"THE HEROIN EPIDEMIC AND PARENTAL SUBSTANCE ABUSE: USING EVIDENCE AND DATA TO PROTECT KIDS FROM HARM"

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

MAY 18, 2016

Serial No. 114–HR10

Printed for the use of the Committee on Ways and Means

U.S. GOVERNMENT PUBLISHING OFFICE

22–105 WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON WAYS AND MEANS

KEVIN BRADY, Texas, *Chairman*

SAM JOHNSON, Texas
DEVIN NUNES, California
PATRICK J. TIBERI, Ohio
DAVID G. REICHERT, Washington
CHARLES W. BOUSTANY, JR., Louisiana
PETER J. ROSKAM, Illinois
TOM PRICE, Georgia
VERN BUCHANAN, Florida
ADRIAN SMITH, Nebraska
LYNN JENKINS, Kansas
ERIK PAULSEN, Minnesota
KENNY MARCHANT, Texas
DIANE BLACK, Tennessee
TOM REED, New York
TODD YOUNG, Indiana
MIKE KELLY, Pennsylvania
JIM RENACCI, Ohio
PAT MEEHAN, Pennsylvania
KRISTI NOEM, South Dakota
GEORGE HOLDING, North Carolina
JASON SMITH, Missouri
ROBERT J. DOLD, Illinois
TOM RICE, South Carolina

SANDER M. LEVIN, Michigan
CHARLES B. RANGEL, New York
JIM MCDERMOTT, Washington
JOHN LEWIS, Georgia
RICHARD E. NEAL, Massachusetts
XAVIER BECERRA, California
LLOYD DOGGETT, Texas
MIKE THOMPSON, California
JOHN B. LARSON, Connecticut
EARL BLUMENAUER, Oregon
RON KIND, Wisconsin
BILL PASCRELL, JR., New Jersey
JOSEPH CROWLEY, New York
DANNY DAVIS, Illinois
LINDA SÁNCHEZ, California

DAVID STEWART, *Staff Director*
NICK GWYN, *Minority Chief of Staff*

SUBCOMMITTEE ON HUMAN RESOURCES

VERN BUCHANAN, Florida, *Chairman*

KRISTI NOEM, South Dakota
JASON SMITH, Missouri
ROBERT J. DOLD, Illinois
TOM RICE, South Carolina
TOM REED, New York
DAVID G. REICHERT, Washington

LLOYD DOGGETT, Texas
JOHN LEWIS, Georgia
JOSEPH CROWLEY, New York
DANNY DAVIS, Illinois

CONTENTS

"THE HEROIN EPIDEMIC AND PARENTAL SUBSTANCE ABUSE: USING EVIDENCE AND DATA TO PROTECT KIDS FROM HARM"

WEDNESDAY, MAY 18, 2016

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

The Subcommittee met, pursuant to call, at 2:06 p.m., in Room 1100, Longworth House Office Building, Hon. Vern Buchanan [Chairman of the Subcommittee] presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
Wednesday, May 11, 2016
No. HR–10

CONTACT: (202) 225–3625

Buchanan Announces Human Resources Subcommittee Hearing on "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm"

House Human Resources Subcommittee Chairman Vern Buchanan (R–FL), announced today that the Subcommittee will hold a hearing entitled "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm" on **Wednesday, May 18, 2016, at 2:00 p.m. in room 1100 of the Longworth House Office Building.** At the hearing, Members will examine the effectiveness of programs designed to address parental substance abuse and protect children from harm. Members also will explore State efforts to better use data to identify and serve children most at risk due to parental substance abuse, and the impact of the substance abuse epidemic on the child welfare system.

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. However, any individual or organization not scheduled for an oral appearance may submit a written statement for consideration by the Committee and for inclusion in the printed record of the hearing.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit written comments for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov*, select "Hearings." Select the hearing for which you would like to make a submission, and click on the link entitled, "Click here to provide a submission for the record." Once you have followed the online instructions, submit all requested information. ATTACH your submission as a Word document, in compliance with the formatting requirements listed below, **by the close of business on Wednesday, June 1, 2016**. For questions, or if you encounter technical problems, please call (202) 225–3625 or (202) 225–2610.

FORMATTING REQUIREMENTS:

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

All submissions and supplementary materials must be submitted in a single document via email, provided in Word format and must not exceed a total of 10 pages. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

All submissions must include a list of all clients, persons and/or organizations on whose behalf the witness appears. The name, company, address, telephone, and numbers of each witness must be included in the body of the email. Please exclude any personal identifiable information in the attached submission.

Failure to follow the formatting requirements may result in the exclusion of a submission. All submissions for the record are final.

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

Note: All Committee advisories and news releases are available online at *http://www.waysandmeans.house.gov/*.

Chairman BUCHANAN. The Subcommittee will come to order.

Welcome to the Ways and Means Subcommittee on Human Resources hearing on "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm." Welcome to today's hearing on how the heroin epidemic and more general parental substance abuse is hurting our Nation's children and how we can use evidence and data to protect more of them from harm.

The heroin epidemic is a growing crisis affecting children and families across the country and it is reaching into our local communities. In 2014, according to the Centers for Disease Control and Prevention, more Americans died from drug overdose than car accidents, and over 60 percent of those deaths were from heroin, painkillers, and other opioids.

In Florida, we know all too well of the consequences. We started to address this epidemic years ago by reducing access to opioids and decreasing their supply. Now that it is cheaper, and just as potent, heroin has taken over. Heroin overdose in Florida increased by 900 percent 2010 to 2014—900 percent. Unfortunately, the epicenter for the Florida crisis is in my own district, Manatee County, where more people died from heroin overdose per capita than in any other Florida county in 2014.

We have been talking about the issues of opioid addiction more broadly these last 2 weeks here in Congress, and I have been championing a comprehensive approach to provide more education, prevention, treatment programs to those in need. I was pleased to see a legislative solution, the Comprehensive Opioid Abuse Reduction Act of 2016, pass the House last week. The Senate has passed a similar bill, and I hope we can quickly resolve our differences so we can help more families immediately.

While we have made great progress, there is one area that deserves further attention: The impact parental substance abuse has on families. This crisis has a serious impact on our children, especially those who come in from foster care because of parental drug abuse. According to the data and news reports, parental drug abuse is a leading factor in why children enter foster care facilities. And multiple States have cited opiate, heroin, and other substance abuse as a major reason for the increase in foster care.

Caseloads and Federal data support this view. In fiscal year 2014, more than 25 percent of those children found to be victims of abuse and neglect had caregivers with drug abuse problems. Thankfully, many States, including Florida, are leading the effort to combat this crisis.

Today, we will learn about some of these approaches, including ways to serve families at home or in other settings so children can remain safely with their parents or more quickly return home if they must enter foster care. Florida and other States are also using data gleaned from prior child welfare cases to reform their responses to new cases, allowing them to more quickly and effectively respond to prevent tragic consequences.

In addition to those State efforts, the Senate Finance Committee has developed a draft proposal to shift foster care funding into services that will help prevent abuse and neglect. These reforms will encourage States to support programs that better address parental substance abuse and other issues, as well as implement programs that have proven their effectiveness in addressing the needs of parents and their children.

Today's hearing will help us take a closer look at the Senate's proposal and help in moving bipartisan, bicameral legislation. We have taken positive steps forward in the House to address the opioid crisis and substance abuse. Now it is time to turn to the kids that need our help as well.

I look forward to hearing more about these efforts today and discussing how we can work together on a bipartisan effort to protect more children from harm, because strong families make for a strong community.

I now yield to the distinguished gentleman, the Ranking Member, Mr. Doggett, for the purposes of an opening statement.

Mr. DOGGETT. Thank you so much, Mr. Chairman, for your interest in this matter and for holding today's hearing.

As I see it, this hearing is addressing one aspect of a critical problem. It is addressing the question that I think represents a failure by this Congress and by one State after another to deal effectively with child abuse.

Within the past month, on one of the front pages of the *San Antonio Express-News*, there was a report: "Kids who were bound constantly want food." Officers rescued a boy, 4, who was tied by his ankle with a dog chain in the yard at his home. His sister, 3, had her hands tied with a leash above her head, her arm broken in two places. Authorities said the two had been physically abused for at least 2 weeks. "They constantly want food," said their attorney ad litem.

Just a few miles up the road and only a few days apart, a little girl, 1 year old, sexually abused by her mother's boyfriend, along with her sister, she was killed by the physical abuse that she suffered.

And only a few days before that, a young student at the University of Texas was murdered by a child who had been physically abused himself, was in the foster system, but had run away from it.

Time after time, not only in Texas, but across the country, we see the price that is being paid for our failure to deal effectively

with child abuse. And because our courts have also seen it, this is an emerging crisis.

In my home State of Texas, the situation for severely abused and neglected children is so bad that a Federal court in Texas has declared the system unconstitutional, as was done previously in the State of Mississippi, as has occurred in challenges in one State after another.

In her ruling Judge Jack wrote, "Years of abuse, neglect, and shuttling between inappropriate placements across the State has created a population that cannot contribute to society and proves a continued strain on the government through welfare, incarceration, or otherwise."

Certainly the problem with opioids, drug abuse, is a very big factor, from talking to people in the field who deal with this issue every day in Texas.

And it is great that some legislation was passed last week concerning that aspect of the problem. There is only one major concern about that and about what we are not doing on child abuse here, and that is that talking about it, passing changes without approving necessary resources to get to the problem, where caseworkers for child protective services are underskilled and overburdened with cases, just talking about it and not putting the resources out there to deal with and to prevent these tragedies and moving our resources so that they focus on prevention, not just responding after one of these horrible events occurs, and not just lurching from one tragedy to another, that is what this Congress ought to be focused on.

Senator Wyden and I have introduced legislation to try to change the focus to prevention. Our first speakers today, who have worked on child abuse, have raised many of these concerns. A scaled-down version of that legislation Senator Wyden and I introduced has been circulated now in draft form. There is agreement about some of the things that need to be done. There is certainly bipartisan agreement in this Committee about the importance of doing something.

The issue is: Are we willing to put our money where our mouth is? Just reorganizing the deck chairs on the Titanic by moving some money from one part of child abuse to another will not get the job done. Our States need to do more, but we can in this Congress provide resources and provide an incentive to the States, particularly those that are under court order like Texas and Mississippi and the other States that are likely to be under court order when their cases are finished, provide them an incentive to do right by these children.

We won't stop all child abuse, of course, but we can prevent some of these tragedies by applying the resources we have within our ability to provide and work together to address these kinds of concerns, back up and encourage the States, and get the resources we need to reduce the level of child abuse.

And I yield back.

Chairman BUCHANAN. Without objection, other Members' opening statements will be made part of the record.

On our first panel this afternoon we will be hearing from two of our distinguished colleagues, the Honorable Tom Marino of Pennsylvania and the Honorable Karen Bass of California.

Mr. Marino, please proceed with your testimony.

STATEMENT OF THE HON. TOM MARINO, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA

Mr. MARINO. Good afternoon, and thank you, Chairman Buchanan and Ranking Member Doggett and the Members of the Subcommittee, for giving us the opportunity to testify on an issue that is important to both of us.

It is abundantly clear that our Nation is facing a substance abuse epidemic. Unfortunately, one group that we fail to mention as being affected are the children who have been placed in foster care because their parents' have become addicted to drugs and alcohol.

Over 400,000 American children are in foster care. In my home State of Pennsylvania alone, approximately 15,000 children reside in foster care. As a former State and Federal prosecutor, I have seen firsthand how substance abuse directly affects children, and I have seen my share of children on slabs in morgues.

Many of the people I had been tasked with prosecuting were parents whose children ended up in foster care. This was done with the hopes that following treatment, these offenders could become parents again.

This is not always the case. Many of the individuals who enter treatment programs find that their necessary care is cut short due to gaps in healthcare insurance and they are unable to afford additional treatment.

We recognize that substance abuse is a serious disease that requires serious treatment. Nevertheless, there is a great void in the way that our current health system treats substance abuse. In most cases, the only treatment available to those affected is short-term intervention like detoxification.

To adequately treat those who suffer from substance abuse, we must provide serious long-term treatment. Those addicted must have the ability to be treated by specialists and receive proper medications.

In this current environment, we are doing a disservice to those who require treatment. Many addicts are ineffectively treated. Although one may leave treatment and be "cured" by some standards, more often than not one ends up behind bars or in another futile program because their first attempt failed.

The question remains: What can we do to ensure that those who require help get the proper treatment and are reunited with their children?

One treatment option I have advocated for years would be placing nondealer, nonviolent drug abusers in a secured hospital-type setting under the constant care of health professionals. Once the person agrees to plead guilty to possession, he or she will be placed in an intensive treatment program until experts determine that they should be released under intense supervision. If this is accomplished, then the charges are dropped against that person. The

charges are only filed to have an incentive for that person to enter the hospital/prison, if you want to call it that.

In an effort to keep them in touch with their children, we can offer them the chance to continue to visit with and eventually care for their children as they undergo treatment. This is a massive project. Not only are we dealing with trying to cure the drug addict, but we are trying to keep a family together.

And it is going to take a lot of money. The Feds are going to have to be involved in this, the States are going to have to be involved with this, the local child welfare agencies are going to have to be involved with this. This isn't just one entity that is going to take care of this.

Initially, we would have to separate them. But hopefully, after they have been cleared by medical professionals, one can regain custody of their children while still receiving treatment in the facility. This treatment option may offer a better chance for addicts to finally be cured and have a normal life, but also their children have a normal life.

As with any disease, there is no one-size-fits-all approach to substance abuse treatment. Some people respond to treatment in different ways, and for most it takes a very long time. Congress must continue to address the current drug crisis and keep searching for better ways to treat addicts and tend to foster children.

We must also continue to protect the children of parents who are suffering from substance abuse. Placing these children in foster care is necessary. However, in the instances where we can keep the families together, it remains an important key to curing drug addiction.

With that, I yield back.

Chairman BUCHANAN. Thank you, Mr. Marino.

Ms. Bass, please proceed with your testimony.

STATEMENT OF THE HON. KAREN BASS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Ms. BASS. Thank you, Chairman Buchanan, Ranking Member Doggett, and Members of the Subcommittee. Thank you for the opportunity to give remarks to you today.

Tom Marino and I serve as two of four Co-Chairs of the Congressional Caucus on Foster Youth and have been very much involved in this issue.

This is a critical time in our country, and from my perspective we actually have an opportunity to learn from the last drug epidemic—crack cocaine in the 1980s and 1990s.

I can assume that many of you were not in Congress during those years. I was in Los Angeles serving as a member of the faculty at the USC Medical School and I spent several years working in the emergency room in LA County.

Our response during those years to the crack cocaine epidemic was one of outrage and anger. We were angry at people who were addicted, and we were particularly outraged at women and mothers who suffered from addiction and neglected their babies, and even abandoned their babies in the hospital after delivery.

We passed laws that eventually led to an 800 percent increase in the incarceration rate for women, and the number of children re-

moved from home and placed into foster care skyrocketed. At the height of the epidemic, there were over 40,000 children in foster care in Los Angeles County alone. Today that number has been reduced by over 50 percent.

The crack cocaine epidemic and advances in science led to today's understanding that addiction is a brain disease. One of the characteristics of addiction, unfortunately, is relapse. And so far in the latest epidemic we are not hearing cries for incarceration. I do worry, however, that those cries might still be coming.

So far we seem to be approaching the opioid epidemic and addiction differently. Just as science advanced our understanding of addiction, research has certainly advanced our understanding about how to handle families that are in crisis. We know the majority of children in foster care are removed from home because of neglect, and we know that that neglect is secondary to addiction, mental illness, or both, dual diagnosis.

We know that removing a child from home is traumatic for the child regardless of the circumstances. We certainly know that there are times we absolutely must remove a child for their safety. However, we have also learned that families can benefit tremendously when services like drug treatment are provided in a fashion that allows families to remain intact.

I agree with my colleague, Mr. Marino, that you need to have a variety of approaches. There is no one-size-fits-all. I want to suggest a couple of programs, some of which I believe you are going to hear from today.

Members of this Committee passed legislation allowing States to apply for IV–E waivers to use Federal funds in developing evidence-based programs to see if the number of children in care can be safely reduced and outcomes can be improved. Many States have used the funds to target parents with substance abuse disorders. Kentucky and Maine are implementing a program known as START, Sobriety Treatment and Recovery Teams. I know you will hear from them directly in the next panel. Oklahoma connects parents to substance abuse services. San Francisco has a program called Family Link that includes both residential and outpatient substance abuse treatment services.

In LA County, SHIELDS for Families has created a therapeutic community where entire families live in an apartment community. In the last 5 years, more than 81 percent of the participants have completed all phases of the program, which can last up to a year, and maintained their sobriety and kept their families intact. This program has saved LA County millions of dollars that would have been spent placing children in foster care.

The legislation this Committee passed allowing States to apply for title IV–E waivers is set to expire in 3 years, 2019. After years of implementing programs, States and counties have developed many evidence-based practices that have successfully and safely reduced the number of children in care or improved outcomes. So now is the time to consider implementing Federal finance reform.

I believe this Committee will soon be discussing the Family Stability and Kinship Care Act that will provide flexibility in the use of title IV–E dollars. If and when this Committee does consider the

legislation, I would hope that substance abuse will be up front and center.

When people suffer from addiction, sometimes they have to hit rock bottom before they face the reality of their disease. Sometimes rock bottom results in them losing their children. Many times women refuse treatment because they don't want to leave their children and enter a program. Then their addiction spirals so far out of control the government has to intervene.

