems on how things get into the system, and I hope with our new law, with the training that will come as part of that, that there will no longer be that confusion. We as state legislatures can make appropriate decisions based on accurate information, and we have that transparency.

Also I think another step we took forward, major step this year, is the Critical Incident Rapid Response Team that we are putting in place. This is for child deaths, but also the Department and the Secretary can say if there is a critical incident or near death or something that really they want to have that Rapid Response Team come in and take a very clear look at. That has to start within two days. I mean we want to know right away what's going on, and they have to have a preliminary report out within 30 days. And that will have to appear on the new website that has just been instituted as part of that statutory reform that we did this year. We want to make sure that again the transparency is there.

The purpose of the Rapid Response Team is really to look at root causes and do a root cause analysis. It's not the overview, the epidemiological view that the State Child Death Review Committee is doing, but this is down on the ground, looking at what happened and then reporting out to us what that root cause is and what is going on. What is systemically wrong within our system so that we can, especially in the legislative level, make appropriate changes in our law that are going to address that. And the department and our CBCs, because we have a privatized system here in the state of Florida that our communities, which I think are so much a part of being this team effort in addressing child deaths and child abuse that they can make changes in their system. We can do it at the case management level with our CBCs. We can do it at the CPI level with our department in investigations. So we want to make sure we have that information as rapidly as possible.

When there is a final report they have to put that on the web as well. And I think it's very important that people look at that, they know it and that that's how we hold our department and our providers, our CBCs and our providers on the ground, that's how you hold people accountable. With that bright ray of sunshine and transparency that comes down and illuminates what is truly happening, all the while protecting the confidentiality when necessary, and there are sections that will be redacted, that will not be able to be part of that official record. The incident reports will be available on the website.

I hope you have a chance, the website is up and running now. Our law took effect the 1st of July, so we now have the website online, take a look, it really gives you by county and by state all the child deaths. You can look at what the category is. You can see a synopsis of the incident report and actually link to the incident report. I think this is a major step forward. The review teams are made up of people who come from outside the district in which the death took place. So we want to make sure that we don't have people who are part of the process doing the review. So they come from out of the district in order to be part of that, and there are five members on that team and they have to have experience in child welfare, in child investigations, or management experience, to make sure if it is a situation that we didn't have adequate systems in place from a management prospective, they can make recommendations on that. Their goal is to look at it, identify root causes, and make recommendations back to us.

Also, on our website—I'm very excited about the website, but we are restricting the amount of specific information to that child. Again, putting the child at the center, and you disclose

the date of the child's death, we're not putting names, siblings, families. The date of the child's death. Allegations of the cause of death, of the preliminary cause of death or the verified cause of death. So we're looking at allegations, we're looking of preliminary cause or a final verified cause of death. We also want to know the county and that's why we are doing it by county.

I'm going to be looking for the next year at revamping this law. I would very much like to see us do it by CBC district. So as part of the accountability that's necessary, we can look at our CBC districts and know what's going on with those districts as well. You have to put the name of the CBC, the case managing entity or the out-of-home licensing agency that's dealing with that child, if they were involved in our system. And also whether the child was subject to a previous investigation or a DCF hotline within the last year. Also, whether the child was younger than 5 years old. So I think we're on the right course. We've come a long way, baby. We have some more way to go, but we are definitely going to make sure we're doing that very careful balance between confidentiality and transparency. Thank you.

Dr. Sanders: [05:01:02] Thank you, Representative Harrell. Judge Essrig.

Judge Essrig: **[05:01:26]** Good afternoon. I too want to welcome you to Florida and to Tampa. I am a circuit court judge and I sit in the Dependency Division here in Tampa. You've heard so much, I've sat through the various presentations that started first thing this morning. And you've heard a lot about our system of care in Florida. Some of you already know, had some familiarity, some of you not so much. We are doing a lot of things well and I'm very proud to be a part of our system. We are far from perfect. We have a long way to go in many respects, but much of what we've shared with you is exciting. Much of it is new. You heard Representative Harrell talk about this sweeping overhaul of our child protection laws that was just made this session. It just went into effect nine days ago. I am not as well versed in it as I would like to be. It's brand-spanking new, but we are excited about many of the changes. I should tell you at the outset, much like my predecessor Howard Davidson, my comments here today are on my behalf only. I don't speak on behalf of any other judges. I don't speak on behalf of the judiciary as a whole. And I also chair our Model Courts Project and I don't speak on behalf of Model Courts either.

So my thoughts today are merely my thoughts, and I offer them to you. So we all know from having heard the earlier presentations, first of all Florida has a very complicated system of care. Systems of care generally tend to be layered and bureaucratic, as you know. Ours is even more so. We have a total privatization as you've heard. You heard much talk about CBCs, what we refer to as CBCs, our case management organizations. Our Department of Children and Family statewide contracts with these various entities in various circuits. The idea being that local groups and individuals understand their communities' needs better.

We are one of the few states that has been fully privatized, and it has worked well. I've been on the dependency bench for many years. My tenure predated privatization and it has postdated privatization. Much like it has predated and postdated our receipt of the waiver,

which we are most appreciative of. I can tell you how we've seen the difference from before we had the flexible use of those federal dollars and since we now have the use of flexibility in those federal dollars. So we are most appreciative and thank you for that and for reminding us of that.

So you've heard we had a number of, as many states have and as many communities have, we have had our share of tragedies and fatalities locally here, which as you heard now Secretary Carroll speak, and of course he was in our region here in Tampa prior to his being appointed as Secretary. We had nine children who died in a two-year period here, which was unheard of. I don't need to repeat, and I'm sure you'll hear from Carol Marbin Miller more about her series, "Innocents Lost," highlighted a six-year period in which there were 477 deaths here in the state of Florida, including some here in Tampa, but we're in that two-year period that I spoke of a moment ago.

There was a horribly gruesome death in South Florida. There were several, but there was one in particular which is well known to all of us who work in the state. The Nubia Barahona case. All of these things, tragic as they were, horrific as they were, avoidable as they were, have had a good result. It has caused us as a state, it has caused us as a community, I think it has caused us as a nation to really examine what we're doing well. What we are not doing well. How we can do things differently. What confidentiality and transparency mean in our system. And I'm very sensitive to confidentiality issues. I take them seriously. Yet I feel like transparency is so important, and we really need to ensure that when things do go awry and when our system is not doing what it should do, and when all of us, and it's not just the department and our local community-based care providers, it's all of us who are accountable and need to be accountable. The courts, the legislature, law enforcement, everybody, our child protection team, we all are accountable and need to be accountable and need to be able to honestly look our constituents in the eye and say, this is what happened: good, bad, or indifferent.

So, in large response but not solely in response to the *Miami Herald* series, our legislature this past session implemented a number of changes. This bill was unanimously passed in the Senate and the House, which is pretty impressive in my state, I don't know about yours. But now as you've heard and I don't want to go into too much detail because I only have a brief period of time. Now the Department of Children and Families must report when it fails children by listing the deaths of children under the age of 5, who have died from abuse or neglect, they must immediately review all reported child deaths, and as you've heard that's a change for us. All reported child deaths from abuse or neglect, not just verified deaths. They are to contract with a university think tank to oversee the department's death reviews. The reviews themselves, the child death reviews, there is a more thorough process that's required, and I don't want to bore you with all the details, but we have really dramatically changed how these things occur and what is being made public.

We've shifted our focus as a state and in our child welfare laws, from making family preservation paramount, now safety of children is paramount. You would think that that

would be so obvious, that it would have always been the case, but I'm sorry to report it wasn't. This new bill that you're hearing about also requires that we have our safety plans be robust. We have had a history, as many states have, of having safety plans that are not what I would consider to be truly safety plans and they are not worth the paper they are written on. So this will hopefully ensure that our safety plans, according to the law they are to be specific, sufficient, feasible and sustainable. Interpret that as you will, but the bottom line is that in order for there to be a safety plan now in a case, there must be provision of services adequate to ensure that the causes of the families' problems are being addressed.

The legislature, all due respect to Representative Harrell, was kind enough to provide additional funding to the state for additional child protective investigators, for our local community case providers, some money for substance abuse, expanded domestic violence and child welfare services. I don't think it was quite enough, again and Representative Harrell as you've heard is very well versed in these issues and very knowledgeable and has been a tremendous advocate, so I am not speaking of her personally, I can assure you. They have a history of mandating that we do certain things and not adequately funding it, and it's frustrating for all involved when that happens. So I think they have really made an effort. It could have gone a little further, but they've made an effort to fund the things that they require that we now do.

It goes further. I don't want to go into too much detail because I want to talk to you about a couple of other things. I do think, and again I don't want to read you the statutes, but I do think Florida has done a good job in balancing the transparency/confidentiality issues, and I'll just give you the statutory references. You may want to go back and review them when you have time to do so. It's our Florida statute 39.202 Section 1; 39.202, Subsection 2, Subsection 0. I think if you follow those carefully, if you want some more detail I'm happy to go into it later, but I think that Florida has done a good job of taking the CAPTA mandates and fashioning a statutory model that works.

So where do we go from here? You've heard I think we're doing certain things well. There's lots more that needs to be done here. What can you as a Commission do? First of all, I think that a two- or three-year commission is great, but you heard Dr. Alexander this morning. I don't want you all to do this work and gather this information and write a report and have it sit on a desk for the next 20 years. That doesn't help anyone. I would like to see this be an ongoing standing commission of some sort. Perhaps a different iteration. I don't mean to suggest that the 12 of you should have a lifetime tenure on this Commission but I do think, it's important to have ongoing input to the presidential administration and to Congress.

I think you all can really play a big role in centralizing much of what is going on in these silos. We do tend to have silos. We have silos within a state and I don't often disagree with what Secretary Carroll says publicly, but I disagree that those of us in Tampa, or at least me here in Tampa, doesn't care what goes on in Miami. I care greatly what goes on in Miami. I care greatly what goes on in Michigan and Texas and other states. I don't want a child who's in Tampa, even if they're on my caseload and even if it's a family that I've been overseeing, to

be treated any differently or any better or worse than any family or child in any other jurisdiction. I think you all can really do a great job of making much of these best practices and much of the guidance that you heard is lacking to states available, and I would leave it to great minds on your Commission to come up with the best approach to that, but I do think there are some easy ways of doing that, relatively easy, via a website, via ongoing updates with breakdowns by state as to what's being done well, and recommendations as to how we as states and communities can do better. So my time is up. Thank you.

Dr. Sanders: [05:12:53] Thank you, Judge. Next is John Jackson from DCF.

John Jackson: **[05:13:03]** Good afternoon. Like Commissioner Sanders said, my name is John Jackson. I am an attorney for the Florida's Department of Children and Families. That's Florida's child protective services, obviously. Throughout my presentation, I'm just going to refer to it as the Department because I'm going to do anything to preserve time. I'm going to go quick. I also want to thank you the Commission for addressing confidentiality and transparency. It's very important for the department, not simply because of recent developments or recent news stories, but it's also important for the department because we found over the past few years that transparency actually overall makes the department work better.

And transparency not only through the media, which is a very important part of transparency, and we consider the media our partners as well in getting the word out about issues, but also just in general getting the information out to others as well, including child advocacy groups who take long looks at information and data that we provide them and then bring it to the legislature as well. And of course the legislature themselves getting information from us when they need to draft legislation.

Florida is a great state for this Commission to come down and address this issue. Because Florida has had a history of openness both in open records, open meetings, just open government in general. I take issue with the B+. I personally think we are at very least an A-state, but I might be biased doing the work I do.

In Florida, it all starts with it open, records in particular. It starts as open, and then from that point it can only be held back from public release if the legislature specifically passes the law that makes it confidential or exempt from our public records law. It's not an easy thing to do. But that's where we start. We start with openness. And if there is ever any question about whether something should be open or not, the law says that we need to go in favor of openness. If there is any kind of a gray area, we need to go with openness. Laws also have to be construed narrowly. At least laws that otherwise would require information records, whatnot, to be held back. Now I think there are other states that are like that but I would argue that Florida system of openness transparency, open government is the best in the nation. I think my department, the Department of Children and Families, I think is a great example of that. There have been times in the past where maybe the department was not as open as we could have been. Certainly going back I can remember times 10, 11, and 12 years

ago, and there could be various reasons for that, all of which I think that you can probably imagine. Whether it be people in certain positions of the department were scared to let certain information go out. No one wanted to make us look bad on their watch. But of course, for the people that work, that have the boots on the ground so to speak, our actual child protection and caseworkers, the real professionals that do the real work, they have a very valid and sincere belief in protecting the privacy of their children, their clients. And that's something that we can't ignore.

Secretary Carroll talked about a tightrope that in Florida, between confidentiality and openness, the Department lives on the tightrope all the time, and it's not an easy job to do. And it's not easy for leaders like Secretary Carroll to provide all the openness that everyone's asked for but at the same time, you can't ignore the privacy of our clients. You can't choose one day to follow one law and the next day to follow another law. You have to find a way down the middle to do both, and it's not an easy job for anyone in this Department and certainly not for the leaders.

Still, over the years, certainly for the past eight years, we have tried our best to be as transparent as possible and get as much information out there as possible, because we know that it improves the system. It improves the department, it improves the lives of the people we serve. We know that. We've seen the proof of it. The public has more confidence in the Department and the leadership when we get the information out there. The public is better informed when the information is out there. So the public, who is a partner in all of this, knows what to look for. Knows what signs of abuse to look for. You name it, it helps.

Our elected leaders are more informed when the information gets out there. Lastly, we have better relations with all of our partners when the information is out there. The advocates that work so hard on behalf of our clients. The media that works so hard to get the information out there to the public, and others as well. Even our providers that we contract with, when the information is out there so they can make their own judgment on the information that's out there and do what they want or what they see as fit. So transparency helps everybody. It might be hard for the department or some of the people in the department, but so be it, we will carry that burden. Because the benefits that come from it are just undeniable and we've seen that.