I come before you today out of concern for the individuals and families that have lost everything. So if they had insurance, they lost it, and if they lost their jobs their families cannot afford expensive drug treatment programs.

So we as a society have a choice. We can incarcerate them when they begin criminal behavior to support their addiction. We can remove their children and place them in foster care. Both choices cost the Federal Government billions of dollars and in too many cases result in the government supporting the individual their entire life when they end up in prison. Or we could look at how we increase funding to SAMHSA for community-based drug treatment services.

Thank you.

Chairman BUCHANAN. Thank you, Ms. Bass.

Do any of the Subcommittee Members have questions for our colleagues on the panel?

If there are no further questions, then you are free to go, and I want to thank you for testifying before the Subcommittee today. Thank you very much.

Ms. BASS. Thank you.

Chairman BUCHANAN. Now we will move on to our second panel. On the second panel this afternoon we will be hearing from four experts: Ms. Tina Willauer, Director for Sobriety Treatment and Recovery Teams, START, of the Kentucky Department for Community Based Services with the Kentucky Cabinet for Health and Family Services; Mr. Hector Glynn, Vice President for Programs, The Village for Families & Children; Ms. Katherine Barillas, Director of Child Welfare Policy for One Voice Texas; and Mr. Bryan Lindert, Senior Quality Director for Eckerd Kids.

We will begin with you, Ms. Willauer, whenever you are ready.

STATEMENT OF TINA M. WILLAUER, MPA, DIRECTOR, SOBRIETY TREATMENT AND RECOVERY TEAMS (START), KENTUCKY DEPARTMENT FOR COMMUNITY BASED SERVICES, KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES, AND CONSULTANT, CHILDREN AND FAMILY FUTURES

Ms. WILLAUER. Thank you, Chairman Buchanan, Ranking Member Doggett, and Members of the Subcommittee. Thank you so much for conducting this hearing on our Nation's opioid crisis and the effects of parental substance use disorders on our Nation's child welfare system. I am honored to talk with you today about Kentucky's efforts over the last 10 years to address these very issues. And in my career of 25 years in child protective services, this has been my dedication. So thank you.

The good news is that we know a lot more today about what works with families in this population. There are good programs all across this country that really save money and have improved out-

comes. I am going to talk to you today about the Sobriety Treatment and Recovery Team, or START, program that has been implemented in Kentucky, and I have three primary points today.

First of all, START has better outcomes for children and families than standard CPS.

Number two, strategies that work for families include collaboration across systems, intensive work, quick access to substance use disorder treatment, shared decisionmaking, peer supports, and a nonpunitive approach, among other strategies.

Number three, the current opioid epidemic reinforces that the most important policy issue in child welfare right now is changing the financing model to prevent foster care placements whenever safe and possible and taking the programs that work to scale by using the lessons of prior Federal investments.

So why did Kentucky invest in START? Well, in 2006 we had a terrible opioid epidemic going on with prescription drugs in Kentucky. And at that time, 80 percent of the children in Kentucky's foster care system were there because a parent had a substance use problem. So this was a real crisis and an opportunity for our State to invest in a program that works.

So what is START? START is a child welfare-led program that helps parents achieve recovery, and it keeps children in the home when safe and possible. START serves CPS-involved families with a substance-exposed infant or young children. And in START we address addiction as a brain disorder because we know that it affects the whole family and it requires treatment.

So in START we pair specially trained CPS social workers with family mentors, and family mentors are persons in long-term recovery from addiction who actually had a CPS case in their past. They are now stable and in recovery, and they help new parents engage in treatment.

Together, that worker and mentor dyad serves families, a very small caseload of families, and they intervene very quickly upon the CPS report, right away. Kind of maximizing on that window of crisis, we partner with substance use treatment providers, and parents can get into treatment from START within 48 hours.

So creatively working with families, giving quick access to treatment, and providing wraparound supports can allow us to leave some children in the home safely while the whole family gets treatment.

So at the same time that we were implementing START in Kentucky, Kentucky was lucky enough to be awarded with two RPG grants, in 2007 and 2012, and it was just the right initiative at just the right time. The reason is because we receive a lot of technical assistance and there was a real push for rigorous program evaluation that allowed us to study START.

With RPG support, we have now produced four peer-reviewed journal articles, and START is now listed in the California's Evidence-Based Clearinghouse for Child Welfare as a program with promising evidence.

The work isn't done, however. We continue to build START in Kentucky. And we are building on the evidence. We are actually expanding the program in Louisville, Kentucky, under the title IV–E waiver program.

So what did we learn? START serves the top highest risk cases in the entire State, but the mothers in START achieve double the sobriety rates of those moms who didn't receive START services, children in START were 50 percent less likely to enter foster care, and at case closure, over 75 percent of the children served by START were actually reunified with their biological parent or they remained there in the home the whole time.

Because of our low rate of recurrence of maltreatment, very few children ever reenter foster care, and for every dollar spent on START, we save the Commonwealth of Kentucky $2.22 just in the avoidance of foster care cost alone.

So in closing, I can't think of a better time in the midst of this opioid crisis to better protect children and families with substance use disorders. START has more than a decade of study behind it as to what works. We know what works now. And I am thankful for the IV–E waiver program, as well as the RPG program.

But we now must move from demonstration projects to system-wide reform, meeting the problem at the scale of need. So really at this point, we would like to move the financing of child welfare so the family can remain intact, and receive services. And what we know is preventing kids from entering foster care not only saves money, but it reduces trauma to children and families.

Thank you so much.

[The prepared statement of Ms. Willauer follows:]

WRITTEN TESTIMONY OF
TINA M. WILLAUER, MPA
DIRECTOR, SOBRIETY TREATMENT AND RECOVERY TEAMS (START)
KENTUCKY DEPARTMENT FOR COMMUNITY BASED SERVICES
KENTUCKY CABINET FOR HEALTH AND FAMILY SERVICES
CONSULTANT, CHILDREN AND FAMILY FUTURES
before the

COMMITTEE ON WAYS AND MEANS
SUBCOMMITEE ON HUMAN RESOURCES
U.S. HOUSE OF REPRESENTATIVES

START
SOBRIETY TREATMENT AND RECOVERY TEAMS

"Serving families with child maltreatment and substance use disorders: A decade of lessons learned"

Introduction

Chairman Buchanan, Ranking Member Doggett, and Members of the Ways and Means Subcommittee on Human Resources, thank you for conducting this hearing on our nation's opioid epidemic and the effects of opioid and other substance use disorders on our nation's child welfare and foster care system. My name is Tina Willauer and I am currently the Director of the Sobriety Treatment and Recovery Teams (START) program in Kentucky and a Consultant for Children and Family Futures.

I am honored today to talk to you about the efforts of Kentucky over the past decade to address the systemic and family issues arising from the co-occurrence of substance use disorders and child neglect and maltreatment. My entire professional career of more than 25 years has been dedicated to the effort of improving the lives of parents and children affected by substance use disorders. We know much more today about what actually works with this population of families and there are many programs across the country finding success with improved outcomes for children and families. I will be discussing the START program and what we have learned about implementation, strategies, improved outcomes, cost and opportunities to inform national efforts. The challenge and need is to bring evidence-supported strategies, systemic interventions and programs that work, like START, to scale and make them sustainable to keep families together and help parents gain competence.

START Brief Overview

The Sobriety Treatment and Recovery Team Program (START) was initiated in 1989 as the Alcohol and Drug Addiction Protection Team program in Toledo, Ohio and later developed in Cleveland with the help of the Annie E. Casey Foundation (2001) and expanded to additional

communities in Kentucky under the Regional Partnership Grant program in 2007. It was developed to address the needs of families with infants affected by prenatal exposure during the crack cocaine epidemic. The goals were to keep children safe and reduce placement of these exposed infants within state custody. START was designed as an integrated program that incorporates multiple effective strategies such as family decision making and family preservation into a single program.

START is a child-welfare led program designed as an integrated treatment intervention for families with the co-occurrence of child abuse and neglect (CA/N) and parental substance use disorders (SUDs). START serves families that have substantiated CA/N, parental substance abuse as a primary risk factor for child safety, and at least one child five years or younger, are not currently receiving services through Child Protective Services (CPS), and are referred to START within 30 days of the initial CPS report. As an integrated intervention, implementing START requires intense collaboration between child welfare and SUDs treatment providers, including establishing shared values, common goals, common case plans, and joint responsibility for both parent and child outcomes.

This brief program description of START understates the amount of effort and values clarification that must occur prior to achieving fidelity to integrated practices between child welfare, treatment providers, and the judicial system. Infusing shared values, shared decision making, common case goals and shared responsibility for child and family outcomes into everyday practice in a way that essentially changes the paradigm for the system of care is an arduous and time-consuming process. Thus START is both a program with specific strategies to address the needs of parents and children AND a catalyst for reforming the service delivery system between child welfare, substance use and mental health disorder treatment, and the judicial system.

A START Success Story

The story of Carrie is a classic example of how, with the right services in place, a family can safely stay together. When Carrie was a child, her family was well-known to CPS due to physical and educational neglect, sexual abuse, and parental substance abuse. Carrie was never removed to a safer setting, began using drugs and alcohol as a teenager, and ended up having a CPS report with her own first child due to her substance abuse. Carrie gave guardianship of her first child to a relative and had trouble trusting "the system" because of her past experiences with CPS. Carrie's drug use then escalated to IV heroin supported by prostitution.

When her second child was born substance exposed, Carrie was referred to START by the CPS investigative staff. In START, her worker and family mentor worked hard to engage her. She received intensive child welfare services, peer recovery coaching, quick access to treatment services, coordinated treatment planning, and shared decision making between CPS, treatment providers and the family. Carrie was unable to abstain from heroin until she received medication assisted treatment. With methadone, Carrie completed addiction treatment, counseling for past trauma and domestic violence, parenting classes, and in-home family-based services. She attended 12-step meetings to support her recovery. Her baby received occupational, physical, and speech therapy for developmental delays. START's collaborative model helped support

Carrie in getting the help she needed and participating in parent-child services, all while overcoming the stigma and discrimination related to her history of addiction and use of methadone. This case was successfully closed in the spring of 2015 with both children reunited with their mother. John, the father of the older child, received treatment is now drug-free, working, and has an active role in his child's life. Carrie delivered another baby in December 2015, this time drug-free! She continues to parent her three children.

START is an Evidence-Supported Intervention

Since its beginning in Ohio, START has been fortunate to have increasingly rigorous program evaluation that has spurred scientific thinking in the START teams, improved implementation, and documented both program outcomes and opportunities to improve. Currently, START is listed on the ***California Evidence-Based Clearinghouse for Child Welfare*** as having promising research support (http://www.cebc4cw.org/program/sobriety-treatment-and-recovery-teams/detailed), with continued studies underway to advance the level of evidence. START has operated in Kentucky since 2006 and has spread to implementation in Indiana in 2013 with two START sites and a third planned for 2016. New York City and the state of Georgia piloted START, and other states have inquired about embedding START into their systems. Because it is a complex intervention with multiple integrated strategies that transforms the system of care, it requires jurisdictions and their leadership to make a sustained commitment to implementing the program with fidelity over several years.

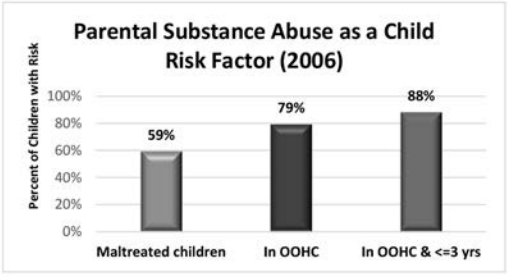
Purpose of This Testimony

My written and oral testimony will:

- Illustrate the processes used in the past decade to achieve system reform in Kentucky.
- Describe how these efforts were augmented by the support of the Regional Partnership Grants and broadened through the Title IV-E Waiver program.
- Outline the outcomes of START including cost benefits.
- Depict effective START strategies and lessons learned to inform national efforts.
- Define national opportunities to expand best practices.

Kentucky's Persistent Efforts in the Past Decade

In 2006, Kentucky's data showed that 59% of maltreated children, 80% of all children in Out Of Home Care (OOHC; also called foster care) and 90% of children three years and younger in OOHC had risks to their safety due to parental substance abuse. Kentucky was unique in the capacity to identify these trends because it has a fully approved



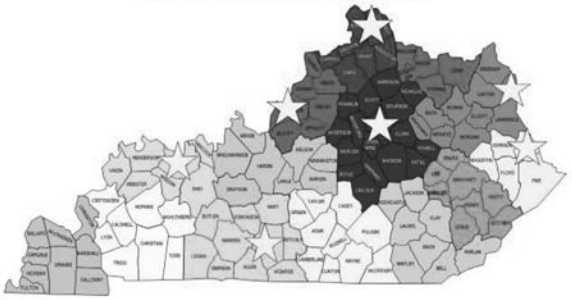
SACWIS system, leadership in using child welfare administrative data and the ability to integrate information from the CPS investigations (NCANDS data) including the State's risk assessment with data on OOHC placement (AFCARS data) to describe family needs and risk factors. Families with both substantiated CA/N and substance abuse risks were likely to have four additional safety and risk factors including poverty, domestic violence, criminal history, and multiple adult partners in the home. Often there were multiple prior reports of suspected child abuse or neglect made to CPS.

At that time, Kentucky was one of a few states that did not pay for substance abuse treatment using Medicaid, and funding for substance abuse and mental health treatment had remained level for 15 prior years. Except in a few isolated urban areas, there were minimal SUDs treatment services available, with 454 mothers across the state on wait lists of four or more months to receive any treatment. Workers and the courts removed children and made referrals for parental SUDs treatment knowing that parents were unlikely to be able to access treatment; they waited for the family to fail because no one had a better alternative. The relationship between the Division of Behavioral Health (DBH) and the Department for Community-Based Services (DCBS) on a state level as well as between local DCBS offices and regional Community Mental Health Centers (CMHC) was marked by mutual blaming, distrust, philosophical differences, and competition for limited funds.

To begin to change that situation, the child welfare system invested $2 million TANF MOE (state general fund dollars) in substance abuse treatment to jump-start collaboration with DBH and CMHCs in order to stimulate change and improve outcomes in both systems. This was the beginning of the Kentucky Substance Abuse Initiative.

The TANF MOE funding for START and the Substance Abuse Initiative has been augmented by two Regional Partnership Grants (RPGs) and more recently the IV-E waiver program. The START sites were placed in the State to be 'hubs of influence' in different CMHC regions with the intent that the efforts of START would transform the system of care in the hub site with improved collaboration and practices spreading through the regional DCBS and CMHC structure.

Kentucky – CMHC Districts and START Sites



The goal was to establish an integrated treatment model between child welfare and the behavioral health system with increased court collaboration. The site in Daviess County

(Owensboro, semi-urban) is the newest site with Jefferson County (Louisville, urban) being the longest running and largest START site. Sites were established in Barren County (Glasgow, rural), Kenton County (Covington, urban), Boyd County (Ashland, semi-urban) and an RPG site in Martin County (Inez, rural Appalachian). Although it would be easier administratively to have the START programs more contiguous, the hubs-of-influence approach has been more effective in transforming the system of care in larger geographic areas.

In addition to START, Kentucky tried other approaches with different strategies including an RPG grant for the Families in Safe Homes Network (FISHN) program and Solutions (state funded), both in Eastern Kentucky. Each of these models taught us more about what works best. For example, the Solutions program provided SUDs treatment to mothers but not fathers, focused primarily on treatment rather than on changing CPS practice, and placed most children in OOHC.

System reform was both stimulated and expressed through these efforts:

- Contract agreements between DCBS and DBH with funds for treatment resulted in shared visions, infusing of best practices in both CPS and behavioral health, and rapid and more intensive treatment for parents.
- A common data collection system between DCBS and the CMHC on START clients included details of behavioral health treatment that supported fidelity to rapid access to treatment with more intensive services for parents. These data promoted shared accountability for fidelity to the model and shared understanding of both child and parent outcomes.
- Program evaluation efforts were embedded into START before it was implemented, using an empowerment model of evaluation. The internal program evaluation effort that worked with staff and providers to design and interpret results was an additional catalyst for change toward shared understanding and shared accountability.
- The quality of substance abuse treatment by START providers was improved with the introduction of high quality evidence-based practices such as Living in Balance and Seeking Safety.
- The Network for the Improvement of Addiction Treatment (NIATx) process was used in Kentucky to improve collaborative service delivery in both DCBS and the CMHCs.
- As part of In-Depth Technical Assistance provided by the National Center on Substance Abuse and Child Welfare (NCSACW), a series of statewide regional forums and drug summits strengthened specific practices like co-location of staff and consultation with the courts to improve the three-agency collaboration around parental substance abuse.
- Through expanded Medicaid funding and provisions of the Affordable Care Act (ACA) there has been a dramatic increase in access to behavioral health treatment services for child welfare engaged families: mothers, fathers, and children. The entire family unit is the focus of START. Because of a managed care system, the focus now is on entry into the appropriate level of care and type of service and the reduction of addiction symptoms rather than the completion of a treatment regime, making treatment more targeted to achieving results rather than compliance. The original two million dollars in state funds are now being used to fund other innovations in START and continue to augment treatment for the most needy.

- Fathers and significant partners in the family are all served by START, reflecting a shift in practice for CPS and treatment providers to understanding the value of fathers to families. Although we have a long way to go to provide optimal service to fathers, the inclusion of fathers has pushed the program to consider new ways of delivering services.
- Services to improve child well-being are an included standard practice in START, requiring collaboration with early childhood specialists in behavioral health, child development, and home visiting.
- Although it has taken a decade of concerted effort, policies and procedures are being rewritten in the three agencies - child welfare, behavioral health, and the judicial system - to reflect best practices in drug testing, placement of children in OOHC, behavioral health treatment strategies, and integrated service strategies. These changes in standards of practice and policy reflect system reform and ensure sustained performance improvement.

Regional Partnership Grants and IV-E Waiver Support

We thank this committee for the vision of the IV-E Waiver program and their continued support of the Regional Partnership Grant (RPG) program in Title IV-B part 2 which provides services for children and their families affected by substance use disorders. The RPG was just the right program at just the right time to prepare us to deal with the crisis in child welfare due to parental substance use disorders. In total, 74 grants have been awarded under the RPG initiative in three rounds of funding.

Kentucky has been fortunate to receive two RPG awards to support START expansion into two additional counties, one a rural Appalachian county (Martin) with an epidemic of diverted opioid prescriptions and another in a semi-urban (67% urban) county (Daviess). In addition to supporting two more 'hubs of influence' to transform the system of service delivery in the regional CMHC and to provide evidence-supported interventions to families, each START site teaches us more about what works under what conditions and improves implementation.

All states and tribes receiving RPG awards regularly participate in on-site and off-site training as *'communities of learning,'* which has dramatically enhanced the capacity of professionals in Kentucky to respond to the substance abuse crisis. The best speakers in the nation were engaged to develop the capacity of states to identify trends in child welfare and substance abuse treatment, best practices for integrated programs, collaborative strategies, program evaluation strategies, funding options and sustainability, and a wide range of practice innovations. Participating in these learning communities helped Kentucky invest in a national effort and contribute to the nationwide learning organization. We developed expanded expertise in all three systems to improve program implementation, shared best program and evaluation practices, and actively collaborated with many other states. For Kentucky, the RPG and related efforts have influenced policy development, training programs for child welfare workers, the adoption of effective evidence-based practices, and the commitment to both the local and national effort.

Notably, the RPG program modeled at the federal level the collaboration needed to address the problem of parental substance abuse and child maltreatment. The Children's Bureau and SAMSHA share the same goals for this initiative and model how shared projects, shared data,

shared goals, shared funding, and a shared vision can shape powerful programs. We strove to emulate that model at the state and local levels.

Importantly, the RPG initiative supported increasingly rigorous program evaluation of the START program and its strategies, which contributed to understanding what works with which type of client under what circumstances. To date, the RPG efforts produced six papers on START that in turn resulted in inclusion of START in the *California Evidence-Based Clearinghouse for Child Welfare* so that effective program information is shared nationally. Additional studies are underway. The RPG led to Kentucky's completing two years of In-Depth Technical Assistance (IDTA) through NCSACW that supported statewide collaboration efforts between child welfare, behavioral health, and the judicial system. These efforts helped evolve the system of care to one with far less contention and far more agreement on common goals and common strategies to improve lives of children and families affected by parental substance abuse.

Although Kentucky is fairly new at the IV-E waiver effort, these funds will expand START services in Louisville and Kenton County because of a large underserved population and implement START in Lexington (Fayette County) and possibly Madison County. The IV-E waiver will support rigorous testing of program effectiveness. Additionally, the IV-E waiver effort will allow Kentucky to use learning from START to apply the principles to the development of a new program to serve families in which the youngest child in under 10 years of age.

Outcomes and Cost Benefits

In line with national findings from the RPG Program, the outcomes achieved by families in START align with the five R's: Parental *Recovery*, Children *Remain* at Home, *Reunification*, reduced *Recurrence* of CA/N, and decreased *Re-Entry*.[1]

Recovery:

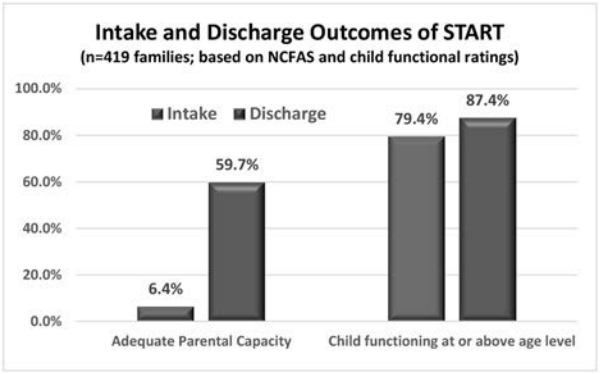
Between 2007 and December 2015, START served 806 families including: 1,426 mothers and fathers and 1,643 children. Of the families served, 63% include a newborn, with 95% of newborns having documented substance exposure at birth.[2] An average of 3.1 substances were abused per parent, with 78% of mothers and 72% of fathers being polysubstance users. The risks to child safety were rated in the highest 10% of families by investigative workers. Despite these high risks, mothers achieved nearly twice the rates of sobriety (66% vs. 37%) than similar mothers served without START.[3] The measure of sobriety in START includes achieving three goals: progress in SUDs treatment including drug test results, engaging in community based

[1] Young, N.K. (February 23, 2016). Examining the Opioid Epidemic: Challenges and Opportunities. Written testimony before the United States Senate Committee on Finance.

[2] Huebner, R. A., Willauer, T., Posze, L., Hall, M. T., & Oliver, J. (2015). Application of the evaluation framework for program improvement of START. *Journal of Public Child Welfare, 9,* 42-64.

[3] Huebner, R. A., Willauer, T., & Posze, L. (2012). The impact of sobriety treatment and recovery teams (START) on family outcomes. *Families in Society: The Journal of Contemporary Social Services, 93 (3),* 196-203.

recovery supports, and improving parental capacity to care for children. The comparative measure from TEDS (Treatment Event Data Sets) includes only a favorable discharge from treatment. Thus, the measure of sobriety used in START is a higher standard. Unfortunately, we do not know how mothers treated in standard SUDs treatment fare in caring for children and committing to life-long recovery supports. Recovery in START also includes developing parental capacity to care for children that is displayed in this graph. Despite the high number of newborn children with substance exposure at birth, at close of the case, 87.4% of children were rated as functioning at or above age level.

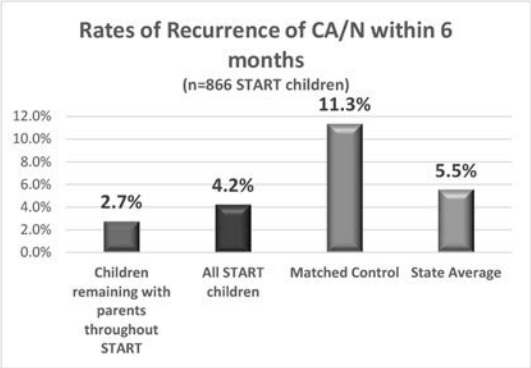


Children Remain at Home: Children in families served by START were half as likely to be placed in state custody in OOHC (21% vs. 42%) than children in the matched comparison group[3]. Interestingly, children in families referred to START but unable to be served due to full caseloads, also entered state custody at a lower rate, suggesting a spread of practices within the county offices where START was active. Our **cost benefit analysis**[3] further demonstrated that cost avoidance on foster care costs alone amounted to $2.22 for every $1.00 spent on START.

Reunification: When studying 420 families with 673 parents and 866 children in closed START cases using cluster analysis techniques, we found two groups based on short term outcomes for children and family. Forty percent of families retained custody of their children throughout the START program; this group was least likely to abuse opiates (46%) and made solid progress in improving parental capacity and attending recovery supports for the 11.6 months the case was open. In contrast, for 60% of families, children were removed at least briefly with 84% being placed in the temporary custody of relatives. This removal group was much more likely to abuse opiates (68-72%) and have significant deficits in parental capacity at intake. Of this 60%, more than half of the parents were reunified with their children at case closure and the other half had often fled, had frequent relapses, and failed to make progress in parental capacity. **Overall, at case closure 77.6% of children served by START remained with or were reunified with their biological parent.**[3] The group that achieved reunification had older children at removal, while those failing to achieve reunification had very young children at removal. Although speculative, we theorized that removing newborns or young infants before a parent/child bond

occurred may have been detrimental to reunification. In response we are strengthening the program with additional supports for parent/child attachment.

Decreased Recurrence of CA/N and Re-Entry to OOHC: The START program seeks to maintain children with their biological parents when it is safe by providing natural supports such as relatives to assist the parent in caring for their children, frequent visits by family mentors and CPS workers, rapid access into an intensive treatment program, and involvement of the whole team including the parents and relatives in establishing a safety plan. The rates of recurrence of CA/N within 6 months are shown in this graph. Notably, children who remained with their parents throughout START had the lowest rate of recurrence while all START-served children have a much lower rate of recurrence than all children in the state but especially for the matched control group where the rate was nearly three times lower. Because of this low rate of recurrence and the intensive case management with families, very few children ever re-enter OOHC; at last count there were six children who had re-entered OOHC.



Lessons Learned: What Works for START

The findings of START and the related recommendations for national efforts are consistent with the nationally identified key ingredients of improved practice and policy leading to better family outcomes.[4] In this section, the lessons learned specific to START are discussed and include five of the seven key ingredients:

- Increased management of recovery services and compliance
- Earlier access to assessment and treatment services with expanded treatment options
- Improved family-centered services and repair of parent-child relationships
- Increased judicial oversight
- Responses to participant behavior—contingency management

Additionally, START was implemented in a rural Appalachian county and includes medication assisted treatment that engendered additional lessons learned.

[4] Young, N.K. (February 23, 2016). Examining the Opioid Epidemic: Challenges and Opportunities. Written testimony before the United States Senate Committee on Finance.

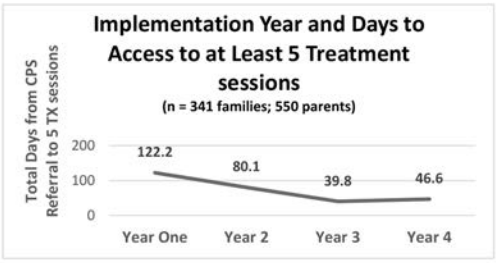
Recovery Management and Cultural Change Are Essential: Family Mentors are an essential component of START; they serve as peer recovery supports within the child welfare (rather than the behavioral health) system. Family mentors are full-time employees who have at least three years of sustained recovery and experiences that sensitize them to issues in child welfare. Most of Kentucky's family mentors have direct experience with child welfare including loss of child custody at some point. These mentors work directly with a child welfare worker and the 'dyad' handles a caseload of 12-15 families. Family Mentors are critical to supporting parents through the behavioral health and child welfare systems. They transport parents to treatment and engage them in recovery supports. From our START data, we know that if a parent attends even one community recovery support group meeting that they are twice as likely to achieve sobriety. Mentors coach parents on sober living and sober parenting; they are persistent and can 'talk and walk the talk'.

> "It's hard to stay sober in a substance abusing community. The counselor helped me learn that addiction is a disease, and how to deal with the substance abusers around me. We relapsed several times, but they keep working with us and helping us stay sober longer." Mother in START.

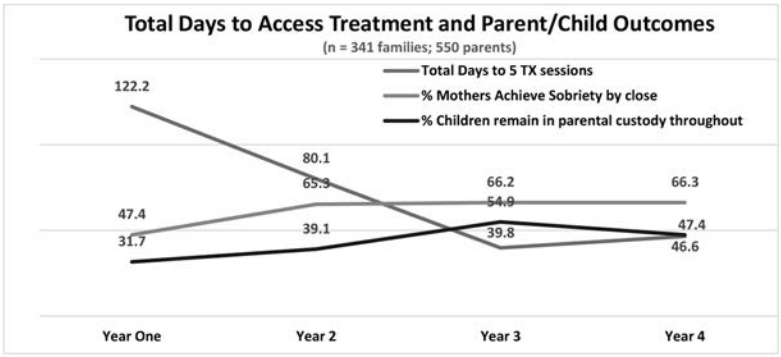
Their presence in the DCBS offices working side by side with child welfare, behavioral health and the judicial system has been a primary catalyst for changing the culture and the community by reducing stigma, setting an example of what recovery looks like and demonstrating that recovery and worthy contributions to the community are indeed possible.[5] Moreover, the experience often reinforces the family mentor's own recovery and several have earned college degrees through the tuition reimbursement program that is an employee benefit.

Timely Access to Substance Abuse Assessment and Treatment Supports Better Parent and Child Outcomes. START evaluation has found what all RPG sites have found, that it is critical to help parents into substance abuse treatment quickly.[1] START has a service delivery standard that specifies the number of days from CPS referral to at least the first five treatment sessions be within 45 days. Achieving this service delivery standard may seem relatively easy, but it is intensely difficult because it depends on complex collaborative efforts between CPS and treatment providers. To achieve full fidelity to the service delivery standards of START usually

[5] Huebner, R.A., Willauer, T., Brock, A., & Coleman, Y. (2010). START family mentors: Changing the workplace and community culture and achieving results. *The Source, 20 (1),* 7-10.



takes several years of persistent collaboration to transform the system of care. Most importantly, as parents gained access to services more quickly, mothers and their children achieved better outcomes as illustrated by the following graph.[6] As shown here, children were more likely to remain with their parent the more quickly the mother accessed treatment. Rapid access is a critical strategy necessary to keep families safely together. Treatment, furthermore, must be comprehensive with evidence-based, trauma-informed substance use disorder services that serve the entire family and include medications for opioid use disorders when indicated.



Comprehensive Family Services Tailored to Family Profiles Are Needed.

We learned from our cluster analysis study[2] that families benefit differentially from treatment. One group of families (40%) retained custody of their children throughout treatment, achieved sobriety, and improved parental capacity, optimally benefiting from the services included with START. The other group all lost custody of their children at least briefly, but one sub-group achieved reunification while the other sub-group did not. Families with very young children at removal were more vulnerable to permanently losing custody of their children; 44% were

[6] Huebner, R.A., Posze, L., Willauer, L. & Hall, M. (2015). Sobriety Treatment and Recovery Teams: Implementation fidelity and related outcomes. *Substance Use & Misuse*, 50:10, 1341-1350, DOI: 10.3109/10826084.2015.1013131.

'AWOL' at case closure and failed to make progress in achieving sobriety or parenting capacities.

For the sub-group that lost custody of their children and were not reunified, more attention is needed to form a parent/child attachment with their young children or repair the parent/child bond with older children. Some parents may benefit from increased or more intensive judicial oversight and strengthened collaboration between agencies in helping these families voice their choices and understand consequences. Fathers involved with START are much more frequently 'AWOL' and achieve lower rates of sobriety, yet we know that when fathers are involved in treatment that mothers do better. Thus we need to include fathers actively in treatment that is specific to their needs; we are introducing father-specific interventions into START designed to improve outcomes for fathers. All of these findings support the notion that no single strategy or program is adequate to serve every family. Programs like START and others must engage in continuous learning about those who fail to benefit and strive to create more comprehensive and effective family-based services.

> "They (START) weren't discriminating against us as drug abusers. They were trying to keep us together. I knew that for once I needed to finish what I started". Father in START

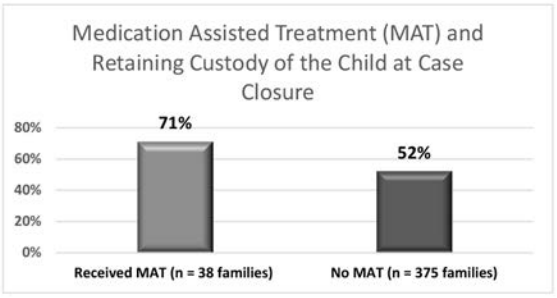
Rural Environments are Underserved and Require More Time to Build System Capacity.

The first round of RPG awards funded a START site in Martin County, a rural Appalachian community, with extraordinarily high rates of CA/N and parental substance abuse. Adapting the START program to a rural area with virtually no pre-existing treatment infrastructure was a challenging, long-term but worthy process. In rural, underserved areas, longer start-up periods with additional funding may be needed to accommodate infrastructure development and leadership readiness. Implementation of programs like START in rural counties should be built incrementally through persistent attention, cross training, and collaborative meetings. Persistence and consistent messaging in a variety of venues from formal training through personal contacts was the most important strategy to replace mistrust and myths with knowledge of addition, recovery, and a focus on child well-being. The challenges associated with program development in such areas should not impede attempts to address co-occurring addiction and child maltreatment. Without potent integrated interventions like START, families may be abandoned to poor outcomes. Our findings demonstrate the need for extended time and funding for infrastructure building in under-resourced areas, following which more comprehensive determinations of efficacy can be made.[7]

Medication Assisted Treatment (MAT) is Associated with Parents Retaining Child Custody.