It also affects prevention, as well. We are here talking about child fatalities, but if we're going to deal with child fatalities we would much rather deal with them I guess before they occur and keep them from occurring. And there is a direct impact between transparency and getting information out there and prevention in general. Because again, the public knows what we'll look for. The public also knows how to rate us in the work that we're doing when they know more about the work we do. The public can have input into whether or not we're taking the right course. Maybe we should try this way, maybe we should do that. Always into it. So it's very important, transparency. And I don't think you can deny that. When I first prepared my remarks for this panel, I was thinking in terms of CAPTA, and Mr. Davidson previously, he spoke about CAPTA and the laws dealing with specifically the confidentiality

provisions of CAPTA. To be honest with you, CAPTA is absolutely, positively no barrier to anything the Department does. The Department had gone so far beyond CAPTA that we don't even recognize so many of the confidentiality reasons for CAPTA anymore.

What CAPTA says states should or must release, this state has been well beyond that for years. Well beyond it. For instance, CAPTA does not require automatic release, it just says "by request." We do put information out there automatically anyway. Of course, you've heard it, many people speak about it, and the website that we're putting up right now based on legislation that was passed through a series of articles with information that was released from the Department. And the website requires even our legislature only put five or six different kinds of information on that website. Important information to get out there to the public about dead children. Not just verified deaths from abuse and neglect, *all* children who died and we investigated, whether or not it was from abuse or neglect. Because if we can't meet that bureaucratic level of deciding, okay it's a verified abuse or neglect death, that doesn't mean that there's no information, there's stuff to be learned from those deaths.

We put it out there, and my boss Secretary Carroll is going much further than that. He's putting out more than what the legislation requires. He's actually putting out death reviews. The actual death reviews online for people to read and see it themselves, and I would encourage you all to go in and read, it's a lot of reading. We have a lot of deaths unfortunately in Florida. Verified alone deaths could be 120 reports on there, but you learn from those reports. I've read so many of them in the past couple months it's terrifying, but you learn, and although we are not releasing the names of all children who have died because under our laws we cannot do that, but we are in those reports leaving in the names of the children who died from abuse and neglect.

CAPTA doesn't require that we release identities, but in cases where the child has died from abuse and neglect we think it's important that a name gets put with that death. And possibly maybe even a picture. It needs to have an identity. I believe that you were all passed out the "Innocents Lost" series that Ms. Marbin Miller did for the *Miami Herald*. It's a fantastic series and it had a lot of impact in this state. But let's be real about that. If Ms. Miller didn't have the names of many of those children or the pictures put up of those children, that would not have had much of an impact. You are all professionals and you work in this area of child protection somewhere. Some of you more than others. So without the names and without the pictures, okay granted, it could still be very valuable information to you and the people you work with. But to the public in general, even hearing that there was a child abuse death or seven child abuse deaths in Bay County and get some of the details of those deaths, okay that might have an impact. But you put a face and you put a name with it, and see it was an actual little person that died, that makes a big difference. CAPTA might not require that we get those identities out there, but the state of Florida does believe that people should have that information and it makes a difference.

So overall, in this state, transparency and accountability, it is a good thing and it has shown to be effective in this state. There is room for improvement though, and we are always trying

to improve. We are not always going to get it right. Including the Department itself, as far as what information we actually release. Sometimes we will not release information that we shouldn't have. We find out, we pull it back as much as we can, or quit doing so. And there are times when maybe we don't release as much information as we should, but we certainly in the recent times have been open to fixing that problem and getting it out there. Because again, we understand the value of getting that information out. And we work with our partners. It's not always a battle with the media. "You should give us this information." "No, we can't give you this information. We won't give you this information." No, we actually have a dialogue and we discuss it. And we have been talked into releasing information before that we shouldn't. We also have provisions that allow us to go to court, in the law, not just the Department but any person in the public can go to court and go to a judge, and if they can establish good cause for releasing this confidential information to the public, that avenue exists. The Department, for media, and everyone else.

Dr. Sanders: [05:23:42] Mr. Jackson. You need to wrap up.

Jackson: **[05:23:46]** So, thank you everyone for allowing me to get through the first page of my five-page presentation. And again, thank you.

Sanders: [05:23:57] Ms. Miller?

Carol Marbin Miller: **[05:24:06]** No one child had come to personify the challenges and failures of Florida's child protection system in recent years quite so much as Nubia Barahona. But before she became a tragic symbol, Nubia was a happy little girl with a radiant smile set off by blonde bangs and big hazel eyes. She smiled like a girl with her whole life ahead of her. Nubia was born to a drug-abusing former prostitute. Her father was jailed for improperly touching another child. Nubia and her twin brother were sent by the Department of Children and Families to live with Carmen and Jorge Barahona, a Miami couple that had already adopted two other youngsters.

The rest of Nubia's story is well known. On Valentine's Day in 2011, Nubia's decomposing body was found stuffed inside a black trash bag in the back of her adopted father's pest control truck along Interstate 95. She had been tortured, police said, beaten to death and soaked in a toxic stew of Pine-Sol, gasoline, liquid chlorine, chlorine tablets, and Drano. Nubia's torture and death led to a series of public hearings by an independent panel, a grand jury report, and new state laws that bore her name. Yet the 10-year-old was never counted among Florida's 2011 deaths by the statewide Child Abuse Death Review Committee. Nubia was not verified as an abuse fatality until April 28, 2014, a month after the *Miami Herald* published its series detailing the deaths of 477 children whose families were known to the state.

The newspaper had spent much of three years poring over DCF child death records. Limited and comprehensive death reviews, incident reports, emails, investigative summaries, case management files, and inspector general reports. One of our findings surprised us. Over a period of about five or six years, DCF had provided Florida's governor and legislature an

incomplete and artificially reduced count of the children whose lives were cut short by maltreatment. In 2008, the first year of our sample, DCF counted the deaths of 79 children whose families had a prior history with the agency or priors. But when we explored DCF's own records, the *Herald* counted 103. The next year DCF counted the deaths of 69 children whose parents had priors. We counted 107. Now before I go any further, I need to tell you why all this matters. The answer is very simple. You cannot fix what you will not acknowledge is broken.

Using tallies that our research shows presented significant undercounts of the loss of life, DCF had for several years resisted efforts to reform. Though news articles and broadcasts provided a glimpse into the carnage every day, official pronouncements insisted the problem was well in hand. This in turn gave cover to a variety of state actors who are invested in maintaining the status quo. Leaders who had convinced themselves that the path to long tenure sometimes lies not in improving efficiencies but in minimizing them. Lawmakers who have long insisted that it was not their role to rehabilitate troubled parents, other lawmakers who perceive the state's social service budget as bloated and unaccountable, and some civil libertarians who believe that parental rights are more lawful than the welfare of children. So even as children perished in greater and greater numbers, agency heads and lawmakers joined forces to cut budgets. Not just for child protection but also for the services parents need to become better caregivers. Drug and alcohol treatment. Mental health care. Domestic violence intervention and counseling.

How did Florida come to so dramatically underrepresent the scope of the problem? First, beginning in around 2010, Florida child welfare administrators simply changed the definition of neglect. The redefinition had far-reaching consequences as certain types of neglect, particularly drownings and unsafe sleep accidents, are among the leading causes of child fatalities in Florida. Until then, most alleged child deaths due to drowning and unsafe sleep were verified as resulting from neglect. But that September, DCF's top death review coordinator rewrote state policy. Going forward, a child's drowning was to be counted as neglect only if the caregiver understood that a child was, "at risk and with intent allowed the child to be placed at risk." This placed a greater burden on child abuse investigators than even their police counterparts, who need not prove intent to charge a parent with neglect.

Among smothering deaths, DCF decided that a child did not die from neglect if his or her parent's behavior met, "a socially acceptable threshold." Because many choose to co-sleep with their children, though most all parents now are warned of the dangers, then such behavior, while perilous, is not neglect. The socially acceptable standard eventually crept into other types of maltreatments. In 2011, for example, a Tampa mother sat on a lounge chair during a Memorial Day weekend cookout and texted her friends away from the poolside while her 1-year-old boy played near the pool. The youngster was retrieved from the public pool by a 10-year-old boy. His mother had not noticed that the toddler had drowned. Doctors later said that the little boy had been in the pool for an extended period of time judging from his body temperature. But DCF never counted the toddler's death.

A report said, "along with the boy there were several other children in attendance that were likely not being supervised properly." In essence, this boy's mother was given a pass for neglecting her child to death because several of her peers were equally irresponsible, though fortunately not fatality so. The manipulation of numbers, as some agency critics have called it, has not been the only blow to transparency in Florida.

Over the last decade or so, DCF administrators and public records custodians have tightened and loosened the reins on records depending on a variety of factors. Some administrators release child death records almost immediately after the tragedy occurred. Others have taken a position that such records are privileged and confidential until every aspect of the death investigation is complete—a task that often takes a year or longer. In Miami, for example, the backlog of incomplete death investigations became so acute that in late 2013, members of the local review committee complained that they had nothing to study.

Among the cases that were pending was the November 13, 2012, death of 8-year-old Julia and 4-year-old Daniella Pradeno. Nearly 2 years after Nubia's death, sisters Daniella and Julia are asphyxiated by their estranged stepfather. The corpse of one of the girls was then sexually assaulted. In a fit of rage, the man also raped and stabbed the girl's mother. Six months earlier, the stepfather had bitten one of the girls in the arm. The two girls' deaths remained open for investigation for two years. The probe was closed only after the newspaper asked about it before publishing it.

The redaction of public records is another way in which administrators have control over transparency. A year ago, DCF requested several months of incident reports, the first written record of a child's demise. As you can see from the picture on your left, those records contain very few deletions. Later, we asked for the same record, and those records looked like this. The same exact report.

One region of the state simply ceased filing required incident reports for about six months. In the prelude and aftermath of the series, a DCF investigation concluded that this was done to address insufficiencies in data security. The investigation into the missing records did not generate a single record. When I studied journalism, a long, long time ago, we were taught how to write leads and transitions, and we were taught how to make interview subjects feel more comfortable. But in hindsight, the most important skill we developed was the ability to think critically. To postpone the drawing of conclusions until every fact had been gathered. To seek out sources of information who may disagree with your initial thoughts. To question assumptions and then question them again.

After our series ran, we heard from a number of people, some of them in the legislature, who were struck by the number of times agency employees up and down the chain of command made decisions that seemed at odds with common sense. One lawmaker insisted that critical thinking skills be added to the list of qualifications the state wanted from its child protective investigators, and it was. The active ingredient in critical thinking, I would suggest, is the capacity to seek and accept input from others, which cannot be done in a closed

environment. Such openness is the yeast that allows quality improvement to rise. One last thought: I'm a true believer in transparency, and I would love to go off script if you all have any questions later.

Sanders: [05:34:33] Thank you very much. Last speaker is Curtis Krueger, then we will have time for questions.

Curtis Krueger: **[05:34:39]** Hello there and welcome to the Tampa Bay area. Thanks for the chance to talk to you. My name is Curtis Krueger. I'm with the *Tampa Bay Times*, formerly called the *St. Petersburg Times*. I'm a court reporter now, but for many years I covered child welfare issues and there are lots to write about in Florida. I got the opportunity to read a lot of death reports, and I also once even sat in on the training for child protective investigators and passed the test. So I learned a little bit more about the work that you do, and my editor after that told me I was now qualified to make not very much money in two professions.

I want to talk today about transparency, as we are all talking about. In Florida, which is not the same as other states, so I understand. Obviously most child welfare records are not public. So if I wanted to read the initial report of abuse or learn what kind of follow up there was, I could make a request but I'm not going to get that. It's not public. However, that changes if the child dies because of abuse or neglect and that file does become public. So I think there may be other states like that, but I know it's not the nationwide standard, but it is a really good standard and something that reporters across Florida use all the time. As you've heard, there can be good and bad redactions. But just knowing that you can see that file often gives you a real incredibly detailed insight that you would never get in any other way.

My recollection on this, and I may need to stand corrected by Mike Carroll or somebody else, but my recollection is about 20 years ago the Department actually requested that authority from the legislature. I don't know how they got to that point, but they were on board with it. So they are essentially saying, "Look, we don't want there to ever be another child death but if there is, we recognize that we need to be really open about it." So in the same way that the National Transportation Safety Board studies the plane that crashed, everybody can, not just the Department but everyone, can look into what happened in this case of a child death, which is the ultimate tragedy. Some of those records were used really effectively in Carol's work and in work by a lot of journalists around Florida.

I wanted to just mention one simple story, which I wrote. It's been several years ago and I believe you have it underneath your binders, which I wanted to mention just to give an example of how that transparency can help. So several years ago some of the death reviews, I think were relatively new, and there was a report that came out that listed the death reviews. A summary, there was no names attached to it, but it talked about those child abuse and neglect deaths that had occurred and those which occurred in which the child was known to the system. It also singled out 10 of those deaths that the review team found the department's response or handling of the case to be inadequate.

So we took a special look at those that were inadequate and since the records are public when there's been a death, I requested the full file of each of those 10 deaths in which the review team found it to be inadequate. And so like you'd expect, there had been a lot of media coverage on most of these cases. Hopefully there would be if an infant dies and it has been abused or neglected, it's a big story and reporters from TV or newspapers would learn about it from the police and there would be a lot of scrutiny and that's what is supposed to happen.

But I was kind of surprised that one of those cases, I didn't find anything on. It was a girl who was about 7 months old in a town called Palatka, and as near as I could tell there had not been so much as an obituary on this girl who had been basically crushed to death. That was kind of stunning to me and so I looked through the report and the reports were detailed. I got a lot of information, including when the child died and they did the autopsy they found previous broken bones. And there was also another finding that the girl's parents had been ordered to take her into a child protective team, which would be a medical examiner and Department of Children and Families was told to do that but they did not. So you think of those things together and maybe if they had made that medical exam they might have found the broken bones that would have obviously developed a stronger response like removing the child, and maybe that child wouldn't have died.

So, it amazed me to think of a child dying from abuse and there is not a word breathed about it. I only found out about that because of these records, which are open in Florida. So I would think that not only journalists but the public in other states would like to have that as well, and that's the main thought I'd like to leave you with. Thank you for the opportunity.

Sanders: [05:41:12] Thank you. So we have time for questions or comments from Commissioners. Commissioner Rubin.