Parents who use opioids and are involved in the child welfare system are less likely to retain custody of their children than parents who use other drugs; opioid addiction is more difficult to

[7] Hall, M.T., Huebner, R. A., Sears, J. S., Posze, L., Willauer, T. & Oliver, J. (2015). Sobriety Treatment and Recovery Teams in rural Appalachia: Implementation and outcomes. *Child Welfare, 94,*119-138.



treat than addictions to other substances and has recently resulted in high rates of overdose fatalities. Because of the way data are collected for START, we examined the prevalence and correlates of MAT utilization among parents in the START program with a history of opioid use, and compared child outcomes for families who received MAT services to those who did not. Of the 596 individuals with a history of opioid use in the START program, 55 (9.2%) received MAT. Families where at least one member was receiving MAT were significantly more likely to have custody of their child at case closure; additional months of MAT increased the odds of parents retaining custody of their children.[8]

Opportunities to Expand Best Practices to Scale Nationwide

In this section, recommendations for bringing best practices to scale nationwide are identified including those that align with two of the seven key ingredients of improved practice and policy leading to better family outcomes.[9]

- Collaborative approach across service systems and courts
- System of identifying families

A New Paradigm for Collaboration between Child Welfare, Behavioral Health and the Courts. The RPG program taught us what could be achieved through greater collaboration at the federal level. START has shown the power of collaboration at the State and local level. Collaboration, however, is a term that fails to capture the paradigm shift needed. The paradigm we seek is one of a shared vision for children and families, shared goals between systems, shared decision-making between agencies, mutual accountability for outcomes, and a replacement of the hopelessness associated with addiction with hope. Such a paradigm needs to be grounded in compassion for children and parents who fight shame, despair and trauma. Addiction is very powerful and requires more carrot and less stick then currently used; we need more collaboration to decide WITH families which is the best tool to use when. Such collaboration is difficult to achieve but can be modeled at the federal and state levels first. Strategies might include shared

[8] Hall, M. T, Wilfong, J., Huebner, R. A., Posze, L, & Willauer, T. (in review). Medication-assisted treatment improves child permanency outcomes for opioid-using families in the child welfare system.

[9] Young, N.K. (February 23, 2016). Examining the Opioid Epidemic: Challenges and Opportunities. Written testimony before the United States Senate Committee on Finance.

funding streams, cross-training, cross-system protocols, shared data sources, and long term commitment to difficult changes. We need to fully understand and integrate into our policies and funding the notion that treatment alone is not enough. Foster care for children is not enough. Court oversight is not enough. Working with mothers is not enough. Healing children is not enough. All of these strategies are necessary, but none are sufficient in isolation. Families are integrated, so must our approach be integrated. This is the most important national effort moving forward.

Data Sharing Between Child Welfare, Behavioral Health, and the Courts. Data are the 'touchstone' that has kept and keeps the entire START program focused on understanding and addressing important problems, agency practices, fidelity to new practices, and the services needs and outcomes of families. We appreciate the proposed rule for a *Comprehensive Child Welfare Information System*[10] that will facilitate collection and exchange of data between agencies to identify families in need of service. To achieve the aims of this proposed rule will require national training programs and convening groups to lead this effort, demonstrate best practices, explore logistics and policy implications, and explore the results of analysis. Integrated programs such as START will benefit from the intent of this proposed rule.

"START is one of the best collaboration efforts I have ever been involved in during my 35 years in the addiction treatment field. We have Child Protective Services, hospital social work departments, many different addiction treatment programs with different approaches all working together for the purpose of keeping families together and children safe in an alcohol/drug free home." Diane Hague, LCSW, CADC

Peer Recovery Supports Working in Child Welfare. Engaging persons in sustained recovery with experiences that sensitize them to child welfare has been an effective strategy to change the culture within the three systems. Although there are challenges in employing family mentors with these credentials, the worth to parents, children, child welfare staff, behavioral health, and the courts cannot be overstated. There are various models of providing this support to parents but there needs to be standardized training, coaching and ongoing support for personnel such as START family mentors, exploration of best practices nationally, and a change in beliefs from one of fear to one of valuing the unique perspective and skills of these individuals.

Increased Capacity for Expertise within Child Welfare Agencies for Program Evaluation and Application to Continuous Quality Improvement. The IV-E Waiver effort has allocated a substantial portion of its funding to external program evaluation which is quite laudable and consistent with its aims. Future funding for embedding interventions with existing evidence of effectiveness into agencies will require different methods of program evaluation that include models that empower staff to be engaged in and contributing to continuous improvement of

[10] Department of Health and Human Services, Administration for Children and Families. Proposed Rule Comprehensive Data Welfare Information System. Federal Register / Vol. 80, No. 154 / Tuesday, August 11, 2015 / Proposed Rules. Available at: https://www.gpo.gov/fdsys/pkg/FR-2015-08-11/pdf/2015-19087.pdf

programs with a reduced burden of data collection over time.[11] Agencies need to know that programs work, but they also need to know how such programs affect important results in the agency and how these can be modified to reflect changing conditions. Other models of program evaluation may be more efficient to test the impact of specific strategies, rather than entire programs, and to guide agency actions and continuous quality improvement.[12]

Flexible IV-E Funding. The ability of states to try new models of intervention and to support children in their homes depends on the ability to divert funds from foster care to other services. Services might include programs like START and other in-home service models. We highly recommend institutionalizing flexible IV-E funding options for child welfare so that states and communities have on-going access to funds to build these systems which prevent child placement and the trauma of foster placement.

Resources and Funding to Take Small Programs to Scale and Support Long-term Sustainability.

The programmatic strategies of START have proved to be effective in achieving important family and child outcomes including preventing child placement, facilitating reunification, supporting parental recovery including parental competence, and reducing recurrence of CA/N and re-entry into foster care. Despite the number served, there are hundreds of unserved families in Kentucky and the START sites are unable to take all referrals due to full caseloads. We need additional sites to influence all the CMHC regions. But every county does not need nor can they support a full-scale START program. It may be helpful to apply START strategies, without necessarily the entire program, to serve more families. For example, expanding the use of family mentors will likely result in system and cultural changes and better engagement and retention in treatment.

Closing

In the 25 years of my work in CPS and more specifically in START, I cannot think of a more important time in the midst of this opioid epidemic to better protect children and infants with prenatal substance exposure. We have more than a decade of evaluations and science in understanding what works to keep these children safe and to foster their well-being. This is a critical window to move financing of child welfare services to prevention so that families can stay intact whenever possible and so that parents can get the substance abuse and mental health treatment that they need to prevent their child from being placed in foster care. We know this saves foster care costs and reduces trauma to children. It is time to take the lessons of all of the prior Federal investments in these families and move them to scale by providing states with the funds and technical assistance needed to reform their systems and by allowing states the

---

[11] Framework Workgroup (February, 2014). "A Framework to Design, Test, Spread, and Sustain Effective Practice in Child Welfare." Children's Bureau, Administration for Children and Families, U.S. Department of Health and Human Services.

[12] Huebner, R. A., Watson, P., Dyer, L, Borsheim, C, & Caron, C. M. (in press). Building learning organizations within public child welfare agencies through internal research capacity. *Child Welfare.*

financing flexibility they need to prevent children from being removed from their birth parents whenever that is possible and in ways that ensure children are safe and families recover.

Chairman BUCHANAN. Thank you, Ms. Willauer.
Mr. Glynn, please proceed with your testimony.

STATEMENT OF HECTOR GLYNN, VICE PRESIDENT FOR PROGRAMS, THE VILLAGE FOR FAMILIES & CHILDREN

Mr. GLYNN. Committee Members, thank you for the honor of being here. My name is Hector Glynn. I work with The Village for Families & Children in Hartford, Connecticut. We are a large non-profit provider for the area.

We are part of the National Traumatic Stress Network, which has allowed us to expand our expertise in evidence-based models and treatment, to include models such as eye desensitization and reprocessing, child-parent psychotherapy, modular approach to therapy for children with anxiety, depression, trauma, and conduct problems, and trauma-focused cognitive-behavioral therapy.

But today I am here to talk about a truly unique program called FBR, Family-Based Recovery. In Connecticut almost half of the foster care placements for children under 3 have at their core an issue of substance abuse.

So in 2006, the Connecticut child welfare agency, the Department for Children and Families, brought together Yale and Johns Hopkins to develop a new approach in dealing with this crisis. It was really focused on the idea that most parents really have a strong desire and drive to be good parents and that that could be the motivating factor to changing their behaviors.

So FBR combines treatment of substance abuse using a reinforcements-based treatment and a child connection adaptation type of approach, which helps to motivate and control the desires.

When FBR started in 2006, it quickly got expanded to 10 regions throughout the State of Connecticut. When we looked at the outcomes in this model, it is really about transforming the system, because what we asked the child welfare agency to do is keep families together, even though there was evidence and proof of substance abuse.

So these families, we go in three times a week at a minimum to provide both the child-parent psychotherapy together and the substance abuse treatment, and we are testing for substance use at least three times. This type of monitoring helps to create a shared risk profile between us, the providers, and the child welfare agency and the parents and constantly gives feedback on how they are doing.

Since 2007, 564 caregivers have been in the program; 51 percent of these clients have had positive tests in the first week, and that rate drastically drops down to, like, 14 percent by the time they are being discharged. Eighty percent of the families that we are working with are intact when we are discharging them from the program, and it really shows the strength.

And this isn't just about the program that The Village offers. It is a program of network. The model was developed out of Yale. It is an evidence-based model. And for our terminology, that means there is a higher level of monitoring to fidelity. Yale comes in and reviews our tapes of how we are doing within sessions. They look at our substance abuse logs. They look at the connections and the

types of work that we do. And that is really what is crucial. It is about what does work versus just providing services.

So for us at The Village, 62 percent abstained from drugs or alcohol 30 days prior to their discharge, and 88 percent of the families were intact at the point of our discharge. But the network continues to be extremely strong. And like I said, there are 10 others that are involved within there.

The substance abuse, they have tested thousands of parents, and only 8.2 percent of the families have had ongoing relapses in which they needed a higher level of care or newer levels of treatment.

We really do believe that this is a model that builds upon the strengths of what parents can do and what families can do. And this type of approach, along with case management to help support the poverty and other factors that make it difficult for families to stop using drugs, is the way to—at least one approach—to dealing with this crisis.

Thank you.

[The prepared statement of Mr. Glynn follows:]

The Village
So every child believes in tomorrow

TESTIMONY OF THE VILLAGE FOR FAMILIES & CHILDREN

Family-Based Recovery

Committee on Ways and Means
Subcommittee on Human Resources
"The Heroin Epidemic and Parental Substance Abuse:
Using Evidence and Data to Protect Kids from Harm"

May 18, 2016

Submitted by Hector Glynn,
Vice President for Programs, The Village for Families & Children

Two hundred years ago, The Village was one of the first agencies in the country to provide homes for neglected children. Today, we continue to achieve our mission, "To build a community of strong, healthy families who protect and nurture children," by providing a full range of behavioral health treatment for children and youth, foster care and adoption, and community support services for children and their families in the Greater Hartford region. As part of SAMHSA National Traumatic Stress Network we have expanded our expertise and use of evidence based treatment models. Recognizing that no one treatment is right for everyone The Village offers a variety of treatment models, including:

- Eye Movement Desensitization and Reprocessing (EMDR)
- Child-Parent Psychotherapy (CPP)
- Modular Approach to Therapy for Children with Anxiety, Depression, Trauma or Conduct Problems (MATCH)
- Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT)

But today I am here to offer testimony on our experience with a truly unique and promising treatment model called Family-Based Recovery (FBR). In Connecticut, parental substance abuse is reported as a factor in half of foster care placements of children under the age of 3 (National Data Archive on Child Abuse and Neglect, 2015). To address this, in 2006, Connecticut's Department for Children and Families (DCF) brought together the Yale Child Study Center (YCSC) and Johns Hopkins University (JHU) to develop an innovative approach to address the needs of parents with substance use disorders and have young children. They created Family-Based Recovery (FBR) for families with

children under the age of 3 using a treatment model based on the hypothesis that (1) children have the best chance of thriving in a substance-free, safe and stable home with their biological family; and (2) parenting a child is a primary positive reinforcement in substance abuse recovery.

FBR is an intensive, in-home, long-term clinical treatment program that provides substance abuse treatment, individual psychotherapy, attachment based parent-child treatment and developmental guidance, and comprehensive case management. FBR integrates and expands a JHU evidence-based substance abuse treatment model, Reinforcement-Based Treatment, and a YCSC home-based parent-child program for parents with substance use disorders. By providing dual treatment foci, FBR offers the opportunity to effect change in both areas and enhance treatment access and efficiency. FBR clinicians are trained to provide all aspects of the model, which allows for the seamless integration of treatment components. Team members conduct observed urine toxicology screens and breathalyzer tests of clients at each home visit. (Hanson et al, 2015)

In 2007, CT DCF funded teams at six agencies to implement the model, and in 2013 it increased the number of teams to 10, including two at The Village. This network has treated 1,098 families, representing 2,315 mothers, fathers and children (January 2007-Dec 2015). Families enrolled frequently experience multiple risk factors including but not limited to lower socioeconomic status, limited educational attainment, trauma exposure, comorbid psychiatric disorders and multi-generational involvement with the child welfare system. The average duration of service is 6.4 months; only 8.2% of all families are discharged in less than one month. (Hanson et al, 2015)

Outcome data suggest that in many cases FBR engages, stabilizes and effectively treats parents and promotes healthy parent-child attachment. FBR Services analyzes toxicology screen data for all clients (41,988 tox screens) but in order to highlight change overtime results are examined for all clients who were in the program at least 20 weeks.

Since 2007, a total of 564 caregivers have been in the program at least 20 weeks. Fifty-one percent of these clients had a positive tox screen in Week 1 of the program; by week 5 this rate is 25% and by week 20 the rate decreases to 14%. In addition to decreases in substance use, parents report statistically significant changes in depression scores and parenting stress. This suggests that FBR is meeting its goal of improving parental well-being, which we believe benefits the parent-child relationship. As of December 2015, 80% of index children were living with a biological parent at discharge. (Hanson et al, 2015) FBR Services has found that many parents benefit from accessibility of treatment that includes a focus on parenting and mental health as well as substance use. A strong working relationship between DCF and FBR clinical teams that focuses on collaborative risk management has been found to increase safety for children in their homes.

Since beginning to implement this model at the end of 2013, The Village has provided FBR services to 82 families. We currently have two FBR teams. For this current fiscal year, we have discharged 21 families. Of those:

- 62% abstained from alcohol and other drugs during the last 30 days of treatment.
- 88% of the index children lived with a biological family member at discharge.

While we are far from the experts in this model, our results mirror those of the rest of the network. This can be attributed to the team from Yale that provides ongoing training, oversight and regular consultation provided by Yale's FBR Services team which includes:

- Initial training
- Weekly telephone consultation
- Parent/child consultant joint home visits
- Booster trainings
- Quarterly meetings
- Web based data management system
- Quality assurance
- Quarterly reports
- Annual credentialing to sites

FBR Services and the Yale Child Study Center will be happy to provide further information about the model. Please contact Karen Hanson at karen.hanson@yale.edu if you are interested in learning more.

We are encouraged by the progress we've seen in the clients in the FBR program and believe that it has the potential to reduce child abuse and neglect and out of home placements of children and to build safe and stable homes that can foster the healthy growth and development of children.

Hanson, K. E., Saul, D. H., Vanderploeg, J. J., Painter, M., & Adnopoz, J. (2015). Family-Based Recovery: An Innovative In-Home Substance Abuse Treatment Model for Families with Young Children. Child Welfare, 94(3).

National Data Archive on Child Abuse and Neglect (2015). Adoption and Foster Care Analysis and Reporting System (AFCARS) FY 2013. Cornell University, NY: Family Life Development Center.

Chairman BUCHANAN. Thank you, Mr. Glynn.

I would like to advise Members that a series of votes has been called. I anticipate this series of votes to last about 30 minutes. I would ask the Members to return to the hearing as quickly as possible from voting. This hearing will stand adjourned subject to the—oh, recess, recess, okay—subject to the call of the Chair.

[Recess.]

Chairman BUCHANAN. The Committee will come to order.

I recognize Ms. Barillas for 5 minutes.

STATEMENT OF KATHERINE BARILLAS, DIRECTOR, CHILD WELFARE POLICY, ONE VOICE TEXAS

Ms. BARILLAS. Good afternoon, Chairman Buchanan, Mr. Doggett, and Members. My name is Dr. Katherine Barillas, and I am Director of Child Welfare Policy at One Voice Texas, a health and human services advocacy organization. Thank you for the opportunity to testify today.

As you heard from Mr. Doggett, our child welfare system in Texas is in crisis. And let me say this is a crisis of resources, where the needs of children in the child welfare system far outpaces the State, Federal, and local resources currently allocated.

Substance use, almost 80 percent of the cases in the foster care system, has a profound impact on resources, just as it did when I was an investigator for Child Protective Services back in the late 1990s. What I have observed over my 20-year career is that we often do not get to these families and children soon enough.

One of the reasons it is so critical to ensure cases involving substance abuse receive expedited services is the impact that being separated from a parent can have, particularly on a very young child. Women and Children Residential Services is one specialized program that promotes parent-child bonding. This program allows mothers to stay with their children while the former is in inpatient treatment.

Despite the benefits implied with this model, it does face challenges, one of which is judges are seldom willing to put children in treatment, so to speak. There is also a myth that women can't focus on their treatment if their children are there "bothering" them. The truth is that when women enter programs with their children they are able to work on parenting and try out improved techniques under supervision and modeling.

Unfortunately, providers of this program are scarce. Part of the challenge is funding, which would be somewhat alleviated if States had the option of using title IV–E funding to pay for these services and were able to draw down Federal foster care match for the children when they are living with their parent who is receiving treatment.

Another area where we must direct resources is kinship caregivers, particularly those caring for children not yet in foster care. These are fairly stable living arrangements with the right resources, but without them they can easily break apart.

Texas provides financial benefits to informal arrangements when a child is in conservatorship but not to parental child safety placements. A PCSP in Texas is basically an arrangement between CPS, a parent, and a relative caregiver to prevent a child from coming

into foster care. These are short-term placements used to alleviate risk so parents can address issues in the home relatively quickly.

PCSPs are sometimes used in cases where parents are struggling with substance abuse, but time is limited in these cases—not a good match unless time and family-based safety services are extended, with strong support to the kinship caregiver.

The research is clear that children in kinship placements have better outcomes than their peers in foster care. So imagine outcomes for those children who age out of the system. These youth face far worse than their peers in terms of lower rates of high school graduation and college attendance, higher rates of homelessness, substance abuse, and mental health problems.

These young people have a desire and the ability to be independent, but without the appropriate preparation they can easily become the next generation of drug users and parents in the CPS system.

Recommendations for this population include transition living services being extended up until youth are 23 years old and the time limit on family unification vouchers being extended past 18 months to 2 years to meet standard lease requirements and give youth time to attain stability in their lives.

For kinship, we need Congress to direct resources such as monthly payments and reimbursements at these placements, which keep children out of the very expensive and detrimental foster care system, and to allow payments to kinship families to be used to draw down IV–E dollars.

Congress also needs to ensure that title IV–E coverage can be used for more than just out-of-home care in order to address substance abuse issues early. We also need to support the expansion of IV–B funds and a time extension around family-based safety services and family reunification.

We also need States to have guidance regarding the importance of family treatment programs and visitation and the promotion of women and children's programs as a vital treatment option for women with young children.

Thank you.

[The prepared statement of Ms. Barillas follows:]

One Voice Texas
A Collaborative for Health & Human Services

Keeping Kids Safe In and Out of Foster Care

Testimony to the House Ways and Means Committee, Subcommittee on Human Resources

Good afternoon Chair Buchannan, Mr. Doggett and members. My name is Dr. Katherine Barillas and I am the Director of Child Welfare Policy at One Voice Texas (OVT). OVT is a health and human services collaborative that works on policy and implementation projects in behavioral health, health care and child welfare. Thank you for the opportunity to testify today.

Back home in Texas our foster care system is in a crisis state. While workers leave in droves and the number of children in foster care escalates, we are also under the ruling of a lawsuit regarding how Texas treats children in the Permanent Managing Conservatorship of the state. This is a crisis of resources where the need of children in the child welfare system far outpaces the state, federal and local resources currently available.

Substance use, almost 80% of the cases in child welfare, has a profound impact on resources just as it did when I was an investigator for child protective services and then when I conducted psychosocial assessments on parents whose children had been taken into state custody. What I noticed most often was that we hadn't reached these families soon enough.

It is critical we intervene as soon as possible with families possibly going as far as working with those who have Child Protective Services (CPS) history and now have another child. Texas is currently doing this with an initiative called Helping through Intervention and Prevention where CPS data and vital statistics are matched to target families with early support. Early intervention is also critical in the area of family treatment, family caregivers and the sometimes forgotten youth who if we are not careful, can go on to be our next generation of users self medicating for untreated trauma.

SUBSTANCE USE AND THE TEXAS CHILD WELFARE SYSTEM

The choice that individuals make to use is informed by the circumstances of their life which create a desire to self-medicate. Once that influenced choice is made, research has shown that chemical shifts in the brain create a disease that must be treated in order to be tamed. However, time limits of child welfare systems and recovery do not match up. For families that encounter CPS, they have very limited time to address their dependency and learn to parent their children in a healthier environment.

Deliberate but quick action can be better taken in a drug court versus a regular juvenile or family court. Drug Courts consist of different models but are generally designed to provide specialized supervision and treatment options for individuals who would otherwise be facing jail time. In Harris County Texas, the drug court (known as STAR) operates a docket once a week and is focused on second time offenders with serious drug problems. Those who participate are placed on deferred adjudication for four years, but usually graduate from the program in 18 months. This does not fit into more short-term child welfare interventions such as Family Based Safety Services (FBSS); however it does provide an opportunity for a parent to work their service plan and have their child returned to their custody. If the time limit around FBSS were longer, this would be a viable option. Child Protection Courts function in a similar way in that they only see specific child welfare cases. These courts, or specialized dockets within other courts, allow for closer observation of the various parties to the case which can contribute to better and quicker access to services as well as adherence to best practice of all stakeholders.

Visitation:

"Regular, frequent family time increases the likelihood of successful reunification, reduces time in care, promotes healthy attachment, and reduces the negative effects of separation."
– Susan Dougherty, Ph.D.

One of the reasons it is so critical to ensure cases involving substance abuse include expedited and specialized services is the impact that being separated from a parent can have particularly on a very young child.

When a child is removed from the home, visitation is critical to supporting parent-child attachment, child well-being, and permanency. Because of everything that is required of a parent whose child is in CPS custody including transportation issues, it is often very difficult for parents to frequently participate in face-to-face visits with their child. This is especially true if a parent is receiving inpatient treatment. However, frequent and meaningful visitation benefits the child and the parent and provides the latter with the opportunity to practice some of the new skills they are learning through treatment. This interaction also provides an opportunity for clinicians and caseworkers to observe this family relationship.

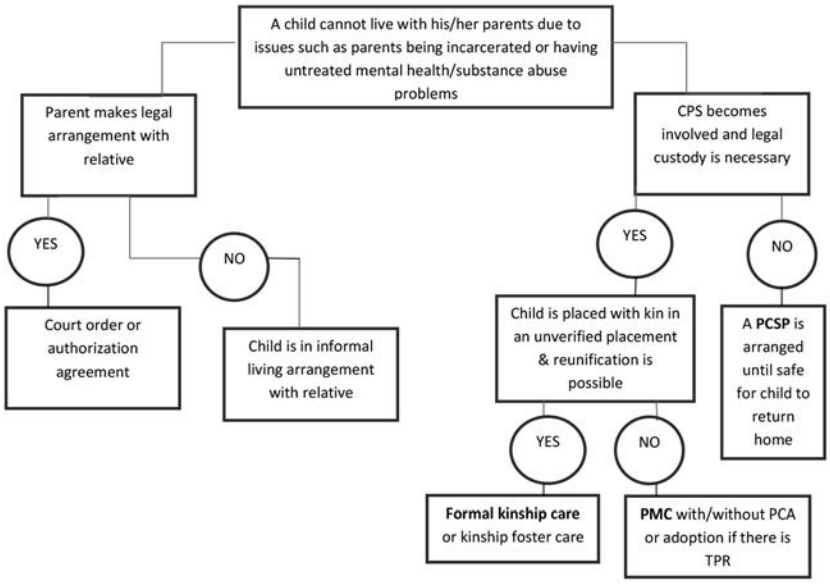
Women and Children Residential Services is one specialized program in Texas that promotes parent-child bonding. This program allows mothers to stay with their children while receiving in-patient treatment. Even if CPS or a judge determines that overnight visitation is not in the child's best interest, mothers may participate in residential services as long as the child resides at the facility for a minimum of 12 hours each day up to 30 days. At the end of this period of time, the child must begin to stay overnight or the mother must move to another program. Despite the benefits implied with this model, the Women and Children Residential Services program is underutilized. Courts can be a barrier when the judge doesn't believe the child should go into treatment; this opinion may also be reflected by the father's or child's attorney. There is also a myth that women need to focus on their substance use disorder without "being bothered" by children. The truth is that when women enter programs with their children they are able to work on parenting and try out improved techniques under supervision and modeling. This model also reduces the risk that a mother leaves treatment and is overwhelmed with parenting sober.

Unfortunately, providers of this program are scarce. Part of the challenge is funding which would be partially alleviated if states had the option of using IV-E funding to pay for these services and were able to draw down federal foster care match for the children who are living where their parents while the latter are receiving inpatient treatment.

Recommendations:

- Adjust Title IV-E funding to current TANF (instead of AFDC) poverty rates to ensure better coverage of children in foster care;
- Ensure Title IV-E coverage can be used for more than just out of home care in order to address substance abuse issues early, particularly in areas where there are shortages, and in time to keep families together or reunify them quickly and safely;
- Support expansion of IV-B funds and the timeline around Family Based Safety Services and family reunification to better balance reunification efforts and permanency for a child;
- Promote drug courts and child protection courts as they provide specialized evaluation and treatment of complex cases and provide a perfect laboratory to develop best practices. One way to promote these practices is to utilize the federal Court Improvement Program that provides grants to state court systems to conduct assessments of foster care and adoption laws and judicial processes.
- Provide guidance to states regarding the importance of family treatment programs and visitation;
- Promote women and children's program as a vital treatment option for women with young children

TEXAS KINSHIP CARE



Another area where we must direct resources before it is too late is kinship caregivers, particularly those caring for children not yet in foster care. Research shows that the most positive results for children involved with child welfare come from living with relatives as opposed to people with whom they do not have a relationship. Parental Child Safety Placements (PCSP) and kinship placements are relatively stable living arrangements with the right support, but can break apart without it.

Types of Kinship Arrangements in Texas:

1) **Informal Living Arrangements**
   - children cared for by a relative or fictive kin without the involvement of child protective services;
     - approximately 250,000 children in Texas live in this type of arrangement (estimated 2.5m in the United States); mostly grandparents who are low-income and single;
     - arrangement with the parent can be done through a court, an Authorization Agreement for Nonparent Relative or Voluntary Caregiver (parent, caregiver & notary) or with no formal agreement;
     - caregiver/child may be eligible for various financial and/or health benefits

2) **Parental Child Safety Placements (PCSP)**
   - when there is risk of abuse or neglect, but not to the level at which CPS believes they must take a child into the state's legal custody;
   - meant to be temporary and short-term however;

- Some relatives report that children are left in their care even after CPS has closed the case leaving the relative with little control of the child's situation;
- safety plan put in place and parties must sign an agreement form);
- caregiver/child may be eligible for various financial and/or health benefits

3) Formal Kinship Care
- formerly approved through DFPS after a home study is approved (preliminary evaluation and background checks (CPS and criminal) must be completed before child is placed; full evaluation must begin within 48hrs of placement and be completed as soon as possible unless otherwise ordered by a court);
- CPS oversees placement until child is reunified, adopted (if Termination of Parental Rights [TPR] is granted, ages out or Permanent Managing Conservatorship (PMC) is awarded to the relative or the state;
- caregiver may be eligible for $1,000 one-time payment(with additional payments up to $495 per additional sibling) and $500 reimbursement for expenses for child (at the year anniversary of child's placement in the home); caregiver/child may be eligible for other public assistance benefits;

4) Kinship Foster Care
- kin caregiver must become a licensed foster parent (paid at the regular foster care rate)
- permanency Care Assistance (PCA) – regular foster care rate & then a PCA benefit till the child is 18 or 21
  - utilized if child cannot be reunified with the biological family or adopted;
  - caregiver must be verified as a foster parent & child must then live with them for a minimum of 6 months;
  - caregiver must sign PCA agreement before receiving legal custody;

Benefits of TX Kinship Placements:
- broad definition of "kin;"
  - similar to South Carolina, Colorado and Washington that utilize fictive kin in addition to 3rd degree consanguinity and relatives by marriage and adoption;
- have Parental Authorization Agreement that allows parent(s) to provide relative with ability to care for child's medical, educational and other needs without the involvement of CPS;
- kinship placements do not have to be licensed, but can choose to do so;
- financial benefits provided to informal arrangements while child is in conservatorship;
  - Colorado provides a generous benefit with households caring for children 0-11 receiving $5.26 a day (up to $160 a month) and 12-19 year olds $6.24 a day up to $190 a month.
  - Missouri provides a monthly benefit for 90 days at which point the kinship placements is expected to begin the licensing process;
- waivers for certain requirements (not related to safety) available for kinship placements that want to be licensed as foster parents
- Collaborative Family Engagement model pilot between Child Protective Services and Texas Court Appointed Special Advocates (CASA) to identify and engage kin and fictive kin to be a part of children's lives as connections, placements or adoptive homes;
  - South Dakota and Illinois both use diligent search units or workers;
- utilizes Parental Child Safety Placements (PCSP) with kin to avoid taking children into legal custody
  - similar to New York that also provides assistance with legal custody when appropriate;

Challenges faced by kinship families:
- Parental Child Safety Placements (PCSP)
  - in Texas, these are short-term placements used to alleviate risk so parents can address issues in the home relatively quickly. However, some relatives who serve as placements feel PCSPs to be a "dumping ground" for cases where the solutions aren't long-term, but CPS is limited in what other immediate action it can take;
  - PCSPs are sometimes used in cases where parents are struggling with substance abuse, but under current timelines this is not always appropriate because recovery is often a long-term process;
  - 2,400 cases were closed with a child left with the relative; these children were at found to be a greater risk of maltreatment
  - of those PCSPs that ended in FY '15 (25,517); caregivers could not keep the child due to finances for 1,366 children at case closure and 441 for the same reason during the stage of service;

- the only benefit to these relatives is daycare; there is no caseworker assigned to help the relatives in these cases and they are not eligible for IV-E match
  - there is a $500 per child expense reimbursement for relatives caring for a child in conservatorship that could be beneficial to PCSP families and allow them to continue caring for a child if the PCSP must be continued past 60 days at which point it has been shown that placements begin to break down;[1]
- kinship workers should be involved in these cases, but only if consideration has been given to the load these workers already carry;
- eliminating or reducing these placements is extremely problematic in that it puts a strain on CVS workers as more children come into foster care;
- informal placements have no legal guidance/support unlike Florida that has ongoing involvement with private kin arrangements

❖ No Kinship Navigator Program outside of guidance by kinship caseworkers who in some areas have cases in excess of 50 families.
- Georgia has a Kinship Navigator who provides information and referrals in each region of the state and Washington has Kinship Navigators in 30 counties.

❖ Minimal benefits not provided quickly
- grandparent kinship caregivers must first apply to the Texas Health and Human Services Commission (HHSC) for a one-time grandparent grant (TANF funds of $1,000) and be turned down before requesting the integration benefit from DFPS (also TANF but within the budget of DFPS); relatives must be approved through a formal home assessment before receiving the benefit. This assessment takes time to complete; thereby causing the time frame of a worker having at least 120 days before applying for the benefit;
- the caregiver is reimbursed $500 for child-related expenses on the year anniversary of the date the child was placed with the relative. To request reimbursement, the kinship caregiver must: complete the Application for Kinship Reimbursement; designate which child-related items were purchased; designate how much the items cost; and sign the form, affirming that the money was spent for the designated child;
- grandparents should receive the same clothing voucher provided to foster parents in Texas. The amounts vary according to the child's age: 0-1=$60; 2-5=$72; 6-12=$113; 13-17=$133
- families could also be eligible for funding in addition to qualifications for child-only TANF such as is done in Tennessee [eligible families receive monthly payments as follows: children 0-11 $5.26 a day up to $160 a month and 12-18 $6.24 a day up to $190 per month]

Recommendations:
❖ encourage the establishment of kinship navigator programs;
❖ discourage children being left in a PCSP placement after a CPS case is closed unless CPS has assisted the relative caregiver in obtaining legal guardianship of the child as well as appropriate resources;
❖ encourage use of kinship workers in FBSS cases where a child is placed with a relative;
❖ direct resources such as monthly payments and reimbursements at these placements which keep children out of foster care;
❖ allow payments to kinship families to be used to draw down IV-E match

YOUTH TRANSITIONING OUT OF CARE IN TEXAS

The research is clear that children in kinship placements have better outcomes than their peers in foster care. So imagine outcomes for those children who end up aging out of the foster care system. These youth face far worse outcomes than their peers in terms of low rates of high school graduation and college attendance and high percentages of homelessness, mental health problems, unemployment and substance abuse. These young people have a desire to be independent but without the appropriate preparation they can easily become the next generation of drug users and parents in the CPS system.

[1] Supreme Court of Texas Children's Commission Roundtable Report on Parental Child Safety Placements. 2015. Available at: file:///C:/Users/kmhba/Desktop/Katherine/KB%20DOCS/Policy/OVT/C&Y/Permanency/Kinship/PCSP-ROUND-TABLE-REPORT-FINAL.pdf

- ***transitional living services in Texas include:***
  - ensuring youth have their basic documents such as a driver's license, birth certificate and social security card;
  - assisting the youth with life skills such as financial literacy, learning how to cook and wash clothes, how to reach education and job goals and how to find a stable place to live after they leave foster care;
  - PAL classes - consists of six classes with each day spent on a different subject (financial literacy; healthcare etc.); if a youth completes the classes they are provided a stipend of $1,000;

These resources are technically available to kids at 14[2] but additional money needs to be allocated to cover these costs and therefore they remain a benefit that starts for most children at 16; [3] (number of kids in FY '15 eligible and not served 1,552[4]; eligible and served[5] 6,698)

- ***challenges for this population include:***
  - most transitional living services end when the youth turns 21;
  - PAL classes are a one-time service with few experiential components. They should start when a youth turns 14 and be age appropriate for each year up until the child ages out of care or finds another form of permanency;
  - aftercare in Texas consists of $500 a month with a cap of $3,000, but eligibility requirements are a challenge for most kids including the amount being based on the need at the immediate moment. Service providers indicate that there is inefficiency in this money having to come to a service provider versus straight to the source of the cost (i.e. apartment).
    - rapid re-housing dollars need to be included in funding for this area;
      - additional finances need to be allocated to ensure the amount available for emergencies meets actual emergency situations; to a minimum of two years and a certain percentage of vouchers need to be set aside specifically for youth who've aged out of foster care.
  - there is a weak infrastructure for extended foster care (there are rarely placements) or Supervised Independent Living (SIL) across state –
    - more housing and funding for services are necessary as well as less restrictions on who can participate as well as less restrictions on a youth's ability to return to care; housing first should be the model for these young people
  - additional funding for aftercare/PAL workers is necessary. Currently the state is paying for 1 meeting, between caseworker and youth, three times a month when most of these youth need weekly contact. In addition, PAL workers have very high caseloads;
  - A life skills assessment is not done soon enough for proper planning

Recommendations:

- ❖ transition living services should be extended till a youth is 23 years old;
- ❖ youth need to have at least one year of funding for housing;
- ❖ rapid re-housing dollars are essential to prevent homelessness;
- ❖ return to foster care requirements should be waived if youth is facing homelessness/housing instability;
- ❖ the time limit on HUD FUP vouchers (Family Unification) needs to be extended past 18 months to a minimum of 2 years to meet standard lease requirements and give youth time to achieve stability in their lives;
- ❖ life skills assessments should be required starting when a youth is 14.