Dr. Rubin: **[05:41:21]** I know there's been a lot of focus. First of all, thank you for all the panelists here. There were a lot of different insights. I do want to take the opportunity with such a interdisciplinary panel. I think one of the things we established this morning is that we narrowly define child welfare as child protective services and so all of our confidentiality issues have been defined in terms of the narrow perspective and we haven't thought more of, what is a community. What is a child welfare system from the perspective of community. I am a primary care pediatrician. Not to say that I'm the solution or my colleagues are the solution, and I think the privacy issues notwithstanding because they are important. We're bound by confidentiality as well too. Yet I don't know when a new infant shows up on day life three what the history of that child is. We're trying to take a lens around adverse childhood experiences and the issues of confidentiality, yet I'm not permitted to know unless the parent volunteers to me or if I'm in the NICU, I have a mandated reporter I can ask at that moment. What is it going to take? I wanted a lens of opinion in terms of extending the bounds of who has access to information, whether it's a primary care pediatrician, a nurse home visitor, a community provider. How are we going to advance the discussion of confidentiality as to who can at least know which children are at risk, and it's certainly germane to our conversation

this morning about risk segmentation and predictive analytics. I have a legislature, I have a court judge, I've got a lawyer from the department, I've got a journalists here. Go for it.

Judge Essrig: **[05:43:09]** I'll try. About six years ago, the department put forth legislation, we call it the Open Records Legislation. It did a lot, for instance, in getting foster kids better access to their own records for things they use later on in life. One of the provisions in that law was a section that basically stated that all state agencies in Florida and their contracted providers that provide services to children or are responsible for a child's safety can have records on that child regardless of any other existing law. Of course, that's state law. We can't legislate something in opposition to federal law, but still that was an accomplishment for one thing. It took a couple of years to try to get it through, but in my mind it takes something like that, the legislature to look at something like that to agree that medical professionals all who are mandatory reporters anyway, so they are part of the system, there is no question about it, that can have that kind of access. I can't say for certain how easy it would be for something like that, to get it passed.

There is another provision in Chapter 39, Section 39-202 I believe, is in that section that also allows that information to be provided to any professional who is providing services or treatment to a child. I think it's more in terms of once that child comes into the system. It means that when we're getting stuff for the child we can give it to anyone that we're taking the child to, or something along those lines. But to me the passing alternatively legislation in the state, creating the law to enable that would not be the problem. The bigger problem would be how to make it work. It would have to be database driven. I mean it would have to be a system that you guys could tap into. I hate to use the word registry, but any kind of data-based system that we have or we could develop to get you into it. So you could do checks like that. It might become alarming to certain people who are very reluctant to get on board with child protection and social services, etc. We always have that pushback, but legally I don't think that would be something that would be too difficult to accomplish.

Dr. Sanders: [05:45:38] Anybody else? Representative Harrell. Carol Miller.

Rep. Harrell : **[05:45:45]** That's one of the reasons we have CPTs, child protection teams that are medical professionals, and when there is suspicion of child abuse or the department refers to that CPT he or she has access to all that information. I think that's a key component and that really helps our system work well as far as being able to get additional information. You have many federal restraints, however, when it comes to substance abuse and mental health information. Those of us who work in the medical arena as I do, between HIPAA and 42 CFR Part 2, you have major constraints on what can be released and what information you have access to. As we're moving further down the road into electronic health records, and I sit on a federal advisory committee dealing with health IT policy, more physicians have medical records, as a physician you can download the information, you can download the medical record for treatment purposes of a child. So you can get additional information from ERs and whatever if you have suspicion of abuse. And you are in the state of Florida a mandatory reporter. If you have any suspicion whatsoever.

Sanders: [05:47:09] Ms. Miller.

Marbin Miller: **[05:47:11]** I want to respectfully suggest that with regard to evaluating the agency's performance or anyone's performance within this arena, if you don't know everything, you don't know anything, and I think the release of records after a child dies is important. Those are the cases that you learn the most from. When everything goes wrong, and the checks and balances fail. In the media, Curtis and I are not special. We do this because my next-door neighbor has a job and she can't. And I want to suggest that the information that we have access to now, that the public has access to now, is great. Florida leads the nation in openness when a child dies.

But I would also suggest that what we can learn would be significantly greater if some of the records that they are redacting now were not redacted. For instance, one of the things we learned in our series was the overwhelming majority of these children who died were very, very young. Infants and toddlers were about two-thirds of our sample. And in those cases, the department's history with the family generally involved an older sibling. I can't get those records. Though I will tell you, I did get them four/five years ago. And that's part of what I was referring to with the spigot. The public record spigot. Depending on the governor, depending on the secretary, more or less information flows. Depending on, I would argue, the whims of the administration.

And so four/five years ago I would get information about the sibling priors, though the names would be redacted. I don't get that now. I would suggest that we should be able to have access to medical records for the deceased child, particularly when that child was significantly disabled. That's part of the story and part of what went wrong. Police records are redacted. Despite the fact that I can pay $25 and get the same records from the Florida Department of Law Enforcement. They are open. That makes no sense. All that does is make me have to spend money.

Substance abuse records, particularly for the child himself or herself. We saw many cases where teenagers committed suicide after having a lengthy drug history that usually began when the parent provided the drugs to that child. If we all agree, and I think we do, that sunshine enables all of us to get a better glimpse at how to fix this system, bring in more sunshine.

Dr. Sanders: [05:50:00] We will take three more comments from Commissioners. Commissioner Rodriguez.

Rodriguez: **[05:50:07]** Thank you. Since we're talking about specific children from your community, I just want to take a moment to say I'm really sorry for y'alls loss, and I think my heart is with you all. And I also have to say in addition to that when I hear about some of these specific stories, I feel angry, because on this topic of confidentiality it feels to me like we're often willing to give the most intimate details of a child's life—where they were abused, who they were abused by—and the confidentiality and the protection seem to extend

often times to the folks who work for the government agencies and that's where the protections end up residing.

And as somebody as myself I grew up in foster care and found that records from group homes and shelters followed me all the way through becoming an attorney. They came up in my moral character examination, and people were allowed to look at what staff had said about me at that point. I just find it ironic that when we read stories like this, and there's actually neglect that happens due to the actions of people who work in the system. Not parents, not adoptive parents or biological parents, but professionals that we pay to do a specific job, that we shroud sort of their actions in confidentiality and we don't shine the sun in, specifically on them. I mean it's inexcusable, and the cases that I quickly was reading, the story of the child, when you have caseworkers who are claiming that visits were made that weren't actually made. That referrals were made to a doctor that weren't actually made. That we protect them with confidentiality, and instead we are laying out a child's most intimate details, even if they are no longer with us. Those were still very private pieces of their life, while we are protecting somebody who was paid to care for them. So I want to say that out loud.

That I think part of that confidentiality if we're going to, and it is true, for the siblings that survive now in the age of technology the details about their sibling and their life will follow them. Their grandchildren will be able to Google and look up and see those. Even their employer. Even when they wish to move on with their life and have a different life. So I feel, I'm really not commenting, I'm venting now, but a couple of things I wanted to ask about: Number one is confidentiality as it relates more to protecting the adults that work in the system, and what your experience has been with that. And secondly, just to bring up the issue of, I know it's a hot button topic to talk about criminal charges for folks who work in the system who neglect actively where a child would not have died had they actually done their job. But I feel it's important to put it out there on the table.

Dr. Sanders: [05:53:10] I'm going to ask to keep your comments short because we are getting close to the end but it would be great to hear from people. [*Pause*] I didn't mean to intimidate everyone into silence.

Jackson: **[05:53:26]** Commissioner Rodriguez, I can only speak for my department. As far as the people involved with specific cases, we don't redact out names of employees. We don't do anything to hide employees of the Department. With a certain class of employees, we may give out their addresses because of certain professions they may have worked in. But we don't hide behind confidentiality, to hide the employee. That being said, the number of employees that go into policy decisions, etc., and any given situation could be a bunch, a few, and whether or not there is any direct link to all the employees, how you could figure that out, I don't know.

What you said made a lot of sense about putting everything out there about the child and all the intimate details. That's not easy to do. It's very, very difficult to do. What disturbs us a lot of times is the surviving siblings. That information will go with them. It's not that they've

been traumatized enough, it's are we going to do it more. We have to provide the names of the dead child, that's the way we read the law, and of their parents because quite often they are the perpetrators. They are the caregivers who are guilty of the abuse and neglect. By law we can redact out the names of the siblings. But we know very well that that isn't doing anything to protect those siblings.

Not every report, not every public record that we feel compelled to release under the law has the same information in it or gets the information from the same source, and it will impact on how it's redacted. But in the end, even courts have recognized it, that redacting out a couple of names, especially in the age of Google and everything else, what it's protecting I don't really know. So there is information that goes out on siblings, a lot more than Ms. Marbin Miller, I don't think she meant intentionally to give that impression because it goes out all the time. So many of our reports are done with all the siblings in the same report. We don't have separate pieces of paper for each sibling when it's the same call out to the house. So information does get out there on the siblings. There are times and situations when you have to say to yourself, this child has been identified. These parents aren't supposed to be identified under the law. If they are identified can we let information about when the parent was a child or about the siblings, when it's going to be so clear who they are.

Again, it's that tightrope that we're walking that is so hard for people that don't work at the department to acknowledge. Don't for a second think that the people of the department don't acknowledge the difficulty in putting that intimate information out on people. Not for the people that work on the ground with these kids every day. It is. Sometimes it kills them and the people on the top that are making the decisions about what goes out. We're not doing it in a vacuum.

Dr. Sanders: [05:56:28] Commissioner Dreyfus.

Dreyfus: **[05:56:34]** I remember one time being out in the field in Milwaukee, Wisconsin, with a case manager who shared with me that if she went out with her friends on the weekend she didn't want to tell people what she did. And I just remind us all that the vast majority of people that work in this system are phenomenal at what they do. I have had the honor and responsibility of overseeing every part of the human services delivery system in my career, and I don't think there is a harder job in this country than the people that are on the front line in child welfare.

That being said, I absolutely agree with everybody talking about the sunshine has got to be down and it's got to be shining on all of us. The sunshine also has got to shine on what's right. The sunshine also has to tell the stories of the great work that's being done. Of the incredible difference that's being made in the lives of children in the state of Florida and across the country from the work of the child welfare system. So I just want to be on record saying that, because I think that balance is real important. Because in public policy, pendulums swing wildly, and we can't forget the fact that the vast majority of kids do not have these horrific things happening to them. There is sunshine to be shed on what's right in the system.

Two quick questions. Howard Davidson gave us his 10 other key issues, and one of them was that state law should improve immunity protections for those who CPS asks to assist in serving abuse and neglected children. And I read "who CPS asks to assist" as being broader than public sector employees. And I wanted to ask Representative Harrell, is the legislature looking at this issue of immunity as it relates to being a privatized state and the fact that you have a lot of private organizations now who are carrying out these responsibilities that were once done by public sector employees?

Rep. Harrell: **[05:58:31]** Thank you very much, and this is a very controversial issue. We have, as I said, a privatized state. Our CBCs, our community-based care organizations, are required to maintain liability insurance. Up to a certain point. Beyond that point then the state does become liable. So we've tried to walk that line again. Kind of a hybrid degree. Because truly I believe that the state is, that these agencies are fulfilling a state responsibility. We have given this by contract to a private agency. However, the other side of that argument is in the state of Florida, in order to receive more than $250,000 in compensation, you have to have a claims bill come before the legislature, which is a very complicated and a very difficult thing to do. So what we've done here is a mixture, a hybrid, and allow required CBCs to maintain a certain level of liability insurance, I believe is $300,000, I'm not sure, and it depends on the case level and number of children, or whatever. But beyond that point it does become a state responsibility.

Dreyfus: **[05:59:47]** Thank you, and one last question for you too as well if you don't mind. And thank you for being a champion for kids, it's wonderful to have people in the legislature like you. It's about data sharing. So is there anything you are looking at at the state level that would help shed some light for us at a federal level in terms of what is it that is getting in the way of data-sharing agreements across state agencies and the ability for data to flow more easily in order to help protect more kids?

Rep. Harrell: **[06:00:19]** I think there are several things, several problems. You have, especially in the substance abuse and mental health arena, you have very specific federal legislation that really restricts how that information can be released. I sit on the Children's Cabinet, so one of the things coming out of the bill that DCF referenced earlier through the Children's Cabinet where all the state agencies that deal with children have a member sit on that Cabinet. They establish memorandums of understanding between agencies. So that within the state you could have that sharing of information. The Barahona case really shed a lot of sunshine on a default we had with our school districts, because they are separate entities, and there was not a sharing of data between our school districts and the Department in that case. So we wanted to make sure that we have those kids of memorandums of understanding between the school districts and the department so that there could be data sharing. On the federal level though, you've got HIPAA on medical records and you also have the substance abuse and mental health issues that truly someone at the federal level needs to look at very, very carefully to make sure that there's no difficulty for individuals, for frontline workers to get the information on substance abuse of that for treatment or

nontreatment. Those are specific things that I think this Commission should have an in-depth conversation on.

Dr. Sanders: [06:02:07] Last comment, Commissioner Horn.

Dr. Horn: **[06:02:09]** I've been looking forward to this panel for some time, and you have not disappointed. It's been fascinating to see the tension between the brass and the agencies. Twenty years ago I was offered a job to head a state child welfare agency. In the interest of confidentiality, I won't mention the state's name other than say it rhymes with Illinois. I turned it down. The final question I asked the governor was what's your number one priority for child welfare, and he said, "Keep my name out of the paper." It seems to me it's really hard to run a child welfare agency unless you are transparent, unless you are working with the press. The press can be an incredible vehicle to help get information out to the public so they understand things like, it only takes 30 seconds for a kid to drown in a pool. They need to have a lot of information. By the way, I think I've had the honor of being in both of your offices in previous iterations in my career. So it's good to see you both again.

What was interesting to me about Howard Davidson's presentation … I would like to pursue a question I asked him at the end. Is the degree to which there is confusion as to what can be released and what can't be released under CAPTA. And part of that is related to the fact that there haven't been regulations since 1990; I suppose I'm part of that problem since I oversaw that report in that span of time, and because there is a requirement under CAPTA that release of information, there must be criminal penalties. I absolutely understand if I have a choice as a child welfare agency whether to release something or not, and there is confusion, I'd rather have you two write a bad news story about me than have somebody put me in an orange jumpsuit and put me in jail. It seems to me that we need to either clarify what can be released, and perhaps, and this is where I'd like to have your comments on, whether we should revisit whether or not there should be at least some safe harbor for release of information in good faith, with a reasonable understanding of what the statutes are since there are regulations and PIQs. Should there be some effort to decriminalize some of this so that people could be more forthcoming without fear that suddenly they misread the statue, misread the regulations and now they are facing criminal penalties.

Marbin Miller: **[06:05:04]** I'm not aware of anyone ever been charged in Florida for releasing what otherwise would be confidential information. In a two-decade career writing about this issue, more than anything else I've had secretaries give me information regularly and just say, George Shelman was a guy who believed religiously in the curative power of sunshine, and he was known to take a report and just give it. His position was, "It's the right thing to do and I'll suffer the consequences later." The good news is, he never did.

Krueger: **[06:05:51]** I might just add. I have occasionally heard the panic in somebody's voice like, you know, "If I were to do that!" I think it's a valid concern if you hold that over somebody's head, it's going to make it difficult for them to go ahead and do what even the law says is the right thing and release something that's public. I think it's a concern. I like

what John said, that in Florida we're beyond CAPTA, and maybe that's part of it. If states go beyond that, then maybe it's understood. I think having that threat of criminal charges, it kind of has a chilling effect and it could be a problem, and it would be good to get beyond that.

Essrig: **[06:06:52]** I disagree to a certain extent. I think if there's lack of clarity or specificity in a statute, being federal or state, then we need to clean it up. The answer is not to decriminalize something because we're not sure what we can or can't release. The answer is to make it clear what you can and can't release and under what circumstances, it seems to me. That's the lawyer in me speaking. I agree with Carol Marbin Miller, I don't recall anybody in Florida having ever been prosecuted under it. Nonetheless I agree that it has a chilling effect or could have a chilling effect. I think it's important to maintain that. I feel stronger that it's getting back to the confidentiality portion, which is still important. Transparency is important, but not to the point that we throw out confidentiality at times. And I do feel strongly that all of us who work in this system not be chitter-chattering at cocktail parties or with our neighbors or friends.

Dr. Horn: **[06:07:54]** Let me be clear, I am not suggesting that we decriminalize chitter-chattering at cocktail hour. What I'm suggesting is that maybe there is a safe harbor for people with good faith, with a reasonable understanding of the statutes, so some lawyer doesn't come later on and threaten that person. I'm not suggesting there have been criminal prosecutions as all. As someone who was a frontline caseworker, I will tell you that it's on our minds.

Essrig: **[06:08:26]** No doubt.

Dr. Sanders: [06:08:28] We're going to have to finish up on that note of Mr. Horn's comment. This has been a great discussion. This will not be the last time we have this. I think this is incredible information provided, and I want to thank you for taking the time, and hopefully you will be available for some informal questions, because I had some that we didn't get to. So thank you very much.

We're going to go into a break, but before we do that I want to thank a couple of people. Kelley Parris and the board and staff of the Children's Board of Hillsborough County, is she here? [*Applause*]

Also to the Tampa Police Department who provided security for us today. [*Applause*]

And since we are a little behind time, I'm going to ask the next panel to begin to gather in time for us to start at 3:20, and I would ask Commissioners to try to be back by then, and we'll get started with the last two panels.

Afternoon Break [06:09:39]

Dr. Sanders: [06:09:47] If Commissioners could take their seats, we're going to get started with the last part of this. All right, we're going to go ahead and get started. We have our last panel, who is scheduled to talk about strategies for addressing child abuse and neglect fatalities—what's working and what's not working. And we have a diverse group, including DCF staff as well as people from law enforcement and health and from Children's First. We are getting near the end of our day, so each speaker will have eight minutes and we'll have time at the end for questions. I look forward to hearing from you. First is Lisa Rivera from DCF.

Lisa Rivera: **[06:11:05]** Hi, good afternoon everybody. Since I have eight minutes, I'm going to talk kind of fast, but hopefully you'll still be able to understand me. In working with the department I've had nearly 18 years of marination with regards to child fatalities. I've been to numerous reviews. I've done numerous reviews, and the same thing that I'm going to talk about will coincide with those deaths in which there's been prior involvement within the child welfare system and those in which there hasn't been prior involvement, because we review those deaths, too. The first and foremost thing of what's going to work is paying attention. We have to pay attention to what's going on. I'm not talking about parents paying attention to their children at the pools or anything like that, but us in general paying attention.

I think with the website going up, the communities are going to get an idea of what's really happening in their communities because they're going to see at any given time, a three-month-old child was found unresponsive in their bed while sleeping with a parent. A three-year-old drowned in the family pool after getting out of the house undetected. Something like that, they are going to get a snapshot moment by moment currently of what's happening. Once we find out and we realize what's happening, it's understanding these things and understanding it at a broad perspective and not based upon our own agenda items or our own personal belief systems. We really need to kind of engage this to address this in a comprehensible manner.

The other thing that will work is working collaboratively. Coming together for the sake of a common outcome versus a programmatic goal. Because when everybody comes together and we each have our own individual goals, that's how we're working towards a problem. We are going to solve it toward what my goal is of my agency, but we are a nest and we are holding all of these eggs and we have to do this together. Because a lot of the times if the child welfare system isn't involved, somebody else is. So the minute somebody pulls their hand out and says, "Oh, that wasn't my case. I didn't have any involvement," there's already a hole. We have to join together and make sure that the needs that we're recognizing are being addressed, which then clues me into what hasn't been working in the state of Florida. You're going to hear silos talked about repeatedly. I'm glad it's not just here in our state, it does happen nationwide. But working in silos. If an agency cannot or will not operate outside of its organizational structure it will create its own barriers, and this goes with domestic violence, substance abuse agencies, our public schools, the home schooling initiatives that we have,

things where we come together and where we all touch a family at one point or another. If we're not willing to immerse ourselves and begin really a more personal relationship, again we're pulling part those pieces of the nest away and we're leaving holes and gaps that people are going to fall through.

The other thing that isn't working or hasn't worked in the past is planning in isolation. An agency will plan a strategy over here, another agency will plan a strategy over there, and two strategies, although they're great plans, they are not meeting what the overarching issue is. They are meeting the programmatic need of the agency or whoever is involved, but it's not breaching that gap. To kind of give some more specific examples with the paying attention part. Because I've had the type of job that I've had for so long, I've seen all types of deaths come across my desk. It's not uncommon from year to year to see a bad case that happened somewhere in the state of Florida where we had involvement, where we were involved at the time, and maybe missteps happened or opportunities to reach a better outcome weren't really taken, and it was rare. It would happen maybe one this year, one that year, but always it was differently spread out. When we started having issues here in Hillsborough County where there was that influx of deaths that they spoke about earlier, where there was nine within a short period of time. Before the nine, awareness was right, it's about, "Hey, we have a problem here because this is not usual." We've had it on open cases not only within a short amount of time but in the very same county. So it's bringing that to somebody's attention, then they take a deeper look and try to find out what's happening there.

Another issue that we had across this area was we had a rash of deaths involving methadone clinics. Not the methadone clinics themselves, but we had mothers involved in a methadone treatment program and all of a sudden we had one child death, then we had another child death in the same county, then we had another child death in the same county, and it started raising flags, like we need to do something. And we need to get these agencies together and they need to formulate some kind of a working agreement. Not only was it happening in one county, but at the very same time it was happening in another county with the same provider. So we had a methadone death here, and then another one and another one. So we had to get the agencies together and we were talking about the sharing of information earlier and then memorandums of understanding or memorandums of agreement. When people are there on the frontline and they need to develop something, they will. They had to develop for these cases. Major Shingledecker talked about part of her agency was involved in getting one those strategies implemented. But it's paying attention and working corroboratively is what's going to help our state.

Dr. Sanders: [06:16:59] Christina Spudeas, Florida's Children First.

Christina Spudeas: **[06:17:03]** Thank you. Florida's Children First is a statewide nonprofit child advocacy organization. So our function, and we're independent. We take only donations, not from state or federal governments, so we maintain independence and we consider ourselves watchdogs but also partners in trying to help the system make positive systematic changes that affect children in care. Our focus is on child welfare. We like to work

with state agencies and try to promote good policies and positive outcomes. We also work with the state legislature to help draft laws that help children in care. Thank you for letting me come and speak to you today. I am pleased to be here and I want to talk to you a little bit about some of the gaps that I think are in our legislation, that even though we've had some wonderful legislation and a lot of hard work this last session, there are some areas that we need to still consider.

It's important to remember that not only was there a public outcry among the citizens in the state after that series of articles came out, but there was an outcry among the legislature as well, and that did have a big impact on what happened during this session, as well as the fact that we have surplus funding. The impact could not have been that great if funding weren't there. And that legislation was specifically geared toward dealing with the problems that were arising in the review of those death cases. So it was specifically designed in many ways to fill in the gaps that were present. You've heard about the Critical Rapid Response Team, child death websites, improved safety planning … there are so many good things that I don't want to minimize. But I want to talk to you about how our new law fails to offer services to persons other than the parent, guardian, or caregiver.

In the *Innocents Lost* series you will see that a substantial amount of these children that died and then in the death reviews have died at the hands of persons other than the parent, guardian, or caregiver. Boyfriends are often the perpetrator. In some instances it's other people that are visitors to the home or with whom the child was left that caused the injuries and death to the child. In our new law as it's revised, the definition of "prevention services," which include social services and other supportive and rehabilitative services, is only to be offered to the parent, legal custodian, and the child. Well we have a provision in our revised law in cases of domestic violence to be able to get an injunction where you've got now court intervention and court-ordered services for the perpetrator who may not be a parent, guardian, or custodian. There are a lot of adults who may pose a risk of harm to the child who are not domestic violence offenders or have not had a contact with law enforcement for domestic violence. So this would not apply to them.

Also our new law as revised has improved language on safety planning, which now requires as you've heard that the plan be specific, feasible, sustainable, as Judge Essrig said, robust. We have much more information and ability. However, that is also, the "safety planning" is limited to a parent, caregiver, or legal custodian. If we could include other people who pose a risk to the safety of the child, we are not suggesting that they become parties to the process where you have court intervention, but we are suggesting that they be participants if they have a risk of harm to the child, that that offer of services to them is a consideration as to the continued safety of that child. Whether they avail themselves or not, it's something we need to know.

Which leads to the second gap. Which is the lack of documentation of referrals and tracking to make sure that when we offer these services in these cases that are not elevated to that higher level of risk where we have a safety plan in place. We're talking about and we've

heard of times when the child has been the subject of such horrible abuse that they have died at the hands of someone, that the contact with the department started a while ago, whether it was for that child or another child in the family, and you've got a low level of risk, but there's risk there. So maybe this family, there is something happening here, let's give you a referral, we think you might need these services. And then they close that case. There's no case that's opened and so you've got those kind of contacts, now you'll know there was a contact. A CPI will know, a child protective investigator on the third time called to the home will know there were two others. But where were they sent for services? What services were offered? Did they avail themselves of these services? That's the type of thing that is important to know as to the safety of the child that's left in that home.

We had proposed the language that would address that issue and that did not make it into the final bill. But we think this is important in preventing these child deaths. They require tracking of services when (1) there is either probable cause of abuse, abandonment, or neglect, which are the cases we are going to be offering services in. And also, when there's no probable cause but a potential risk of future harm that is moderate or high. Now we're going to do it with high risk, but we need to look at those moderate risks, that's those cases where we keep touching the families.

If a family has availed themselves of the services and you come back again and the situation is still there, that's a red flag. If they've not taken that initiative, that's something that should be considered. We also recommend that in these cases requiring to be tracked, noncompliance with those services would trigger a staffing in Florida, with a children's legal services attorney, service providers, and the child protective investigator. And that way you can have a separate review to see if we need to go further. Thank you.

Dr. Sanders: [06:24:35] Thank you. Major Bullara.

Major Robert Bullara: **[06:24:38]** Thank you. How are you this afternoon and appreciate the opportunity to speak to you all here today. We are kind of a rarity around the country and we're also kind of a rarity in the state of Florida. There are six present sheriffs who have taken on the duty for the kids in their county of performing dependency investigations. So I am the commander of the Child Protective Investigation Division here in Hillsborough. We do the CPI work and contract with the department for this area. For the last four years, our decline in numbers of deaths that are reported through the hotline to us went from 42 in 2010 to 27 in 2013, which I'm sure you are aware of with the stats that have been provided hopefully to you. I've been fortunate to work with some partnerships. We work very closely with the department. All our death investigations are reviewed along with the fatality review specialists and as a team decide if anything was either not covered, should have been covered, or did an outstanding job. We are also a member of the Child Abuse Base Review Board out of our Child Protection Team here in Hillsborough. They meet quarterly. They review all deaths and see if we have any trends that are jumping out at them and we are part of that also, along with Dr. Brooks and his staff.

Things we've learned for the future, we try to analyze the data. We continue to look at paramours, prior involvements with social service agencies from the family. We also choose random investigations that our Q&A section, so that we can provide rapid feedback on open cases to our investigators that things that might jump out from our Q&A staff.

Prevention, we work very well with the community. It's all about getting the information out there I heard earlier. If we are able to identify any children of families under the age of 1, they're provided with safe sleeping information. Because that takes us back to the number one cause of death among children in our county is co-sleeping. Prospective placement of children is by all means an important issue, and those families are gone over safety issues not only with sleeping, there's always water in Florida, with water safety and in our state. Also firearm safety issues in the home before any of our children are placed there.

We are very fortunate that our funding allows us to provide items that contribute to the safety of children in this community. We are able to provide door alarms. We are able to provide air mattresses for sleeping arrangements for some children that don't have beds in these homes that our investigators go into. We are also able to give a "pack and play" and for those that are not familiar that's a miniature crib or a portable crib for infants to sleep in as we again attack the number one killer of children. We also provide training to some of the local colleges. We also provide training on signs of abuse, recognizing abuse, and statutory requirements on reporting abuse to school officials. As we move to within less than a month of school starting back up, yes it's that close, we will meet with all principals, assistant principals as they have their workshops, as they prepare for the upcoming school year, to bring them up to date on the latest statutorial change and what are the requirements and what exactly is abuse.