Conclusion:

The lawsuit in Texas indicates that:

- ❖ our caseworkers are burdened by excessive caseloads preventing proper fulfillment of duties and ensuring children in foster care are free from an unreasonable risk of harm. This makes it difficult to handle the most basic of cases much less complex cases involving substance use;

---

[2] in FY '15 there were 1,740 fourteen and fifteen year olds
[3] PAL classes are still only designated for youth 16 to 18.
[4] 2015 DFPS data book
[5] Is served based on completion of PAL classes?

- there is a lack of sufficient oversight of facilities which has in some cases led to children being sexually abused while in care. It is precisely this kind of experience that can cause a youth to self-medicate to deal with unresolved issues of trauma;
- youth are not properly transitioning to adulthood which leads to instability and an inability to be independent resulting in higher rates of drug use;

These issues, faced by many states, lead to poor outcomes for children and their parents especially when a family is caught in the grip of addiction. Texas case workers, able to spend only a quarter of their time with families[6] cannot provide appropriate support or guidance during critical junctures in a case. This leads to lack of oversight and outcomes that repeat negative cycles rather than break them. However dark this picture is, state legislatures and Congress can act in effective and efficient ways to change the fate of children and their families in the foster care system.

for more information contact Katherine Barillas, Ph.D.; 713-480-3937; kbarillas@onevoicetexas.org

[6] Stephen Group. 2014. DFPS CPS Operational Review, Phase I: Assessment Findings

Chairman BUCHANAN. Thank you, Ms. Barillas.

Mr. Lindert, please proceed with your testimony.

STATEMENT OF BRYAN LINDERT,
SENIOR QUALITY DIRECTOR, ECKERD KIDS

Mr. LINDERT. Chairman Buchanan, Ranking Member Doggett, and Subcommittee Members, thank you for the opportunity to address the Committee on the use of data to keep children known to the child welfare system safe.

My name is Bryan Lindert, and I am the Senior Quality Director at Eckerd Kids, a nonprofit provider of services to children and youth operating in 20 States and the District of Columbia. We also manage the largest privately operated child welfare system in the country, serving more than 6,000 children and youth in Tampa Bay.

The number-one reason children enter the system is for maltreatment from a substance-abusing parent. The aim of my testimony is threefold: To describe how Eckerd Kids ended a tragic pattern of homicides that occurred prior to Eckerd's involvement; to explain how that success has led to partnerships with five States to prevent future abuse fatalities; and to explore the implications of our approach to other child welfare challenges, including a potential improved response to repeat maltreatment due to substance abuse.

Our work developing a priority tool called Eckerd Rapid Safety Feedback was recently featured in the final report of the bipartisan Commission to Eliminate Child Abuse and Neglect Fatalities released in March of this year. To understand why, we must explain why Eckerd Kids was selected to manage the child welfare system in Hillsborough County beginning in July of 2012.

This occurred after that community experienced an unprecedented nine child deaths from maltreatment in less than 3 years. These cases were not co-sleeping deaths or the result of inadequate supervision. Instead, they were intentional inflicted injuries, including one child thrown out of a moving car on the interstate. Worse still, they occurred under the open jurisdiction of the court.

In Hillsborough, as in other jurisdictions around the country, the Department of Children and Families reviewed these cases and came to a frustrating conclusion: The fatalities kept happening to children with similar risk factors and lapses in casework. A more proactive approach was needed.

Therefore, in addition to the review of the nine child deaths, Eckerd Kids conducted a 100-percent review of the 1,500 open child welfare cases in the county. From this review, critical case practice issues were identified that, when completed to standard, could reduce the probability of preventable serious injury or death. Among these case practices were quality safety planning, quality supervisory reviews, and the quality and frequency of home visits.

Now that Eckerd knew what to look for, the next step was to determine which cases needed to be prioritized for review. So Eckerd Kids secured a technology partner that specializes in predictive analytics, Mindshare Technology, to identify the cases most like the prior fatalities on incoming cases in realtime. Cases that were prioritized had multiple common factors, such as a child under the

age of 3, a paramour in the home, intergenerational abuse, and history of substance abuse.

Eckerd Kids then reviewed these cases against the practices identified with better safety outcomes and conducted coaching sessions with the frontline staff when deficits were identified.

The results have been promising. In Hillsborough, there were no maltreatment fatalities in the 3-year period following implementation of the program in the population served by Eckerd. Critical case practices also improved an average of 22 percent. As a result, Eckerd Kids and Mindshare are now working with Oklahoma, Maine, Alaska, Illinois, and Connecticut.

Regardless of the jurisdiction, the problem needs the same ingredients for success. These include: A narrowly defined challenge the jurisdiction is trying to solve, such as the prevention of a fatality to a child with prior abuse reports; daily access to the State Automated Child Welfare Information System, allowing for predictions that continuously improve and update as new data is entered; access to quality assurance reviews assessing case practice; and experienced staff to review the identified cases for the key safety practices and provide coaching to the field.

In closing, it is important to note that we are not advocating decisions made by machines. What is needed is a second set of eyes to ensure we are doing our best casework and positive outcomes for the children and families in our care.

Therefore, we are advocating that data and coaching together provide a support for those men and women working with families to help them focus attention where it is needed most. I know from past experience as an investigator and supervisor in the field I would have appreciated the help.

Mr. Chairman and Members of the Subcommittee, thank you again for the opportunity. I will present my testimony in full for the record and look forward to answering any questions.

[The prepared statement of Mr. Lindert follows:]

Eckerd
Rapid Safety Feedback®

Eckerd Kids | 100 Starcrest Drive | Clearwater, FL 33765 | P: (727) 461-2990 | Eckerd.org/RapidSafetyFeedback

U.S. House of Representatives
Committee on Ways and Means
Subcommittee on Human Resources

HEARING

The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm

May 18, 2016

Testimony by

Eckerd Kids

Bryan Lindert
Senior Quality Director
Eckerd Rapid Safety Feedback®
P: (727) 461-1236, Ext. 3273 | F: (727) 443-1915 | C: (813) 951-0055 | E: blindert@eckerd.org

Eckerd
Rapid Safety Feedback®

Eckerd Kids | 100 Starcrest Drive | Clearwater, FL 33765 | P: (727) 461-2990 | Eckerd.org/RapidSafetyFeedback

Chairman Buchannan and Subcommittee Members:

Thank you for the opportunity to address the committee on the use of data to keep children known to the child welfare system safe.

My name is Bryan Lindert, and I am Senior Quality Director at Eckerd Kids. Eckerd Kids was founded in 1968 by Jack and Ruth Eckerd, philanthropists who became household names for the national drug store chain bearing their name. Today, Eckerd Kids is a non-profit provider of services to children and youth operating in 20 states and the District of Columbia. We also manage the largest privately operated child welfare system in the country, serving more than six thousand children and youth in Tampa Bay. The number one reason children enter this system is for maltreatment from a substance abusing parent.

The aim of my testimony is threefold:

- Describe how Eckerd Kids ended a pattern of tragic child homicides that had occurred prior to Eckerd's involvement
- Explain how that success has led to partnership with five states to prevent future abuse and fatalities
- Explore the implications for our approach for other child welfare challenges including a potential improved response to repeat maltreatment due to substance abuse

Our work developing a priority tool, Eckerd Rapid Safety Feedback®, was recently featured in the final report of the bipartisan Commission to Eliminate Child Abuse and Neglect Fatalities released in March of this year. To understand why, we must explain why Eckerd Kids was selected to manage the child welfare system in Hillsborough County beginning in July of 2012. This occurred after that community experienced an unprecedented nine child deaths from maltreatment in less than three years. These cases were not co-sleeping deaths or the result of inadequate supervision. Instead they were intentional inflicted injuries including one child thrown out of a moving car on the interstate. Worse still, all occurred under the open jurisdiction of the court.

In Hillsborough, as in other jurisdictions around the country, the Department of Children and Families reviewed these cases and came to a frustrating conclusion. The fatalities kept happening to children with similar risk factors and lapses in casework. A more proactive approach was needed.

Therefore, in addition to review of the nine child death cases, Eckerd Kids conducted a 100% review of the 1,500 open child welfare cases in the county. From this review, critical case practice issues were identified that, when completed to standard, could reduce the probability of preventable serious injury or death. Among these case practices were quality safety planning, quality supervisory reviews, and the quality and frequency of home visits.

Now that Eckerd knew what to look for, the next step was to determine which cases needed to be prioritized for review. So Eckerd Kids secured a technology partner that provides predictive analytics and machine learning, Mindshare Technology (Tampa,) to identify the cases most like the prior fatalities on incoming cases in real time. Cases that were prioritized had multiple common factors such as: a child under the age of three,

a paramour in the home, intergenerational abuse, and a history of substance abuse.

Eckerd Kids then reviewed these cases against the practices identified with better safety outcomes and conducted coaching sessions with front-line staff when deficits were identified. Actions needed from these coaching sessions were tracked to completion to ensure accountability.

The results have been promising. In Hillsborough, there were no maltreatment fatalities in the three year period following implementation of the program in the population served by Eckerd. Critical case practices also improved an average of 22%. Eckerd is working with Casey Family Programs on an independent evaluation to determine if these results can be replicated in other jurisdictions implementing the program.

As a result, Eckerd Kids and Mindshare are now working to deploy Eckerd Rapid Safety Feedback® in Oklahoma, Maine, Alaska, Illinois, and Connecticut. Regardless of the jurisdiction, the process needs the same ingredients for success. These include:

- A narrowly defined challenge the jurisdiction is trying to solve such as the prevention of a fatality to a child with prior abuse reports
- Daily access to the State Automated Child Welfare Information System (SACWIS) allowing for predictions that continuously improve and update as new data is entered
- Access to quality assurance reviews assessing case practice
- Experienced staff to review the identified cases for the key safety practices and provide coaching to the field
- Willingness to embrace the paradigm shift needed to move from reactive to prospective review regarding child safety

SACWIS systems present an incredible opportunity for child welfare agencies to better target scarce resources. States have spent billions of dollars building them and countless hours collecting data on their interventions with families and a series of state and federal outcomes in them. As a result, states are sitting on valuable mountains of data about the families that come to their attention that could be used to predict the children who may experience poor outcomes beyond child fatality. These include children who are likely to experience long stays in foster care, who will age out of the system, or be re-reported for substance abuse. Right now, Eckerd Kids and Mindshare are applying the same principles used in Eckerd Rapid Safety Feedback® to identify cases at risk for return to foster care and coaching the front line staff assigned to those cases to toward best practice casework.

In closing, it is important to note that we are not advocating decisions made by machines. What is needed is a second set of eyes to ensure we are doing our best work to ensure positive outcomes for the children and families in our care.

Therefore, we are advocating that data and coaching together provide a support for those men and women working with families to help them focus attention where it is needed most. I know from past experience as an investigator and supervisor in the field, I would have appreciated the help.

Mr. Chairman and members of the Subcommittee, thank you again for this opportunity. I will present my entire testimony in full for the record and look forward to answering any questions.

Eckerd Kids | 100 Starcrest Drive | Clearwater, FL 33765 | P: (727) 461-2990 | Eckerd.org/RapidSafetyFeedback

Hillsborough County, Florida

Using Data to Improve Practice and Keep Children Safe

"If the only thing you do is come up with a list of cases that are high risk, all you've done is identify the train that's coming at you on the tracks. You've got to have a way to switch the track," said Bryan Lindert, Senior Quality Director at Eckerd Kids in Hillsborough County, Florida.

Switching tracks is exactly what leaders in Hillsborough have in mind when it comes to preventing fatalities of young children. They are doing it through an innovative process they developed called Eckerd Rapid Safety Feedback® (ERSF). ERSF uses real-time data to identify a list of high-risk cases, but that is only the beginning. Once the cases are identified, they are flagged and reviewed, often leading to an immediate, intensive meeting between quality management (QM) specialists and the case management team for the family. It is the combination of the two — data and intensive intervention — that makes ERSF both different and promising.

The History in Hillsborough County

The changes in Hillsborough were born from tragedy: A 1-year-old allegedly killed by his mother's boyfriend; a 4-month-old tossed from a car on an interstate; a 16-month-old taken from his mother and allegedly beaten to death by his father. From 2009 to 2011, nine children in Hillsborough County died from maltreatment. Each of these children was under 3 years of age. All but one had an open, in-home child protective services (CPS) case.

Sadly, the state of Florida is no stranger to child homicide, but no other county had as many deaths in so short a time as Hillsborough in those two years. The state response was definitive. Eckerd Kids was named to replace the lead child protection agency in the county. Eckerd officials reviewed all nine fatalities in depth, as well as other deaths in the region, looking for common characteristics. They then reviewed every open case in the county, some 1,500 families with more than 3,000 children, looking for additional system gaps and practice concerns that could lead to serious injury or death.

They found that families in which a fatality or serious injury occurred shared multiple risk factors, including in-home, open cases with a child under 3 years of age; young parents; a paramour or unmarried partner in the home; intergenerational abuse; and domestic violence, substance abuse, or mental health problems. Staff identified current cases with immediate practice concerns, which they used to pinpoint nine critical practice issues.

The goal was to take what they learned from the past and use it to prevent fatalities in the future. But to do this, they needed more data.

Putting Data to Work for Child Safety

Enter Mindshare Technology.[30] Using state historical data about maltreatment, the data software company developed predictive models to quantify the likelihood that a particular child would experience a life-threatening episode. Once the model was finely tuned, staff began to feed it daily with data from Hillsborough about new investigations and new cases.

This technology scans the system, looking beyond cases that match predetermined risk factors. It then identifies cases that match the risk factors and produces reports. These include new cases as well as updates on cases already in the system. "Mining the data daily is critical to the success of this process," said Greg Povolny,[31] founder and CEO of Mindshare. "Predictive analytics is not a one-time job. The intention is to zero in on children for the long haul."

Data Analytics Lead to Action

ERSF is a combination of data and practice change focused on prevention of child fatalities. This is the process in Hillsborough County:

- After getting case notices, QM staff review each case, guided by a list of critical practice questions. If answers to any of those questions raise concerns, QM specialists call a meeting with the supervisor and worker for the family the same day.
- Meetings focus on practice and compliance issues that can jeopardize safety. Together the QM and case management teams address these issues through immediate and more focused visits to the home, improvements to safety plans, access to specific services, and more.
- Additional meetings, follow-up, and coaching continue until risk factors no longer exist, the case is closed, or the child turns 3 years old.
- If necessary, the child is removed. The end goal is always the child's safety.

This Is Not Traditional Quality Assurance

Launched in January 2013, ERSF is different from traditional quality assurance (QA) programs. QA is typically limited to a random selection of cases and uses up to 200 questions to assess practice. Traditional QA is not based on data that identifies specific children at greatest risk of severe maltreatment.

ERSF prioritizes the cases that need the best and most intense casework. "We read the case files independently," said Suzanne Barlow, Quality Manager at Eckerd, which allows them to confront the understandable, but sometimes fixed, frame of reference brought to the case by workers and supervisors.

The QM and case management teams then work together to develop a better safety plan and articulate steps required to keep the child safe. Addition of targeted services and community support — and ensuring parents and caretakers actually receive them — are part of the discussion.

Follow-up is part of the package, as is coaching, which promotes the transfer of new skills learned by case managers and supervisors in one case to others.

The Bottom Lines

ERSF pulls together data sharing, better casework by a CPS agency, and collaboration with a wider range of community services. It requires an upfront investment to identify the risk factors, train the QM team, and produce the operational predictive model. Once it is set up and a trained QM team is in place, it can move forward without a lot of additional expenses. The startup cost for a jurisdiction is approximately $200,000, with approximately $90,000 in yearly fees to support the portal maintenance and for ongoing fidelity activities.

Interest in ERSF has spread throughout Florida and to other states and jurisdictions across the country, including Alaska, Illinois, Connecticut, Oklahoma, and Maine. Although the process and use of data are similar in different jurisdictions, said Lindert, "the identification of high-risk cases and the practice questions will be tailored to each." Oklahoma, for example, is looking to introduce ERSF with investigations. That state's practice questions and risk model will look different from those in Hillsborough.

As of December 2015, more than 2,000 ERSF reviews had been completed in Hillsborough County, including multiple coaching sessions for some cases. Child fatalities still occur. But in Hillsborough, there have been no more abuse-related deaths[32] in the population targeted by ERSF.

A formal evaluation of ERSF is underway, but research shows a 36 percent improvement in sharing critical case information with providers (including mental health, substance abuse, and domestic violence services); a 35 percent improvement in supervisory reviews and follow-up by case managers; a 25 percent improvement in the effectiveness of safety plans; and a 22 percent improvement in the quality of case management contacts and discussion with families.[33] Eckerd and Mindshare have shown in Hillsborough that the intricate dance between data and practice can keep an important sector of children safe.