We also provide training to them on how the steps of the system work. Because they are sometimes the beginning, and in this county they are the number one reporters to the abuse hotline comes from the school system. We like them to be aware of how the system works so that they are able to walk through it with some of the children they have more contact with than most of us. We also again this past year with some funding were able to piggyback on the department's safe sleeping campaign that they did, and we decided that we would give any family that had a child that was an infant that needed a place to sleep, we would give them a pack and play. All they had to do was come to our office, show us that they lived in our county, and that some type of form that they did have a child or were about to deliver a child. During that month we gave over 100 pack and plays away to this community. We received support from local media, both television and print, and hopefully this year if I can convince the Secretary to give me a little more funding we'll be able to continue that. We've also recently joined with the Hillsborough Fire Department. They have agreed that any family name that we provide to them, they'll provide them with smoke detectors. A couple of years ago we had a very tragic accident with a home and no smoke detectors. So other than that, we are very fortunate to have the support system we do in this county. Thank you for your time.

Dr. Sanders: [06:30:53] Thank you. Dr. Philip.

Dr. Celeste Philip: **[06:30:55]** In public health we talk about how everything is built on partnerships. That's the beauty of it, but that's also, as I've heard my colleagues and different presenters throughout the day it's caused me to have to rewrite my presentation several times because a lot of what we have done in partnership has already been presented. So to me that is a sign. We were talking about what's working well in Florida, when we have lots of different groups talking about the same initiatives to address safe sleep, to address drownings, I think that that in and of itself tells us that we are making progress and that's something that's working well. The number of drownings in children 1 to 4 years of age decreased 17 percent between 2010 and 2012, and I think a lot of that is because of the messaging, the emphasis on the layers of protection. Watching your kids, knowing CPR, having the barriers, and also being very aware of who's watching your children. I think that is a message that we are hearing more consistently over time. It's not something that we did for one year and let it go and hope that people remembered. Something that we are seeing being repeated over and over and we are looking for over time the data to continuing in that trend.

Regarding unsafe sleep, in addition to what you've already heard today we have an SUID work group that was convened recently, and in addition to some of what you've heard we conducted a training with the medical examiners to look at the coding to make sure that deaths that were previously coded in a way that maybe we were missing some of the co-sleeping co-factors will now be available so that we can really track those numbers. In addition to that, we've created, I think it's almost finalized, a survey to put out to physicians and would like to also get feedback from residents regarding what they're telling their patients and families regarding safe sleep. Because anecdotally we hear, "well my doctor said it was great because that helps with bonding and with breast feeding," which we support very much in public health, but knowing what people are being told because some of the cultural shifts that have occurred over time are different for folks who have been practicing for 20 or 30 years.

Something I don't think that's been mentioned yet is the work that was done with our statewide task force on prescription drug abuse in newborns. Our Attorney General convened a group, I think it's been about two years now, to look at all the effects, unfortunately Florida had been known for very high amounts of opioid prescriptions. We are happy to say that just last weekend in the CDC's *MMWR* we shared information and data showing that there has been a very significant reduction based on work that's been done with various partners and largely through our legislature passing certain laws that have limited the ability of pill mills to come, and creating the prescription drug monitoring database, that's been very helpful for us to look at our prescribing practices. But also a part of that task force was creating a discussion around neonatal abstinence syndrome and looking at what do we know currently about the prevalence. What do we know about the services available once it's identified during a woman's prenatal period and the postpartum, and as a result of that I think it's been about a month now. The beginning of June we made NAS reportable in the

state of Florida, and we are working on implementing education and outreach to hospitals regarding what the criteria are and how it should be coded so that it's captured.

As a result of this task force, there was also an increase in substance abuse funding that DCF received last fiscal year, and that funding has been sustained going forward, so that's another thank you to the legislature. One more thing before I move on. The Child Protection Team, you heard from Dr. Alexander this morning, the child welfare bill that passed also increased funding to the teams to increase the types of assessments, and there is going to be a broader focus on adverse childhood events and how we're asking those questions, capturing them, and making sure that we refer based on what we suspect with potential future challenges to those children.

Areas that we have some experience but would like to see expansion on. Really go back to what we call the "root causes" or social determinants of health, and these are the factors that really pertain to infant mortality, chronic diseases throughout life, and when you start looking at where the higher risk factors for poverty, unemployment, the ills in neighborhoods that we know struggle. When you start plotting on maps where some of these health outcomes are the worst, they are in the same neighborhoods. I've not seen data around child abuse, but I would suspect it's the same neighborhoods. So from a perspective of really looking at how do we start shifting the culture in these neighborhoods, economic investment is something that will be key going forward. There has been some work looking at, I think they are called Enterprise Zones. I've not heard that spoken in the context of child abuse, but again looking at those same root causes of poverty and the challenges going forward, I think that's something that could be developed in this context and as a part of that tying in the business sector and industry and looking at how they can be incentivized to work with those neighborhoods to support them over time.

And finally the engagement of community. We talk about how we partner. Partnering with communities is an area that probably could be expanded quite a bit. Asking people what is it that they need, and meeting them where they are. There is a framework called the Strengthening Families approach or the Five Protective Factors. My time is up, I'll just list them very quickly. Parental resilience, social connections, concrete support in times of need, knowledge of parenting and child development, and social and emotional competence of children. Thank you. So there are examples of that in the states that should be expanded on, and I think that is part of the direction that we need to look at as a system. Thank you.

Dr. Sanders: [06:38:04] Thank you. Major Shingledecker.

Major Connie Shingledecker: **[06:38:06]** Thank you for allowing me to be here today. I'm also one of those unusual, or my agency is one of those unusual agencies. We've been doing child protective investigations since 1987. We've had it for 17 years. We think we do a really good job at partnering and keeping kids safe in respect to that. I've also been on the Child Abuse Death Review team for the last 12 years, and I'm a 37-year law enforcement officer. So I'm going to touch on some of these more significantly than others. But what's working? I'm

just going to pick on going beyond the data and discovering the trends, and that's something that at both a local and state level was so critical to us, identifying that substance abuse, especially in drownings and co-sleepings, was huge. And we were finding that when women were co-sleeping late in the day, that that triggered a potential for substance abuse issues. Sleeping late in the day when their children were drowning or sleeping late in the day when your children were dying in unsafe sleep circumstances.

We also found in our homicide cases going down into the data that many of these mothers, most of the children were abused physically to death by male perpetrators. The women were not in the house at the time. They were not there. So we found they were working, they were in school, they were in other locations and we found that perhaps daycare might have saved the lives of some of these children, and getting them into a daycare circumstance, so drilling down into that kind of data can be extremely helpful.

So you have to go beyond that and discover the trends and start working locally to see what you can do. Consistency in investigations by CPIs, law enforcement officers, medical examiners, investigators is so critical in these cases. We are not getting them reported. You heard some folks say in some areas of the state, they just don't call them in. That's law enforcement not calling them in. They are going to those death cases. They're going to those drowning cases. They're investigating them. They're not calling the hotline. The medical examiner's office is not calling the hotline. We have to have consistency in the investigation. That's going to drive getting those cases that need to be called in, called in to the right place. So I just wanted to bring that to your attention.

Implementing local initiatives. Oh my gosh, I could spend 20 minutes talking about some of the wonderful things that we have done locally in our community, but I want to just stress one with the local drug clinic. It was the Par Clinic, and you heard Lisa Rivera allude to that earlier when she talked about methadone being the key factor in several of our infant death cases in our county, and we started to recognize that the key issue was these women were on high doses of methadone going daily, and these babies were dying and co-sleeping circumstances and one an actual homicide. So we partnered with that Par Clinic and we found a way to make it work, and I have handed out what that program is so you have a one-sheet handout that explains that methadone-related infant death program and how successful. Since we've implemented that program, we have not had another death. I challenged Par, I said if you think we're the only county that has this issue, I want you to look at Pinellas. I want you to look at Hillsborough. I want you to look at other counties and find out of the women that were pregnant how many of their babies are still alive. And they found over a three-year period that eight infants from the women in their program had died. So they realized the importance of it and they did partner with us. But that needs to be replicated, so I strongly urge you to look at that.

Joint investigative approach with law enforcement and CPIs. When I think about the Nubia case, had law enforcement gone out, that case would have been a completely different circumstance. Because they would have been able to go into that house and find that that

child was in the bathtub. They wouldn't have been just turned away because with certain information they can enter to make sure that children are safe. So the partnerships have to occur between law enforcement and child protective investigations. It's a joint investigative approach, and I have preached that for years. You don't have to take over the investigative piece, you just have to go together and you have to be committed to it. Since that particular case, that's what's going on in Miami. But it's a shame that it took that horrific case to get that law enforcement agency to partner up and go out there. They should have been partnered up long before then. Because we've had MOUs in place. We've had the ability to do it. We need to be looking at criminal issues, not waiting for DCF to tell us that something is criminal. We need to be going out and looking at it ourselves.

Okay, what's not working. Lack of consistency in what is a verified child neglect death by the Department of Children and Families. That still is going to be an issue. Even with the change in the statute. As it relates to unsafe sleep and drowning, if we don't get that consistency and that verification, you are going to have people treated differently in different areas of the state. It has to happen. I don't think it's going to happen unless you all help it to happen by making a uniform child abuse and neglect death across the country, just like we've got uniform crime reporting across the country. Every law enforcement agency reports uniformly to a central receiving location about what's going on. You can make that happen across the country and would probably improve significantly what's going on.

Lack of uniform child abuse and neglect investigations. So we don't have the consistency across the state of Florida or the country in how we investigate. And I think you can help make those recommendations standard procedures for all of us. We don't do doll reenactments. The Center for Disease Control did a nationwide training on SUID, sudden unexpected infant death, investigation and pushed doll reenactments for law enforcement and medical examiners in that investigation so we could get to the bottom of what's going on in those cases. We need to continue to do that. We don't have consistency. Substance abuse and its relation to child abuse and neglect deaths. We don't have that consistent. So again these are the things that are not working. Training is huge! We don't have consistent training going on.

These are the things that I am just going to touch on briefly. About what has not worked in the past. When you hear people talk about the pendulum swinging, when you keep that primary focus to keep families together rather than child safety, that's going to be problematic. And it became problematic for the state of Florida not too long ago. Primary focus on keeping children out of out-of-home care, diminishing those numbers in foster care and out-of-home care, that's that pendulum swinging back and saying that's family preservation. We've got to stop having an initial investigative focus on just social service-oriented issues with children under the age of 5. If that child is being beaten, we need to find out who's doing it and we need to get to the bottom of it. And it's not just a social service-oriented focus; it's got to have that law enforcement component, especially when substance abuse is there. And lastly trends not acted on in a timely manner. We brought trends to the attention of the statewide entities, and they have not been acted on for years. So you'll see

them referred to in our child death review report for several years but not acted on. Thank you.

Dr. Sanders: [06:45:29] Thank you. We have several questions. Commissioner Petit?

Petit: **[06:45:33]** Thank you. With regards to the criminal aspect of this, fortunately very few child abuse cases rise to the level of felony offenses except for the sex abuse cases. The physical abuse cases not so much. We have two tracks of our justice system that address this. One is civil proceedings that effectively can remove a child from a perpetrator. Then we have criminal proceedings that can remove a perpetrator from a child. When we look at the numbers nationally, the number of cases substantiated by CPS that the police confirm it happened and arrested somebody and then the subsequent prosecutions and convictions, it falls off dramatically in the states I looked at. I don't know what the situation is here, and I'd like to hear you speak to when you started with 100 cases, how many end up in a prosecution/conviction situation? In the MOUs investigative protocols you were talking about, which I think is a critical piece on all of these things and I don't know how many police departments you have, but typically a county would have a number of police departments and so are they all adhering to a standardized prescribed protocol that say, the DA has signed off on? Where the DA had to take these cases to go beyond a reasonable doubt, a higher standard of proof. How are you guys dealing with those things? I heard you reference a number of them, which sounded terrific, then you explained it wasn't complete. But in terms of what we're doing across the country this particular issue, you have an immediate situation that somebody is a threat to the family, he's broken bones, he's been convicted in another county or another state, all of a sudden he's in a situation, how do you deal with that person in an expeditious kind of a way.

Shingledecker: **[06:47:13]** Well first I'd like to say that several years ago we lost misdemeanor child abuse. We don't have misdemeanor child abuse in the state of Florida any longer, which I think is a tragedy and needs to be brought back, but we don't have that. So all cases that we move forward with criminally are felony cases and physical child abuse cases. So yes, the burden of proof is extremely high, but the partnering up and the doll reenactments help us present the information, and we video our doll reenactments. So if we have a child with a broken bone, a skull fracture, a burn that can't communicate with us about what happened. We're doing a doll reenactment with that family to have them show us what happened, and then we take that information to the CPT doctor or an all children's hospital expert, and we show them what the family is saying happened because we're bringing the scene in essence to them. So we're having some huge success in our county by using doll reenactment, and that's not just in death cases but in serious injury, and it's helping tremendously for us to get to the bottom and identify who the offender is so that we can put the appropriate services in and get that person that's committing that crime out of there. That's why those are so key.

Petit: **[06:48:25]** Does the district attorney prescribe an investigative protocol that police have to adhere to?

Shingledecker: **[06:048:33]** They don't prescribe it; actually we train them in what we're doing and we present the case to them and we've been successful especially in using the doll reenactment formats, and they are on call and they are able to assist us, but they don't create the procedure.

Petit: **[06:48:50]** Just lastly, do you have data on convictions and prosecutions?

Shingledecker: **[06:48:54]** I don't have data with me.

Petit: **[06:48:56]** But is there such data?

Shingledecker: **[06:48:59]** County by county there would be, yes.

Dr. Sanders: [06:49:08] We have somebody from the State Attorney presenting in just a little while, but I was going to see if she could answer, but maybe if you could hold that for when she comes back.

Petit: **[06:49:16]** Sure.

Dr, Sanders: [06:49:19] Commissioner Rubin.

Dr. Rubin: **[06:49:21]** Yes, I did this a little bit in Texas as well as, too. First, Dr. Philip you are one of my people. You're in the public health department and unfortunately we didn't have a lot of folks in terms of from Medicaid or from the health department to kind of think about skin in the game and other systems. We spend a lot of time thinking about child protective services, to some degree law enforcement. First, I'll say that I really appreciate you mentioning the adverse childhood experiences and a strategy toward intergenerational abuse and neglect. In that context it's very clear, and I think there's a lot of empiric evidence that treatment of parents can impact the lives of children. I believe it intersects with the issue here today.

So the first, it's a little bit of a rant and I did it in Texas. Florida is one of the states that did not expand Medicaid, and whatever you feel about the Affordable Care Act, and I hope there's press in the audience, but sometimes we need to put away our feelings about legislation from D.C. and disentangle it and realize there are real treatment dollars there that actually get at this issue. Particularly as it pertains to parents and mental health treatments and substance abuse treatments. So I'm not going to ask you to comment on that and put you on the spot. I did that to the Secretary of Health in Texas. But I will say the other aspect that I wanted to talk about because you talked about how you worked around prescription drug abuse, there's some issues that sort of, but then I'm also thinking about child welfare and I'm thinking about Randy Alexander, to what degree is there a larger governing group here in Hillsborough County. I'm not saying there has to be, because I know that even in Philadelphia we struggle with this. Let's sit down together and start thinking about child welfare from a broader prospective. Maybe start to triangulate the kids who have had a history of child welfare involvement with those folks we know who are in the methadone program or have a history of prescription drug abuse and then get those pepi-pods

that Dr. Alexander was talking about in the morning and distribute it to every one of those people when their baby shows up in vital statistics having been born. How do we truly get to a model of identifying priorities in terms of prevention, and what structurally, both at the local level, state level, whatever level prevents you guys from sitting down and thinking about these larger primary prevention strategies around child deaths.

Shingledecker: **[06:51:51]** The task force that I described earlier was the statewide task force that had folks from different agencies, and the approach was more a statewide perspective. It was really meant to guide local activities. I'm not local. Before I went to Tallahassee, I was actually in a couple of other local health departments but not here. Most counties do have coalitions of that sort that convene around these issues, and I think hearing some of the data security issues, what can we share, what can't we, working through some of that would be very helpful, I think, but even with the context we're operating in now, there are ways we probably could look at data differently from what we are able to share and look at it locally and decide what the most appropriate approaches are. Healthy Start is one of the groups, one of the partners that has a statewide touch but also has a local approach because they are divided into more local coalitions. A lot of their work centers around substance abuse issues along with DCF, Department of Health, and other partners. Including the CACs, the CBCs, and we do have lots of partners involved. So I think some of that is happening. Hopefully with the emphasis that we've seen recently, we'll see some of that work featured more prominently.

Dr. Rubin: **[06:53:20]** DCF … from your perspective ways in which you feel like your collaboration with the health department is strong and ways in which it could be better, and what prevents that from happening? And law enforcement can comment as well.

Rivera: **[06:53:36]** I'm also on the fetal infant mortality review team, and we look at deaths from 0 to 1, which includes a lot of our co-sleeping deaths, and we're always on the same page about getting the education and preventive messages out there, but it's to an audience that I think knows the information and even the parents that are educated about this. You can have your most highly educated doctor, your decorated civil servant person tell a parent, don't do this, but if you have grandma at home saying, "this is what I always did with you," she's going to trump every time because they trust her more than they trust us. So we have to kind of get in on a level of somebody that's already working with them that they trust. The churches, getting messages through that. If there's a community-based provider like the YMCA where their kids go to school. Something like that where those people that they actually trust what they're telling that to get that message across. I think that's going to be more powerful than bureaucrats that are telling them, this is what we've seen and these are the studies. The other thing I do want to say is, and I don't want to keep tying the website but now we can tell people, "they are all on computers, you can go on your phone, look and see how many kids in your community are dying in bed" when we're looking at those prevention strategies. Not everything is intentional neglect. These are parents that think they are doing good things for their kids, but they don't understand the risk factors. But it has to

come through a source that is going to get the point from the source that they are going to believe.

Sanders: [06:55:05] Commissioner Dreyfus.

Dreyfus: **[06:55:08]** Just for our representatives in the sheriffs' department, two quick questions. First, on mandatory reporters, Commissioner Petit earlier mentioned that more children should be known to CPS, then the few that weren't, and Major you talked about people that weren't reporting. I'm going to use the example of my husband just because he's not here and I can pick on him. He's a judge, and so he is required to maintain certain competencies in order to maintain his licensure, in order to continue to serve as a judge. I think about people, I know I can't hit at all mandatory reporters because some are not licensed, but for those that are, do you see a problem where it is a requirement for licensure to keep your license that you have to be able to demonstrate competencies and maintaining your competencies as a mandatory reporter. That the onus of the training of mandatory reporters isn't sitting on the child welfare agency but the onus of being competent as a mandatory reporter is with you, the licensee, and it's part of your ability to continue your license within a state. Do you feel that's an over reach? Does that make sense to you?

Shingledecker: **[06:56:20]** No, I think it's extremely important, and as a matter-of-fact while I was sitting here today my child protective unit law enforcement officer called me to say that they were investigating a case where a mandatory reporter had failed to call it in for a week, had known about sexual abuse to a child that was at a center and had not called it in. So we're investigating that as failure to report. I think that message has to go out there and it has to continue, you have to keep sending that message with mandatory reporters. I mean, I don't think everything needs to be hit with a hammer, but I think when people see that prosecution is possible if you fail to report, let's look at the Sandusky circumstance. We've made huge strides because of Sandusky here in our state and implemented things that were even more restrictive in reporting noncaregiver abuse, and so forth. Yeah, I absolutely think that it should be on those folks. People do what you inspect, not what you expect.

Dreyfus: **[06:57:26]** My second quick question is, I'm hearing in the state of Florida you have counties where it's done completely by DCF, CPI. You have counties where it's done by the sheriff's department, and then you talked about where there's a partnering between both going out together. So, is there data now that shows what works best? You've been at this a long time in Florida so what are you guys learning from that? What works? What's not working? What's the preferred approach?

Bullara: **[06:58:04]** I think it depends on the individual agencies themselves. I think in Hillsborough, with our partnerships with the department, it works rather well. The confusion I think is, we work it from two different sides. Major Shingledecker's has both the criminal and the civil under her. Where in our department, as large as we are, my workers do nothing but the dependency civil part, and my co-part across the street, he has the criminal side of the investigations, and to answer Commissioner Petit about the question on a lot of times we will

remove or shelter a child where they do not make an arrest because of the circumstances and that we need a little less than a criminal conviction that night to make sure that child is safe. So that depends on the prosecutor once they handle the criminal side of it. We are well in communication with the State Attorney's Office in whichever county it is, and we have an ongoing relationship where they do talk with the protective investigators, as well as the law enforcement officers, when handling those kind of investigations. I don't know if that answers your question Ms. Dreyfus.

Shingledecker: **[06:59:21]** I'd just like to add one thing to that. What's worked really well in our office is that my line officers, we have over a thousand people, I know we're not as large as Hillsborough, but those officers on the street have a better understanding of neglect and of abuse then they ever would have had if we weren't partnering up and doing this. They truly get it. They're going out on domestic violence cases, they are out there first and so they're probably the number one reporter to the hotline in our county law enforcement.

Dr. Sanders: [06:59:53] Commissioner Covington. Go ahead.

Spudeas: **[06:59:58]** There has been a report by the Inspector General in Florida a few years ago that showed no difference between the law enforcement being used, CPIs and the DCFs, that's one report. But yet there hasn't been a scientific study, research done on that. But there are also, they don't use the key way as the Department of Children and Families, so you're going to be viewing it differently.

Covington: **[07:00:32]** I have a question about your child death review process. Major Shingledecker you said you've been doing it for many years. First of all, anyone who needs good death investigations call Major Shingledecker, because she's really well known throughout the country. I know many of our child death review states have used her as a trainer. She does really good training. In our meeting in San Antonio and our prior meeting in Washington, D.C., we talked a lot about measurement of child abuse and neglect and obviously it's a super-hot issue in Florida right now in terms of counting. It seems that you were glad that you changed the law so that you could now review deaths including all reports. Why haven't you expanded that to include all deaths, or at least all known accidents and homicides? Because I can guarantee you you'll find more cases of abuse and neglect when you review more cases rather than just cases that get reported. It's sort of estimated around the country that only 50 percent of deaths ever even get reported as child abuse and neglect. When in fact the studies that have been done, the surveillance studies have been able to identify sometimes twice, even more than that when they've looked at multiple data sources.

Shindledecker: **[07:01:51]** That's correct. Being on the statewide team for the last 12 years, that was a constant request, that we felt that we needed to be looking at all child deaths and not just only the ones that are focused, those that were verified by the Department of Children and Families, and it was even smaller than that. It was those verified with a prior involvement with DCF initially. So when I was first on the team it was 30 cases and then it expanded to maybe over 100 cases and now with the change in the statute we will be able to

look at all called into the hotline. But my concern, just as yours, is we're not going to get the big picture because there will be many cases depending on the area in the state of Florida that will not be called in because the training isn't there, they don't understand the neglect death, they didn't equate it to that and we won't see it, we won't count it because we won't know about it. So that's the tragedy, but we have requested, it just has not been taken to the legislature that all child deaths should be done in the state of Florida. We are one of the few states left that don't look at all child deaths. We should.

Covington: **[07:02:54]** I think it's a real Catch-22 for states, because when you do better reviews, your numbers are going to go up. Just like your numbers probably went up when you added in reports to, but it takes an act of courage I think for many to be able to say, I'm willing to put up with the increase of numbers for a little while until things settle out. We understand what our true picture is. But it is a Catch-22.

Shingledecker: **[07:03:15]** Well the children are still dying. You won't see it, but they're still dying. The medical examiners know about it.

Dr. Sanders: [07:03:18] Commissioner Petit. This is the last question.

Petit: **[07:03:25]** A specific example to give to law enforcement. You have an open neglect case, child protective services, which you guys happen to have in some jurisdictions, it's just regular CPS that has it. There is also a criminal charge that's brought against an individual who was in that home, and it may be previous broken bones and so forth. There's a restraining order that says to the guy, don't go to the place. Every day that the guy is not prosecuted and convicted, let's say that's where it's headed, it's one day more that he's on the street. In some jurisdictions, there would be a priority given to a criminal case in which the victim of the crime is a child. It would leapfrog other cases. I'm talking about felony offenses. Is there anything like that in the way that you guys are doing this? Law enforcement is driving this system it sounds like in many ways, but how would you handle that case?

Shingledecker: **[07:04:22]** I know that you're saying there's an Assistant State Attorney here that could probably answer that, but that's unique to each judicial circuit and that would not be the case. We have specific assistant state attorneys that focus on and specialize in certain cases, and so they have that training and so they are able to carry them forward. That's all they do is child abuse or sex abuse, those are the only cases that they work on, so they would be moved forward in that arena. But I don't know that they would leapfrog anything else. But we do provide a DV or a special crimes unit that would go out and focus on that. If that person is going into that home setting, and we find out about it because we're going out there periodically checking. We will arrest them on a no-contact order if that exists. And we are pushing those no-contact orders, by the way, to protect those children when we can't get the parent that's nonabusing to put a no-contact order in place or a restraining order. We're taking care of that.

Petit: **[07:05:03]** What would the arrest lead to if you already had a restraining order? You must arrest them and charge them with a crime?

Shingledecker: **[07:05:32]** In our county we have an agreement with the State Attorney's Office that it would escalate it and they would probably be asking for a much higher bond or no bond.

Bullara: **[07:05:46]** [Inaudible] with Manatee County, but we do also have a special unit that prosecutes nothing but abuse cases at our State Attorney's Office, and that's who we're in contact with. Now as far as priority, that would be a docket in the court system as to where they fall, but obviously certain cases are more of a priority for those prosecutors than others.

Dr. Sanders: [07:06:09] Well on behalf of the Commission, I want to thank this panel for giving us a good overview of what's working, what's not working, and really appreciate you actually identifying areas that didn't work well and things that particularly tie to some of the issues that we might be address as the Commission moves forward, so thank you. We are going to close with a set of speakers and actually the first one will be Holly Grissinger who is an Assistant State Attorney and here for Bernie McCabe who is the State Attorney for Pinellas and Pasco County and Ms. Grissinger. I'll call up the next two speakers so we can have three up. Ghia Kelly from the Florida Coalition Against Domestic Violence and Mary Beth Vickers, Child Abuse Death Review Committee. Each presenter will have four minutes and we will then have a minute for questions. I'll have Miranda Phillips come up in the next group. Ghia Kelley and Mary Beth Vickers if you're here, come on up.

Holly Grissinger: **[07:07:28]** For those of you, I know the agenda states that Mr. McCabe was going to be here. I am obviously not Mr. McCabe. I have been a prosecutor in the Sixth Judicial Circuit. which is Pinellas and Pasco, for almost 14 years now, and more than 10 of those years I have specifically prosecuted crimes against children. I was recently promoted. Prior to that I was the special prosecutor for all heinous crimes against children. I currently still am very much involved in all child homicides, all Internet crimes against children, as well as any death penalty cases involving a victim under the age of 18. Commissioner Rodriguez, your anger is why I go to work every day. Apparently Commissioner Petit you have a lot of questions for me.

I will start off with the fact that I am not aware, I'm sure someone in my office keeps statistics, it's not me. I prosecute those cases that are brought to me by law enforcement. Because of the length of time that I have been prosecuting those kind of cases I have a very unique relationship with the investigators, the DCF, and the frontline workers. So as much as not everything gets brought in because law enforcement may not think that it's risen to the level of a criminal prosecution, quite often in Pinellas County I get a phone call that says, "Hey, Holly, come take a look at this." We have obviously a much higher standard than the frontline workers for verified cases. I know that we have a unique relationship with our law enforcement agencies. In Pinellas County where all of the sergeants of the different crimes against children units actually will contact me upon any death of any child in Pinellas County and I will start a little folder, and it may not end up being criminal, but it's there for me to look at. That I think is probably unique in some way to Pinellas. I'm not sure how the other agencies or other counties do that, but that was something that based on my time with those

investigators and detectives we determined was a good way to kind of make sure that what had happened was in fact either criminal or not.