To Povolny, ERSF was a welcome opportunity for those in Hillsborough to be thought leaders. "There are so many program areas in desperate need of change," he said. "Florida is doing it."

NOTES FOR HILLSBOROUGH COUNTY, FLORIDA: USING DATA TO IMPROVE PRACTICEAND KEEP CHILDREN SAFE

30 CECANF supports public-private partnerships like the one described here but does not endorse any specific product or corporation.

31 Testimony presented at the Tampa, Florida, meeting on July 10, 2014 (https://eliminatechildabusefatalities.sites.usa.gov/files/2014/05/Transcript-Tampa-FINAL.pdf).

32 There were four infant fatalities in Hillsborough County in 2015. All were tragic, but none was part of the ERSF process. Two of the deaths took place during the investigation period, which, in Hillsborough, is the responsibility of the Sheriff's Office. The other two were unsafe sleep deaths; these were investigated independently by the Sheriff's Office and not substantiated as abuse or neglect.

33 Eckerd Rapid Safety Feedback. (n.d.). Retrieved from http://www.eckerd.org/programs-services/system-of-care-management/eckerd-rapid-safety-feedback.

Within Our Reach

A National Strategy to Eliminate Child Abuse and Neglect Fatalities

COMMISSION TO ELIMINATE CHILD ABUSE AND NEGLECT FATALITIES | FINAL REPORT, 2016

Recommendations

RECOMMENDATION 2.1:
The administration and Congress should support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities.

The steps in this process are as follows:

2.1a HHS should provide national standards, proposed methodology, and technical assistance to help states analyze their data from the previous five years, review past child abuse and neglect fatalities, and identify the child, family, and systemic characteristics associated with child maltreatment deaths. **HHS also should encourage states to explore innovative ways to address the unique factors that states identify as being associated with higher rates of child abuse and neglect fatalities.**

2.1b States will submit a methodology to HHS for approval, describing the steps they would like to take in using data to identify under what circumstances children died from abuse or neglect during the previous five years.

2.1c After HHS approval, states will identify and analyze all of their child abuse and neglect fatalities from the previous five years to identify under what circumstances children died from abuse or neglect, protective factors that may prevent fatalities from occurring, and agency policies and practices across multiple systems that need improvement to prevent fatalities.

2.1d Based on these data, states will develop a fatality prevention plan for submission to the HHS Secretary or designee for approval. **State plans will be submitted within 60 days of completing the review of five years of data and will include the following:**

1. **A summary of the methodology used for the review of five years of data, including specifics on how the reviewers on the multidisciplinary panels were selected and trained.**
2. **Lessons learned from the analysis of fatalities occurring in the past five years.**
3. **Based on the analysis, a proposed strategy for (1) identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data)**

and (2) putting immediate and greater attention on these children.

4. Other proposed improvements as identified through child fatality review teams.

5. A description of changes necessary to agencies' policies and procedures and state law.

6. A timeframe for completing corrective actions.

7. Identification of needed and potential funding streams to support proposed improvements as indicated by the data, including requests for flexibility in funding and/or descriptions of how cost savings will be reinvested.

8. Specifics on how the state will use the information gained from the review as part of its CQI process.

2.1e If states find during the review of five years of data that investigation policy is insufficient in protecting children, their plans should ensure that the most vulnerable children are seen and supported. States should review current screen-out policies to ensure that all referrals of children under age 3 and repeat referrals receive responses. In addition, investigation policy should be reviewed to ensure that reports for children under age 1 are responded to within 24 hours. Alternatives to a CPS agency investigation should be considered. Congress and states should fund the necessary resources. Children under age 5 and children with prior CPS reports should be prioritized for home visiting programs.

2.1f Once their fatality prevention plan is approved, states will implement this plan by identifying children currently in the system who are most at risk of fatalities (which may include both children at home with their families and those in foster care, as indicated by the data), putting immediate and greater attention on these children, and conducting multidisciplinary visits and reviews of cases to determine whether the children are safe and whether families need different or additional supports, services, or interventions. If children living at home with their families are found to be unsafe, services should be provided in order to ensure they can be safe in their home. If removal is determined to be necessary, all existing state and federal due process laws remain in effect. Home visits should only be conducted under state-authorized policies and practices for CPS investigations.

2.1g Once a state begins the review of current open cases, as outlined in its fatality prevention plan, each state should provide a report to HHS every month until conclusion of the review.

2.1h HHS will increase system capacity at the national level to apply the latest statistical and big data techniques to the problem of preventing child abuse and neglect fatalities. HHS will establish a Federally Funded Research and Development Center (FFRDC) on Preventing Child Abuse and Neglect Fatalities to collect data from the states and share it with all those who submit data so that state and local agencies can use this data to inform policy and practice decisions (see Recommendation 6.1c)

2.1i: We strongly recommend a significant appropriation of funds by the federal government to strengthen the child protection system by implementing Recommendation 2.1. There were four different views offered on the funding needed to achieve this goal of fundamentally reforming the country's child welfare system.

1. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded and recommends that Congress immediately authorize and then appropriate at least a $1 billion increase to the base allotment for Child Abuse Prevention and Treatment Act (CAPTA) as a down payment on the funding necessary to ensure that state CPS agencies are consistently effective and have sufficient funding to keep children protected and that families receive the services and supports they need to ensure their children's safety. These Commissioners further believe that the first year of funding should support state efforts to implement the case reviews of children known to CPS. This will help to ensure children's

continued safety and determine the broader reforms necessary both to better protect children from abuse and neglect generally and to dramatically reduce child abuse and neglect fatalities. Thereafter, the ability of a state to draw down its share of these new funds will be contingent upon the state having a fatality prevention plan in place and approved by HHS to fundamentally reform the way the child welfare system is designed and delivered with the goal of better protecting children and significantly reducing child abuse and neglect fatalities and life-threatening injuries.

2. One group of Commissioners recommends an increase in funding but leaves the responsibility to Congress to identify the exact amount of funding needed by all responsible agencies to carry out activities in this goal, sources of that funding, and any offsets in funding that are available to support this recommendation.

3. One group of Commissioners recommends that initial costs be covered by existing funding streams, cost-neutral waivers for children ages 0-5, and a prioritization of services for children ages 0-5 who have been demonstrated to be at the highest risk for a later fatality. An overhaul to the structure of federal funding is required to better align resources pertaining to the prevention of and response to safety issues for abused or neglected children. Furthermore, we still have few approaches, programs, or services that demonstrate evidence in reducing child abuse and neglect fatalities. Rather than continuing to fund programs with no evidence of effectiveness, we should support state and local funding flexibility, innovation, and research to better determine what works. The child welfare system is woefully underfunded for what it is asked to do, but a significant investment needs to wait until additional evidence is developed to tell us what works.

4. One group of Commissioners strongly believes that the federal funding commitment to effective child protection is drastically underfunded but does not favor making a request for specific dollar amounts in this report. However, if funding is recommended, it should be recommended for all recommendations made by this Commission. Many of the recommendations proposed will require dollars, and all of the recommendations will work toward reducing child abuse and neglect fatalities.

These steps not only will save lives today, but will create a state and national learning community that improves practice, interventions, and shared responsibility and accountability across systems that regularly interface with children and their families.

Even as this Commission's report is being distributed to generate action to prevent future fatalities, we estimate that at least 3,000 children will die from abuse or neglect in the year ahead if there is no further and immediate intervention on their behalf. The Commission recognizes that each state is unique and may identify different characteristics of children at highest risk of fatalities in their jurisdiction. However, it is also true that the collective knowledge gained through this process will benefit all states through a national learning community. If this data-driven prospective review of cases works to prevent deaths, and fatality rates decline, states might consider extending the practice beyond this two-year commitment. This may continue until they have integrated the improvements into their practices, developed confidence in the accessibility of needed services and supports, and established shared accountability across systems for day-to-day functioning.

Chairman BUCHANAN. Thank you, Mr. Lindert.

I want to thank all of you for excellent testimony.

We will now proceed to the portion of the hearing that is the questions-and-answers session.

Mr. Lindert, in your testimony, you talked about the thorough review your organization undertook of child welfare cases in Hillsborough County in Florida. As you began handling child welfare cases, you noticed that you found a pattern, you noticed certain common features, such as parental substance abuse, that were correlated with serious injuries or death.

I know you have been working with other States to do the same things, but, from my understanding, you were the first in this area to really work in this area.

Should other counties be doing the sort of review of data to help them better understand the cases of abuse and neglect, from your viewpoint?

Mr. LINDERT. From our view, yes. We are actively searching for additional partners to work with and additional jurisdictions to work with beyond the initial five.

It was also one of the recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities, which is Recommendation 2.1, that other States and other jurisdictions take a look at all of these cases in the same vein.

Chairman BUCHANAN. When you look at data, what type of data are you looking at? When you say review of data, what——

Mr. LINDERT. So we are looking at factors that are demographics, such as the age of the child involved in the case, but we are also looking at system factors, such as the number of police reports that have been received on an individual family.

Chairman BUCHANAN. Why do you find, when you go into these other States, that many States aren't taking advantage of the data or best practices or the idea of continuous improvement? What is your sense of why they are not taking advantage of that?

Mr. LINDERT. My sense is that this is a new area of work. Until recently, we didn't have the technology to take our eyes out of the rearview mirror and put them on the dashboard. We can now, if there is new information learned on a case, adjust what we think the risk level of that case is based upon the new information that is received right when it happens. Until recently, we weren't able to do that. So this is a new opportunity.

But I think the broader issue is probably this. Anytime there is a tragedy, there is an intense focus, and rightly so, on that tragedy that occurs, but it tends to be episodic in nature rather than taking the long view. And I think the recommendations of the Commission are that we must take the long view so that we understand these patterns better, rather than making policy or decisions based on an individual case.

Chairman BUCHANAN. The other thing you mentioned, at least I understood, is the way you operate is a private-public partnership. Tell me how that works and why that works.

Mr. LINDERT. So, in Florida, the child welfare system is called the community-based care system. In each community, a nonprofit provider partners with the Department of Children and Families in order to provide the child welfare services that are received. We op-

erate all services once a child is removed from their home up to the time that they are adopted or have independent living services and even post-adoption support.

So we manage all of those services through the same partnerships that would be required of any State agency or county agency if they were operating the child welfare system.

Chairman BUCHANAN. Thank you.

I now recognize the distinguished Ranking Member for any questions that he might have.

Mr. DOGGETT. Well, thank you, Mr. Chairman.

And each of you provided valuable testimony.

Ms. Willauer, I am just reviewing again your written testimony, knowing you couldn't give it all here, but what strikes me as being very important is your comment there on page 15 that there are hundreds of unserved families in Kentucky and the START sites are unable to take all the referrals due to full caseloads. And then you say: "It is time to take the lessons of all of the prior Federal investments of these families and move them to scale by providing the States with funds and technical assistance needed to reform their systems."

Basically, you have a good approach. It is evidence-based. You can show how it has been effective. Haven't you been doing this in some parts of Kentucky now for over two decades?

Ms. WILLAUER. Yes. Actually, Kentucky implemented START in 2007, but it came out of Ohio. It was operating in Cleveland, Ohio, from 1997 for about a decade and a half also——

Mr. DOGGETT. You still can't cover all of the State——

Ms. WILLAUER. No.

Mr. DOGGETT [continuing]. Because you don't have adequate resources to cover all of it.

Ms. WILLAUER. Well, that is true. And I can tell you that in Louisville, Kentucky, for example, for every family we served, we had to turn away two that had the same exact needs. So we have pockets of excellence in Kentucky and across the Nation, but nothing is to scale.

Mr. DOGGETT. And, Ms. Barillas, in Texas, I believe the same IV–E waiver program that she is talking about only covers one county, only Houston.

Tell me about, from your perspective, what additional resources will be necessary in Texas to comply with this Federal court order declaring the system a failure and unconstitutional to meet the needs of these children and their families.

Ms. BARILLAS. Well, it is definitely a resource issue. Three particular things that the lawsuit mentioned was a lack of oversight of facilities, which was leading to children being sexually abused; caseworkers lapsing in their duties—in fact, one particular report said caseworkers were only able to spend 26 percent of their time with children and families, so the majority of their time was spent on paperwork and more administrative duties; and then youth transitioning out of care. This young man who is accused of the UT student's murder is a prime example. He was 17 and a runaway. He had no particular mental health treatment, no transitioning services to help prepare him for adulthood. And we see that happening too often.

So, certainly, more oversight of our facilities; not just more caseworkers but well-trained caseworkers; and we need a tremendous amount of resources to help our youth actually age out, be independent, and be free of that system.

Mr. DOGGETT. So, in Texas, only about one-fourth of the time that these caseworkers have their child protective services is actually about reaching out to troubling situations like the ones that I described and others have described.

Ms. BARILLAS. Yes, sir.

Mr. DOGGETT. And you have an immense turnover of these caseworkers. They come in, the pay is low, they are cycled through the system, and then you have someone new.

And in Texas also, we far exceeded the recommended load for these caseworkers, sometimes by really tremendous amounts, so that we hear when a child is found chained or a child is found abused that Child Protective Services didn't do its job, and in some cases it did not, but in some cases we are loading up those caseworkers with a load that is so big that they can't possibly do their job.

Ms. BARILLAS. Well, there are certain priority cases where caseworkers haven't been out at all for weeks up to months, especially in Dallas. We have had a crisis in that area, where caseworkers are leaving in droves, and because of all the poor media attention, they are having a lot of trouble hiring anybody. So one of the things they have done, our Health and Human Services commissioner has indicated he wants to remove the 4-year degree requirement and reduce training hours, which, to me, is a very dangerous and explosive combination.

Mr. DOGGETT. Would all of you agree that, knowing we have limited resources here also that we will be able to focus on this problem, that looking at IV–E and prevention moneys, if we have to prioritize, that that is a good place to focus our attention?

Ms. BARILLAS. Yes, sir.

Ms. WILLAUER. Yes, sir.

Mr. DOGGETT. Mr. Glynn.

Mr. GLYNN. Yes, sir.

Mr. DOGGETT. And Mr. Lindert.

Mr. LINDERT. Yes.

Mr. DOGGETT. Thank you very much for your testimony.

Thank you, Mr. Chairman.

Chairman BUCHANAN. I now recognize Mr. Reichert.

Mr. REICHERT. Thank you, Mr. Chairman.

I want to start out a little philosophical, I guess, with a quote from President Adams that kind of goes to the point that Mr. Doggett was making in his opening statement. We can pass all the laws we want to pass, but this is just a portion of a quote, where he says, "Our Constitution was made only for a moral and religious people. It is wholly inadequate to the government of any other."

And so, you know, as we talk about parents who are chaining their children and locking them in closets and taking their life, where is this society headed? Where are we? The fabric of our society is disintegrating and falling apart, and so where is it left? It is left in the hands of people like all of you.

And thank you so much for all the hard work that you do. My daughter was a caseworker, and I know from her experience. You don't know me, but my experience was in law enforcement for 33 years, so I get this from having had to call CPS, I have had to take children out of their homes.

I ran away from home when I was a senior in high school. I was one of those kids at 16 years old who left my home because of domestic violence, because of alcoholism, and but for the grace of God, you know, here I am today to be in this position to help you.

I have so many things that I want to say, I hardly know where to begin. Just the 33 years alone should tell you what I have seen and where I have been. I was the lead detective on the Green River serial murderer case. In that case, that person took over 60 lives. Those young girls on the street were addicts. They were abused at home. They ran away from home, looking for somebody to care for them. They were abused on the street. Then they were abused by the judicial system and victimized over and over and over.

And so we have to start where the problem, you know, really begins, and that is at the family. And that is where we really have to focus in order to prevent those kids from getting into that position where—the young man you spoke about, and me as a 16-year-old leaving home and fortunately not falling into that pathway.

My daughter and her husband also adopted two drug-addicted babies from an organization called the Pediatric Interim Care Center in Kent. My grandson, who is now 13, was adopted at 3 months, and was a meth-addicted baby. My granddaughter, who is now 12, was a crack cocaine and heroin-addicted baby.

PICC, keeping their statistics—a review of 140 infants discharged by PICC in 2013 and 2014 found only 8 of those infants who had changed their placements—only 8 out of 140 had changed placements, and the majority of those infants had moved from a parent to a relative or a relative to a parent again, those 8. So, you know, that is one of the success stories in our neck of the woods. And you have success stories too.

I only have a minute and a half left here. I am really excited about what PICC does and about the blessing that Emma and Briar have brought to our family. And what happened there was the visitation between the parents—I have been to PICC, and those drug-addicted parents come in, they rock the babies, they hold the babies. They try to get off drugs. Sometimes they can, sometimes they can't. Sometimes the babies have to be sent to foster care, and then sometimes, guess what, they have to be adopted. And, in our case, we have just been blessed.

I am curious to know if any of you have programs like PICC in your State. I will stop talking, because otherwise you won't be able to answer the question.

I am just passionate about this. You know, PICC, they take the babies from the hospital, because the hospitals don't have the time to withdraw them, right? So they take the babies, and they get them off drugs. And then they work with the parents, and they work—no? Yes?

Ms. BARILLAS. In Houston, we have a facility called Santa Maria Hostel, and they actually are one of these women and children residential services that I spoke of, and they work with both

the children and the parents. But that early attachment and bonding is so critical to their——

Mr. REICHERT. Yeah.

Ms. BARILLAS [continuing]. Brain development, that that is why they want to keep mom and baby together. And so——

Mr. REICHERT. Yep.

Ms. BARILLAS [continuing]. That has been very successful in Houston.