Petit: **[07:09:59]** Because sex abuse is generally towards children and because there is very little about physical abuse and neglect that is a felony: most of the stuff that you prosecute, is it sex abuse stuff among children?

Grissinger: **[07:10:09]** No it is not. I've prosecuted abusive head trauma cases. Frequently what I see, we do get a lot of physical abuse cases, a lot of them may be discipline that just went a little bit too far and that are not necessarily taken any farther than that: an initial investigation with our office, but I unfortunately regularly see multiple fractures in infant children. I am currently prosecuting a case against a foster mother where the child originally came to my attention because he was the product of two very young parents, and he came to me with 17 fractures and he was at the time 18 months old. Jayden was then taken and placed in a medical foster home, and upon healing was placed in a regular foster home. That foster mother proceeded to rebreak Jayden's bones and burn his feet with cigarettes. Those are cases that I see unfortunately way too frequently.

Petit: **[07:11:33]** Where I was going with this is that in many places around the country that I've been to, district attorneys feel that the quality of a case that's brought to their attention because of the investigation doesn't rise to the level of meeting a standard of proof of beyond a reasonable doubt. I am wondering here if you guys have figured out a way to standardize that protocol of investigations with training or whatever so that you do get something that is prosecutable and that you are likely to succeed.

Grissinger: **[07:11:59]** What normally happens, there is no protocol. We have not standardized anything. I think it really is just a partnership. The crimes against children units in Pinellas County, along with the State Attorney's Office, work together. If there is a case that is serious in nature, we're getting a phone call early on, it's not that it's just brought to us and dropped on our desk. We are actively involved in these investigations from the beginning, and so we're there to say from a prosecutorial standpoint, "this is what I need." And they're law enforcement and they're out there doing their jobs. There's nothing in writing. It's just a relationship that has developed over the years in order to have successful prosecutions in those kind of cases.

Dr. Sanders: [07:12:51] Thank you very much. Thank you for your insights, Ms. Grissinger. Ghia Kelly.

Ghia Kelly: **[07:13:01]** Good afternoon. My name is Ghia Kelly, and I'm with the Florida Coalition Against Domestic Violence. The Florida Coalition is the professional organization for the 42 certified domestic violence centers throughout Florida. We provide funding primarily, but we also do training and technical assistance. So I'm here to kind of brief you on a project that we have in collaboration with the department as well as the sheriffs' departments that do the investigations as well, and it's called our CPI project, which is our Child Protection Investigation Project but it's really to address the co-occurrence of domestic violence and

child maltreatment because we know that domestic violence in Florida is one of the most reported maltreatments.

So around 2007, the Florida Coalition sat and had conversations with the State Attorney, with DCF, with the partners and really talked about how can we really support survivors of domestic violence so that they are safe and their children are kept safe from the perpetrators of violence. And from those conversations we were able to get funding to start our project. The first seven pilot projects started in 2009, and they were very successful, and we were able to then extend from those seven counties to four additional counties. All of the sheriffs' offices that are represented here, some not here, they all have our project. Basically the project co-locates a domestic violence advocate at the CPI unit to be full time and to really serve as a consultant to the CPI staff, because what we found in our research is that child welfare workers were not confident, one, in how to really sift through the dynamics of domestic violence and really what's going on in that family, because we know that the perpetrator's pattern of abuse can be very complex. It's really to have that advocate there not just to perform direct services, because we have centers that do that, but to really help build their capacity around understanding domestic violence and how to partner with survivors, because that is considered nationally to be the best practice.

The co-located advocates, a lot of their work in consultation is based off of the Safe and Together Model, which was created by David Mandel out of Connecticut and has been embraced as the model for domestic violence in Florida and in other states. And so we are really excited, because in our research and in our data we found that in Bay County, which is the Panama City area in Florida, we actually did research and found that removal rates from domestic violence cases—when we started the project in 2011, the domestic violence removal in both counties were at 20.6 percent. By June 2013, the domestic violence removal rates in these counties had dropped to 9.1 percent, and that timeframe was when we launched the project. We went back and had data collected again, and we found both the child welfare staff and domestic violence co-located advocates really attribute the decrease in removals to the project, to the Safe and Together Model, and to the formal partnerships, because it really takes everybody on board to keep these kids safe.

So you have the domestic violence partners, there's really a coordinated response to domestic violence. We have law enforcement at the table. We have the State Attorney and all of that. So that's really been our project that we wanted to model our expansion upon. As of July 1, we received additional funding based on the success of the project that we went from those 12 counties to now we just received funding for an additional 33 counties. So that means we have a total of 45 counties throughout the state of Florida that will have a co-located advocate to be on-site to provide that consultation. Hopefully we can see removal rates drop not just in Bay County but throughout the state, and we can see survivors of domestic violence supported, and their stories heard, and perpetrators held accountable, which is a big push for this project. Thank you for your time.

Dr. Sanders: **[07:17:39]** Thank you Ms. Kelly. Any questions. Commissioner Rubin.

Dr. Rubin: **[07:17:43]** That sounds like a terrific project. We haven't talked a lot about co-location of services and what prevents us from embedding services together. You've given us an example here of what sounds like a really working program and like they say, follow the money. How sustainable is that? What is that money? Describe the funding stream, what it should be? What are the barriers that you saw along the way to embedding a domestic violence specialist in a CPI unit?

Kelly: **[07:18:13]** Our biggest issue is, so much, I think when we were able to show, because our six pilot projects was funded from [*Inaudible*] that are no longer. But they are local funded so to speak. So we really had to show that this worked. The sustainability issue is really getting the training from the Safe and Together Model, which is really expensive and really being able to sustain the training—that's moreso the piece because of the high turnover of CPIs and case managers, which is really tough to train and spend that vast amount of money and then they not be there in a couple of months because of the high stress of the job. So that's really what the sustainability issue is. But DCF, once seeing not just seeing the success in Bay County but in the other counties, we have one in Hillsborough County, Pasco County, when we saw that the CPIs really embraced the co-location, once they understood the benefits of it, then DCF was willing to then give us --

Dr. Rubin: **[07:19:21]** So this is four-year waiver money? Is that what I'm assuming here? They're using the waiver to help support these type of services?

Kelly: **[07:19:27]** Yes. So we were excited to be able to get that because it's been years, and so I think the Bay County success and being able to have those numbers.

Dr. Sanders: [07:19:38] It sounds like we might want to get some written information because I saw some shaking of heads. So I'm not sure exactly what the funding source is. Thank you. Mary Beth Vickers from Child Abuse Death Review Committee.

Mary Beth Vickers: **[07:20:08]** Good afternoon. Thank you for the opportunity to be here this afternoon. I am currently the Florida Department of Health representative on the state's Child Abuse Death Review Committee. That's what I'll be talking with you about this afternoon. Some of what I share you probably already heard. I'll try to be brief and not get a stop sign. I'll start off by saying that the death review teams were created in statute in 1999 for the purpose of achieving a better understanding of the cause and contributing factors of child deaths related to abuse and neglect. With the ultimate goal of reducing and eliminating deaths as a result of child abuse and neglect. The state committee consists of 18 members. There are seven representatives from various state agencies. That would include education, Department of Children and Families, health, law enforcement, medical examiners, as well as 11 appointees from our state surgeon general who represent various disciplines related to children and family issues. An example of those representatives would be one of our medical directors for our child protection teams. A representative from law enforcement. As you heard Major Shingledecker say, she's been on the committee for a number of years. As well as a member from domestic violence. So it's a very broad multidisciplinary team. We also have

24 local death committees that have been in place for a number of years as well. The composition is similar. The size varies depending on the location in the state.

Over the years there have been a number of accomplishments and initiatives that have evolved from these state and local teams. They've done a tremendous amount of work. You've heard a lot about that today. You've heard about the safe sleep campaign. You've heard about drowning prevention. You've also heard about the drug-endangered children and one thing I haven't heard today, which I'll mention, is the campaign regarding who's watching your child. That's an educational campaign which provides parents and caregivers with tips on the importance of selecting a babysitter that is appropriate to watch their child in their absence. Because what we find, as you all know, that often times those are the individuals that end up being the perpetrators.

Opportunities moving forward: We will continue with these prevention initiatives; we're actually involved with the Department of Children and Families now with a drowning prevention campaign, we're in Phase 2 of that campaign, and we will continue with those efforts and of course expand those efforts as we move forward. You've heard from Representative Harrell this afternoon talk about this past legislative session and some of the changes that evolved from that legislative session. One of which, as you've heard, is the expansion in terms of the child deaths that the state committee, as well as the local committees, will be reviewing. We view that as positive and as a step in the right direction. I am happy to report that next week here in Tampa we have our first state Child Abuse Death Review Committee meeting following those legislative changes. So we will spend a lot of time talking about strategies that we need to put in place to expand the focus of that team. Talk about data analysis and how we can identify more prevention-type strategies, as well as mechanisms whereby we can assess outcomes associated with those tragedies. So I've got a stop sign. So I'll be quiet. Thank you.

Dr. Sanders: **[07:24:26]** Commissioner Dreyfus.

Dreyfus: **[07:24:27]** I can't tell you how wonderful it is, so congrats to the state of Florida, to have public health in this state so invested in the welfare of kids. It's really fabulous. So I have a question for you. Earlier on I asked a question about Medicaid. I was talking about the need to influence systems beyond what we think of as traditionally as child welfare, and I think about the education system. I'm going to ask you two quick questions.

Is there anything, when you do these death reviews, when you guys really start looking back and going why, why, why? Is it starting to get you to look even at your education system in terms of how starting in junior high or high school or earlier, kids are being taught about adverse childhood experiences. They're being taught about brain development. They are being taught about parenting skills. That it's normalized within the education system of your state not only for those folks due to be at risk. That's question one. But the reach of your thinking, as it becomes, how did we really from a public health perspective really get underneath this?

Then the second, where I think about that is on the Medicaid fund. And I think as a former Medicaid director I'm going, "I wish I would have done more to influence Medicaid policy as it's related to obstetricians." Prenatal. I mentioned this earlier. When you do these death reviews and you think about the "system influence" that you're trying to have, how expansively are you thinking about that as you're trying to get as upstream as possible from a public health perspective?

Vickers: **[07:26:06]** With regard to your first question. As I indicated, Department of Education is one of the representatives on this statewide committee, which helps gather their insight. We also have, you've heard a lot of discussion today about partnerships. We do try to do our very best with partnering with local school districts and making sure that the education, the message gets carried through to the school system. And speaking separately, apart from the Child Abuse Death Review process, I will say that not too long ago we had a summit, we're going to look to our DCF partners, whereby we had experts in child, medically complex children and child abuse and deaths across the state meet together to talk about what they do and what services they provide from across the state in an effort to educate caregivers, educators, in terms of what kind of services are out there from a prevention perspective as well as an education perspective. I hope I answered your question with that.

With regard to Medicaid, can you restate your question real quick?

Dreyfus: **[07:27:20]** I don't want to take up any more time. We don't have to answer it, I'm just thinking about it. When you think about these kids and you're thinking about all the systems that have intersected in their lives, I just keep thinking at the time of birth and I'm trying to say, as a former Medicaid director we knew a lot of these babies long before they were born. What are we doing to influence the systems that are intersecting with their parents prior to their births, and Medicaid is clearly a big funder of probably many of the children that we're talking about.

Dr. Sanders: [07:27:56] If you have a lengthy answer we'll have do it later. I know we have at least one other question, so I want to make sure we get to that. Commissioner Bevan.

Bevan: **[07:28:10]** My quick question and I can write it down to get the answer later. Who do you report to? Who holds you accountable?

Vickers: **[07:28:19]** The Child Abuse Death Review state, as well as local teams are established within the Florida Department of Health. So ultimately our state surgeon general has oversight for the state.

Bevan: **[07:28:30]** The state surgeon general appointed 11 people and you have 18 agencies. So it doesn't sound very independent to me. That's my concern. A naive concern I'm sure, but how can you make it more independent. It seems like you can get real sunshine in.

Vickers: **[07:28:49]** Right, right. I think historically, and I haven't been on the team as long as many folks have been, but I think historically there were some legal opinions and there was

a lot of discussion in terms of whether this committee is independent or whether it ultimately is established within the Department of Health. There has been a lot of discussion. I think that probably it will be looked at again in the future because statute is pretty clear from the perspective that it's established and administered by the Department of Health. Very good question. A question we've had lots of discussion about in the last 6 to 12 months.

Dr. Sanders: [07:29:32] Thank you. Thank you very much. All three of you, that was really great. Our last speakers: Miranda Phillips, Victoria Zepp, Barbara Macelli and Yomika McCalpine. We'll start with Miranda Phillips with Florida Youth SHINE.

Miranda Phillips: **[07:30:04]** Good afternoon, my name is Miranda Phillips. I am 21 years old. I aged out of foster care, and I'm a member of Pinellas Chapter Florida Youth SHINE. I was recently selected the statewide membership chair for Florida Youth SHINE. The Centers for Disease Control has found that establishing safe, stable, nurturing relationships is a key to preventing child abuse. Far too many of us who enter care are separated from our siblings, families and significant people in our lives. When we are separated from siblings and other important people, we lose our identity support, causing more trauma and negative effects that can last our whole life. We go from home to home and school to school and often start to have bad behavior or mental health problems. We are labeled "difficult" or "impossible to place in foster homes" and wind up living in group homes for our teenage years.

Shift workers in a group home do not replace a family. Without a family to relate to and stable placement to let us grow and have healthy and loving relationships, we don't attach to others, develop a support group, or learn how to handle day-to-day family issues. And how do we learn to be a loving parent? And yet children in foster care and those who age out of foster care are creating families.

According to the Florida "My Services" Survey, 13- to 17-year-olds in foster care, 13 percent of the 17-year-olds have a child, and we learn from the Florida NYTD survey, 18-22 year olds formerly in foster care, by age 20 over 50 percent of the girls are mothers and almost 60 percent are mothers by age 22. The articles in the *Miami Herald* have shown that in many of the child deaths, one or more of the parents had been in foster care. Also, DCF Secretary Carroll has recently told Florida Children's First that when there were nine child deaths in Tampa a few years ago, 100 percent had a parent who came from foster care.

I am here to share my experience of living in a group home and being separated from my bother and how this has affected me. I came into foster care when I was 12 and my brother was nine. We were first placed together, but then within two months I turned 13 and I was old enough to be put in an all-girls group home. So they put me in an all-girls group home, and my brother went to a foster home. We had visitations, but they were awkward because the fact that they would be in the foyer of the group home that I was at. And sometimes it'd be in parks in sketchy neighborhoods and the visits would only be an hour long and only once a month. There wasn't any privacy because the caseworkers would be looking and watching: "Talk, you guys need to talk, do something." But sometimes you don't even like your

caseworker, so how are we really able to communicate when you have somebody watching you? Within two years visitation started to fade away due to rescheduling or cancellations.

The group home I lived at had 40 girls in it, and there were shift workers with three shifts. Everybody shared rooms. My room had three beds, but the biggest room had six beds. Girls often moved and then when they moved you would have a new girl would come in and you wouldn't know this person at all. You would just come into your room one day and there would be a new person there. It's hard to live with other people like that because sometimes they can be mean or be dirty and you can't really do anything about that.

There is no privacy. We had a closet with a lock on it, but you don't really want to lock up all your stuff in one closet. Like your clothes and your decorations. Things would get stolen. If you had your stuff in the shower, you can't leave it there because people will use your stuff in the shower. So when you go to the staff and try to tell them that somebody is taking your stuff they would just be like, "Oh it's he said, she said. We can't really do really much about that because the fact that we have no proof," and they would just tell us to lock our stuff up, but who wants to live out of a locked closet.

We had level systems. There were several levels, and the first level was intake, and you'd have to do a packet to get onto Level 1 and then you would get 30 minutes extra on your walk time. As the levels got higher, you got more packets and the packets got harder to do. With your walk you can only go with another girl in the house and let's say if your friend to go on a walk with, they're on Level 1 and you're on Level 2, so technically you have an hour you can go only for 30 minutes because they only have 30 minutes.

There was a phone room and you could have 10 to 15 minutes on the phone, but there was only two phones in the phone room. So if there was a line you'd have less time. You had a phone, like a phone log, and you could only call the people that were on your phone log. The staff had to call the person, get that person on the phone, and then transfer the phone call to the phone room.

When I turned 14, I started to run away to a friend's house. I wanted to go there because I felt more like it was a natural home because the fact that I had my friend, which would be my sister, and her sister, which would be my other sister, and the mom. I felt like a normal kid. I had rules. I had to come back at a certain time. I had to do certain things. I had to do chores and I couldn't misbehave. I never tried to get real placement there because she was on disability, and I knew the state would say that she doesn't make enough money to take care of her two kids and me. Even though she could, but in the state's eyes it didn't work out that way.

Visitation with my brother was fading away, and I could barely see him, and then when I turned 17 I decided to go back to foster care and get ready to turn 18, and I stayed in my group home. And when I was 17, my brother was 14, we had our last visit, and it was a really good visit this one, and then he got adopted and it was up to the adoptive family after that, if

I could see him or not, and they wouldn't let me see him after that. And I never really knew why. I never talked to the family or anything to know.

This has affected me in ways like I have relationship issues. Like I'm used to people coming and going. Sometimes with like boys it's like, I need them almost. Because I've never had love from anybody else. I'm afraid to be alone. I can't live by myself. I always have to have somebody there. I can't stay by myself in my house. I can't be alone, it freaks me out. The whole point of everything to me is that if I feel this way, I wonder how the kids that went through the things that I went through feel this way with kids, and how they react to these things, because we never learned how to be a parent ourselves, so how can we take care of our kids if we never learned these things. Thank you.

Dr. Sanders: [07:36:40] Thank you. Wow! All right, Mrs. Victoria Zepp, good luck following that.

Victoria Zepp: **[07:36:58]** Well I'm not going to tell anybody how old I am, but I'm twice your age plus a couple, and I grew up in foster care too. We'll talk later because we have very similar stories and guess what, it gets better. That's my baby. Not only did I grow up in foster care, I am a foster parent of a teenage girl in the state of Florida, and I have a special needs adoption of my son Zachary, who has autism as well.

I'm here on behalf of the coalition but also to be able to take a look and have a conversation, and I think because I do have so many connections with foster care it makes it a little bit different, because every time I talk about balancing human welfare and economic prosperity, people get crazy. They look at me like how dare you talk about economic prosperity when it comes to our children. It is an industry. It's billions of dollars. The state of Florida alone, DCF has almost a $3 billion budget. But even more so, we don't really know how much it is in the state of Florida because we have in our statute revenue-estimating on child welfare, but we do not revenue-estimate child welfare.

So there were comments about the Florida Department of Education. We actually do have a curriculum based on abuse and neglect that went into effect a year ago. So tying those different agencies together, we have a five-agency MOU that we have been working closer together. When we talk about this issue that we have within child welfare, if the human toll alone, if that story wasn't enough to move you, or the 17 spiral fractures or whatever, the human toll is not enough to move people. Because otherwise we would have, "not on my watch." This would not be happening again. Why is it still happening? Why are the numbers increasing? Well I'll tell you why, because we don't talk about the whole conversation and the economic impact. When a child goes into foster care, it's not just the child—there's this ripple effect. It's generations that are impacted. The family is impacted. Is that child going to be able to go on and be a tax-paying citizen? How are our taxes being used? This affects every single citizen. It's a societal issue because it does go on for generations. How many kids do go into DJJ and from DJJ go to Department of Corrections? Juvenile Justice into Department of Corrections, because they were raised in an at-risk environment.

So if we do not take back, look at it as an ecosystem with the complexity that it has, can we ever say child safety and diversion could ever be a norm. So when we talk about who's who and who is missing in the state, I used to run the Florida's Children's Cabinet. I served on the state death data work group, and I've been an advocate for years. Until I sat on that Child Death Data Work Group, I didn't know half that stuff. I'm like, how do I not know this? Because there's a communication gap as well, and we're not integrating ourselves. We are not making it mainstream. The public isn't at the table. Walgreen's isn't at the table on this issue. It's an epidemic issue that we are dealing with when it comes to our children, and we need to change the conversation. We look to see, who has the ultimate power? Is it the feds? Is it legislature, states, communities, citizens? It's all of us, but we can't look to the other people to solve the problem or for them to stand up and take the lead. We have to come together, and I think that's what is brilliant about this. Is that you're saying okay, what is working, where are we going, because a lot of times we have the resources. Truly I believe, especially like in areas like Hillsborough, we have everything we need to help our kids in this community. If we could just get the barriers out of the way that are people-made. That are man-made. So how do we collaborate? The conversations that you're having today and what you're learning from … but we have to be more inclusive. I think it starts with changing the conversation.

Dr. Sanders: [07:41:24] Ms. Zepp, you are at time too. You have the PowerPoint and you have other things that would be helpful for us to have in writing. We'll have to continue the conversation.

Zepp: **[07:41:42]** On a closing quick note. Foster children are not a special species. They're our children, and they should be in our care. So that's just the biggest thing, and Florida I think has a tipping point. We have the only community-based care model in the country. Where the communities, and it shows. If you look at the data in here, especially on the dramatic rise in foster care and what we've been able to do in Florida, we, out of all the big five states, we are number one in the shortest amount of time that kids are spending in out-of-home care, and we're transparent with all of our data and such. I think that it is a model to be watched.

Dr. Sanders: [07:42:30] Thank you. Let me hear from our last two speakers.

Barbara Macelli: **[07:42:35]** I'm amazed you guys have gotten to this point and you're not all glassy-eyed. So, thank you. My name is Barbara Macelli and I'm the program director of Healthy Families Hillsborough with the Healthy Start Coalition. Healthy Families Hillsborough is one of 35 programs in the Helping Families Florida Network, and we cover 58 counties of the 67 counties here in Florida. We are sponsored by the Ounce of Prevention Fund and the Department of Children and Families. But here in Hillsborough we are especially fortunate that we receive an investment grant from the Children's Board of Hillsborough County to expand the number of families we serve to all counties. There is no way we could do that without the Children's Board, which is local funding.

Healthy Families in Florida was created by the Florida Legislature back in 1998 as a long-term child abuse and neglect prevention program. In response to some pretty horrific things that have happened here, to the children here in Florida. It's modeled after the evidence-based Healthy Families America program, and here in Florida we've undergone a rigorous evaluation, and I can tell you here in Hillsborough County in the Tampa area, 98 percent of our graduates are free of verified abuse and neglect. One year after the program, two years after the program, three years after the program, and then tacking on that we have really high-risk families that we see. If they had just six months or longer … 98 percent are free of any verified violence or abuse and neglect. That is a huge success for this community.

We are also fortunate that Healthy Families and Healthy Star, we collaborate to have staff in each of the hospitals. Earlier we were talking about when do we see families? We screen families, Healthy Start, especially prenatally, but Healthy Families screens them and Healthy Start at the hospital. Over 16,000 new parents get face-to-face screening for those programs, but also education on the leading causes of preventable infant death through our safety program. So I'll let Yomika talk a little bit more about what the Healthy Families program does, but basically each of those families receives messages about safe sleep, choosing a safe caregiver, and preventing shaking a baby.

Yomika McCalpine: **[07:44:58]** Hi, my name is Yomika McCalpine. I've been a Healthy Families support worker for the last seven years. I am also an adoptive mother, and I'm also a new appointee on the Child Death Review Committee. I'll be starting that next week. Healthy Families services begin during pregnancy or within the first three months of the baby's birth and can last up to five years, depending on the needs of the family. The families I work with have a wide range of challenges, such as mental health, substance abuse, domestic violence, inadequate income, and a lack of knowledge of appropriate child development, that put their children at risk for abuse and neglect. Every family that participates in Healthy Families receives continuous messages and education about safe sleep, how to deal with crying babies. Somebody mentioned "Who is watching your child?" That is very important to us. Water safety and many other safety concerns. We have put parents and other caregivers with knowledge and skills that they need to increase protective factors so that their children can grow up healthy, safe, nurtured, free from abuse and neglect, and ready to succeed in school and life. Just as a family support worker, I think each and every day as I walk into these families' homes that I am the second eyes and ears to these families, to be able to help prevent and look for potential risks and hazards that may trigger child abuse and neglect. I think about all the work that my coworkers and I do and how many lives we have saved. If I'm here for seven years and we have somebody else there for 13 years, and somebody else there for 18 years, just imagine how many lives that we are impacting and able to prevent child abuse and neglect.

Dr. Sanders: [07:46:43] Thank you very much. I know we have a couple of questions. Commissioner Rubin.

Dr. Rubin: **[07:46:48]** First I want to say Hillsborough rocks. You guys are doing some great stuff. [*Applause*] We're trying to connect the dots on strategies at a federal and state level, that we can actually make recommendations that can make change. I think you guys have a lot of positive experience the way you guys have worked together. I've been trying to get at this all day. I've been kind of middling around it. I always think the community provider has a unique perspective because they see the systematic, the silos of behavioral health, child welfare, the health department, Medicaid. You guys see it from the perspective as a community provider. I've done a lot of research on home visiting, and I know that despite what we'd like to see, is think about home visiting as a child abuse prevention program, in actuality on the implementation front they are struggling. There is a lot of data that shows they are struggling. It sounds like you guys are doing a lot better than most programs, maybe because of the connections where tension has been a problem. There's a lack of connection to child care. So incentives to keep families engaged. We've actually in Pennsylvania seen child deaths related to a lack of child care when mom went back to work. That's because of a failed strategy of connecting the dots between systems. So my question to you guys, it's the way you talk about too, which is really making those connections for you as you go into adulthood. What have you seen here that's worked to facilitate you to connect the dots, and where do you feel like you struggle, and how does that lend itself to potential recommendations how we might incentivize the right type of connections to be made so that a home visiting program like yourselves will be effective upon replication?

Macelli: **[07:48:29]** Well again, with Hillsborough County we have so many wonderful programs. Mainly actually funded directly by the Children's Board, as well as other funders. We work together and we meet on a regular basis. We have a very strong, for example at the hospital, a very strong triage unit. If they are not appropriate for Healthy Families or not appropriate for Healthy Start, we have others: Parents as Teachers. We have a whole list, our staff aren't just, from judicial references, just "pushing one drug." They are really looking at the comprehensive needs of all those families in that short face-to-face time that we have, and recommending the best course of action. And that's not just at the hospital, we actually do an intake prenatally too. So in Florida it's actually legislatively mandated that they do a Healthy Start screen on the first prenatal visit, and there are a whole host of risk factors that the family fills out, and then that we can triage really the best services.

Dr. Rubin: **[07:49:29]** That happens? People actually fill that screen out?

Macelli: **[07:49:30]** They actually do. The screening rate in the hospitals, it's done vocally, 96 percent of the families are screened. I believe actually, between 90 and 100. Thank you.

Dr. Sanders: [07:49:53] I see your hand, Commissioner Covington, but we should probably finish since we are finishing on a high note of the number of people that are actually screening. We absolutely need to finish. Some of us are going to miss our flights if we don't. So I do want to thank the presenters. We had just an incredible full day. A lot of information both about what works and what doesn't. I think to the point that Dr. Rubin just made, connecting what's happening here to the federal level. Really appreciate your energy, your

information, the preparation, and how well you're working together. It's really outstanding. I want to thank our staff who put on the day and did a lot of what needed to happen to get us where we needed to be logistically, and put on a very informative day. Our host the Children's Board. Thanks again for allowing us to use the space. Finally, to the audience: we had several hundred people either on the phone or here and many stayed all day, which I find remarkable, but a lot of information that they gathered. So thank you very much. And thanks to all of you.

[*Adjourn*]