Mr. REICHERT. Good. Maybe we can share some information back and forth and——

Ms. BARILLAS. Sure.

Mr. REICHERT [continuing]. Make the programs better.

Mr. LINDERT. I would reiterate those comments for Florida. We also partner with a number of providers of that nature, and would reiterate all the comments made.

Mr. REICHERT. I yield back. Thank you, Mr. Chairman.

Chairman BUCHANAN. Thank you.

I now recognize Mr. Davis for 5 minutes.

Mr. DAVIS. Thank you, Mr. Chairman. I commend you and Ranking Member Doggett for holding this hearing today.

One of my top priorities on this Subcommittee is modernizing our approach to families and child welfare affected by parental substance abuse. For months, I have worked with experts to draft a bill that does just this. My bill amends the current Regional Partnership Grants both to focus the grants on what the research shows works and to scale up these grants to the State level.

I will introduce this evidence-based approach this month in honor of National Foster Care Month. We need to update our laws to reflect the decade of research, and I look forward to continuing to work with the Chair and Ranking Member to advance these reforms.

Although I have championed evidence-based policy, I must raise concern from experts about whether we have the data infrastructure and research base necessary for large-scale implementation of predictive analytics.

And I request permission, Mr. Chairman, to submit for the record this dissenting report of the Honorable Judge Patricia Martin, a Commissioner on the Commission to Eliminate Child Abuse and Neglect Fatalities.

[The submission of The Honorable Danny Davis follows:]

COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

THE DISSENTING REPORT OF THE HONORABLE JUDGE PATRICIA M. MARTIN CECANF COMMISSIONER

MARCH 14, 2016

THE DISSENTING REPORT
of
The Honorable Judge Patricia M. Martin
Commissioner

Table of Contents

PREFACE - The Call for A Minority Report

In early 2014, The Commission to Eliminate Child Abuse and Neglect Fatalities met for the first time. We were equipped with substantial resources and a clear charge from the President and Congress. We met to begin a process that would examine the state of affairs surrounding prevention of child abuse and neglect fatalities. It was my hope that this Commission would be able to gather and to process information and to develop a plan to make a sound attempt to eliminate child abuse and neglect fatalities. Two years and $4 million later, the Commission has produced a Consenting Report that, on the whole, has failed to realize those hopes or to fulfill the Commission's charge.

$4 Million of Testimony and 30% of Child Fatalities Ignored

The Commission spent a considerable portion of its $4 million budget (money diverted from Temporary Aid to Needy Families) to hold numerous **optional** hearings around the country.[1] The purpose of these optional hearings was to hear from expert witnesses. Yet, the Consenting Report either misrepresents or ignores those same experts. For example, the Consenting Commissioners recommend immediate implementation of "predictive analytics." First, predictive analytics needs further testing and requires the building of a solid data infrastructure in order to work. Second, the expert testimony emphasized the inherent limitations of predictive analytics.

> *"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."*

-CECANF Florida Transcript page 26– Emily Hornestein

"The Surge"

Another example of this practice of selective citation and arbitrary creation is demonstrated in Chapter 2 of the Consenting Report by the inclusion of Recommendation 2.1 (originally known as "The Surge" now known in the voted upon report as "Support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities"). Not one witness

[1] Another major expenditure was the Commission's staff of twenty people.

recommended nor intimated such an approach to eliminate fatalities. Instead, Commission leadership unilaterally decided to include it as a "signature recommendation." More troubling is that this recommendation encourages foster care placements despite expertise and research that demonstrates that the better path for our children is providing services in home.[2]

While purporting to "save lives immediately," this signature recommendation corrupts the Consenting Report.[3] The Commission declares, "*Unless these steps are taken by the Administration and Congress, the Commission believes the same number of children will continue to die each year from child maltreatment fatalities. They are essential to reduce the number of fatalities that will otherwise occur this year and next if we fail to act.*"[4] The Consenting Report reads like a tabloid or infomercial relying on sensationalism to convince Congress and the Administration to eschew their good sense and spend an additional $1 billion annually on this recommendation.[5] This Commissioner opposed recommending new funding recognizing that such funding viability discussions are inherently a matter for Congress to address through its able skill and its use of the Congressional Budget Office (CBO). Moreover, there is no single nor one size fits all solution to CAN fatalities. Consequently, if Congress decides to increase funding, this Commissioner recommends allocating that funding across the numerous recommendations in the Consenting Report.

Reorganizing the Federal Government

The Consenting Commissioners believe, devoid of any supporting testimony or evidence of

---

[2] Development and Psychopathology 18 ~2006, 57-76, http://www.kidscounsel.org/Study%20Impact%20of%20Foster%20Care%20on%20Child%20Dev.pdf. Child Protection and Child Outcomes: Measuring the Effects of Foster Care Forthcoming, American Economic Review Joseph J. Doyle, Jr.* MIT Sloan School of Management & NBER. http://www.mit.edu/~jjdoyle/doyle_fosterlt_march07_aer.pdf

[3] Transcripts of deliberations, internal communications, and the Consenting Report itself show that recommendations of this ilk and under this ambit were developed with the intent of removing children without due process.

[4] These and conforming recommendations are interspersed throughout the Consenting Report tainting it with an underlying theme of exaggeration and misrepresentation that presumes the reader's naiveté.

[5] For example, in an attempt to convince the reader of the efficacy of surge like activities in preventing CAN fatalities, the Consenting Report cites the states of Wyoming and Oklahoma as currently implementing its recommendation 6.2c (NOTE: This recommendation proposes to sequester CAPTA funds). However, taken at face value, this belies their argument inasmuch as both Wyoming and Oklahoma have increases in child maltreatment victimization. From 2010-2014, Wyoming increased 18.8% and Oklahoma increased 82.9%. Furthermore, between 2014 and 2015, CAN deaths in Oklahoma went from 34 to 60 (an increase of 57%). Child Maltreatment 2014, Tables 3-3 and 4-2. Oklahoma Child Death Review Board 2015 Recommendations, https://www.ok.gov/occy/documents/Oklahoma%20Child%20Death%20Review%20Board%202015%20Recommendations.pdf.

potential effectiveness, the answer to a failed system is to expand and/or restructure the federal government. According to Recommendation 5.1 in the Consenting Report, this would be accomplished through "Elevate[ing] the Children's Bureau to report directly to the Secretary of the U.S. Department of Health and Human Services (HHS)" and moving the Maternal and Child Health Bureau (MCHB) to the newly elevated Children's Bureau. MCHB is currently housed within the Health Resources and Services Administration (HRSA). Moving MCHB would make sense if HRSA did not exist to provide services as its name suggests. Furthermore, this new placement proposal was introduced for the first time within the last hour of the last phone deliberation - pointing to process problems. Therefore, it was never fully explored as to why this return to a 1969 (H.E.W.[6]) structure would prevent CAN fatalities today. In addition, the consenting Commissioners then wish to expand government in order to memorialize this commission by creating a "Coordinating Council" to be housed in the newly elevated Children's Bureau. Interagency coordination is a necessary step to better service provision and policy creation for preventing CAN fatalities. However, coordination should not require complete reorganization.

If the aforementioned were not enough, the consenting Commissioners suggest in Recommendation 5.1c that the Domestic Policy Council be expanded to include a duplicative position to handle child welfare and family matters across the administration.

Children 5-18

Tragically, the consenting Commissioners were content to ignore preventing fatalities for 30% of the population it was statutorily charged to study – children 5-18. In fact, the only mention of this population occurred when the Consenting Commissioners allowed for a special examination of Native American children; however, the Consenting Commissioners deleted the relevant narrative leaving the recommendation pertaining to this age group without context in the Consenting Report.

The transcripts and Consenting Report reflect that the Consenting Commissioners refused to regard the testimony of experts on Native American children and minority disproportionality of the same importance as those testifying regarding non-minority issues. This perhaps explains why the Consenting Commissioners relegated over half of the recommendations on these children to inappropriate chapters or to the obscurity of Appendix G. In short, for the most part, and especially when dealing with matters of disproportionately affected segments of children, i.e., poor whites, Native Americans, and African Americans, the consenting Commissioners

[6] HEW was the acronym for the Health Education and Welfare Department which preceded the creation of HHS.

balked at the tough questions necessary to eliminate child abuse and neglect fatalities.

A Flawed Process

The Consenting Report reflects that the Commission had no effective process for deliberations. The questionable practice of endorsing organizations rather than methodologies throughout the Consenting Report diminishes the seriousness of any recommendations associated with such promotions. Consequently, the Consenting Report reads both as a failure to fulfill the charge articulated in the governing legislation (The Protect Our Kids Act), and as an inappropriate advertisement of programs. Any disclaimers in the footnotes of the Consenting Report related to endorsements are more of an admission of the existence of rather than an attempt to remove the appearance of impropriety.

The unorthodox process for editing the Consenting Report raises serious concerns. Commissioners have been allowed to submit changes and additional materials after the final vote. Those changes were incorporated into the Consenting Report without being seen, deliberated, or voted upon by the entire Commission. Moreover, the final report incorporating those changes was not released to this Commissioner prior to submission for printing. A simple comparison of the voted upon draft and the final report reflects substantive changes. Thus, the full Commission was deprived of information to perform its duties and/or select commissioners were granted favor to privately shape the report devoid of deliberation. For example, Recommendation 6.2a of the Consenting Report could be viewed with suspicion because the entire corresponding discussion regarding military children and El Paso County CPS was never presented in the voting draft copy of the report. The value of the military paradigm for determining child abuse and neglect is self-evident, but its after-the-vote inclusion elucidates the flawed process. This practice was repeated in association with Recommendations 5.3. Therefore, it is this Commissioner's position that the validity of the Consenting Report must be viewed with trepidation.

Finally, the independent submission of this Dissenting Report is yet another reflection of the flawed process. As the reader may be aware, there were two dissenting commissioners. The process was structured such that the opinions of individual commissioners were limited to two page letters to be printed with the Consenting Report. No commitment was made for dissenting opinions. Instead, the Chairman of the Commission stated that he would review dissents and then decide unilaterally whether to exclude the dissent, to edit the dissent, or to include the dissent without alteration in the Commission's official submission to the President and Congress. As a result, this Commissioner chose to submit the two page letter and to absorb personally the costs of printing and distributing this official document.

The Dissenting Report Of The Honorable
Judge Patricia M. Martin
CECANF Commissioner

THE DISSENTING REPORT

Introduction

In light of the previously raised concerns, this Dissenting Report has been constructed to give the President and Congress a valid perspective of the Commission's work. The following recommendations seek to give the reader a more robust view of the expert testimony and recommendations received, as well as any logical conclusions arrived at from those expert testimonies and recommendations.

Through a systematic evaluation of individual professional observations, research reports, as well as the expert and practical testimony heard throughout 11 separate hearings in different parts of the country, certain conclusions can be reached as to what are the next steps in eliminating child abuse and neglect fatalities. This report captures those conclusions and proffers 19 applicable recommendations to create a clear national strategy for combating CAN fatalities. The National Strategy discussed herein offers The Administration and Congress an alternative to the draconian "Surge" based national strategy and conforming recommendations made in the Consenting report.

Creating An Effective National Strategy

The methodology employed in creating a national strategy should be based in a philosophy of simplicity and common sense. Not to diminish any of the expertise that is relied upon to develop the recommendations in this report, but child welfare and child protection must first be implemented within the context of human behavior. Community elements such as culture and demographics are the foundation for how human behavior is exhibited throughout the world. Research is then applied to those elements which influence human behavior to develop methodologies to further refine human behavior.

As elementary as it may seem, to create a national strategy, it should not be dismissed that:

- In order to prevent child abuse and neglect fatalities, preventing child abuse and neglect is essential.
- Measuring what has happened is necessary to analyze and improve the situation. Thus, child abuse and child neglect must be universally defined and applied in order to accurately

measure progress in the prevention of child abuse and neglect fatalities.

- Child abuse and neglect fatalities involve child maltreatment; thus, one could conclude that efforts which reduce child maltreatment probably will have some effectiveness in reducing child abuse and neglect fatalities.
- Near fatalities due to child abuse and neglect are probably reliable predictors of impending child abuse and neglect fatalities. The difference between a near fatality and an actual fatality quite often can be reduced to medical intervention. Thus, to develop the most effective child abuse and neglect fatalities prevention model, it is essential to examine the mitigating and underlying circumstances of near fatalities due to child abuse and neglect.
- Being able to conclusively predict human behavior with 100% accuracy is impossible; yet, recurring circumstances resulting in the same outcomes establish a pattern not to be ignored.
- Where research, strengthened by empirical data, meets common sense approaches, may be the starting point for efforts aimed at innovation in human behavior modification and eliminating child abuse and neglect fatalities.
- The fact that we don't have enough data is critical. We need to build an infrastructure for using predictive analytics appropriately. Experts agree that currently, predictive analytics is not a viable tool for child protection. Nonetheless, a true 21st century approach is one that fills the data gaps, promotes data sharing, and builds a proactive system from that data exchange.

Statistics show, in 29 reporting states, that only 12.2 % of the CAN fatalities were known to CPS in the prior 5 years immediately preceding the deaths. Extrapolated, that would suggest that 88.8% of those CAN deaths were of children never reported to CPS[7]. This fact points out the greatest deficiency with ensuring our kids' safety through our current child welfare approach – no effective monitoring of our children's well-being before abuse and neglect occurs. The system must be reformed with Primary Prevention Strategies.

Enhance Protective Factors Before Abuse Occurs - Primary Prevention Strategies

The current Child Welfare System is not designed to prevent child abuse and neglect fatalities. Instead, a closer look would suggest that at best, it is designed, through Child Protective Services, to react to abuse and neglect that too often results in a child fatality. The current system ostensibly seeks reunification as the ultimate goal of any removal, though, ironically, it seldom focuses on enhancing protective factors. Hence, the Child Welfare System in our

[7] Child Maltreatment Report 2014 at page 56

country is reactive and somewhat ineffective in the prevention of child abuse and neglect fatalities.

Policy changes to attempt improvement upon the system may occur when a CAN death receives high publicity. However, in its current state, child protection efforts generally do not occur until after abuse or neglect is suspected and, in many cases, has already occurred. Depending on the severity of the abuse or neglect, child protection is a moot issue because of a fatality. In short, the current Child Welfare System has no primary prevention function; it is designed to reactively manage family crises.

Yet, it is impractical and socially dangerous to dismantle the current CPS structure. However, the Commission heard key testimony that suggested elements which could give the system a preventive light and reform the Child Welfare System to include a primary prevention approach to child abuse and neglect. Those elements include reducing poverty, home visiting, addressing disparities, implementing coordinated multi-disciplinary efforts, data sharing, and continued effective data collection on CAN fatalities and near fatalities. Therefore, if the current approach is modified by including these preventive strategies, a deliberate reduction of child abuse and neglect fatalities becomes attainable.

Definitions

In order to create a national strategy to eliminate CAN fatalities, all stakeholders must be speaking the same language. Varying definitions of what is and what is not child abuse or neglect may be one of the greatest hindrances to effectively combating abuse and neglect. Without universal definitions that apply across the board, measurements and data collection will continue to suffer thereby negatively impacting secondary prevention efforts and innovations.

At the Federal level, the Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as:

> *"Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm"*

States and their agencies have developed definitions of their own to conform to this definition. However, given the serious nature of CAN fatalities, more uniformity is needed. Therefore the following recommendations are proffered:

RECOMMENDATION 1.1: Congress, in partnership with the Administration and State Child Welfare Directors, should develop a more thorough and universally agreed upon definition(s) of child abuse and child neglect to be included in the next CAPTA reauthorization.

Data Collection

Current data on CAN deaths is inaccurate. This inaccuracy occurs, if for no other reason, states are not required to report them to the National Child Abuse and Neglect Data System (NCANDS). Reporting is voluntary although through CAPTA, funding is directly tied to submission of data to NCANDS. The Protect our Kids Act anticipated that the Commission would develop a recommendation to address the lack of available data to make an accurate count of CAN fatalities. In 2014, only 29 states reported CAN fatality data through NCANDS.[8]

Too often, interagency sharing of CAN within states is difficult because of confidentiality concerns. The problem is further complicated when that same information needs be shared across state lines.

As well, some states have "birth match" programs. These programs make it mandatory for hospitals to report births of children born to parents who have a previous termination of parental rights (TPO). The result is that services for these families begin immediately. This is a good example of a coordinated multi-disciplinary response where no abuse has occurred; however, the prevention begins immediately.

Because we know that a prior report to CPS, regardless of its disposition, is the single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5[9], we can ill afford not to embrace birth matching. This practice can be further developed to screen not only for risk factors but to confirm protective factors thereby ensuring a comprehensive safety assessment on behalf of children and families.

RECOMMENDATION 2.1: Congress should require that all states report CAN deaths to NCANDS.

RECOMMENDATION 3.1: Congress, in consultation with the Administration and State Child Welfare Directors should develop a universally agreed upon data sharing plan that would allow real time risk and protective factor assessment of children beginning at birth to be included in the next CAPTA reauthorization.

---

[8] Maltreatment Report 2014, page 56
[9] See Testimony of Emily Putnam-Hornestein, CECANF Tampa Hearing

Multidisciplinary Coordination

The current child welfare system has many components. The world of CPS is just one part of that system. While CPS is the reactive part of child welfare, it should be looked to as the secondary prevention layer. The primary layer of prevention must occur before abuse or neglect occurs.

Other players in the child welfare system include law enforcement, clergy, courts and the medical profession. However, the current paradigm lacks consistent coordination between these entities. Still, in order for the primary prevention of child abuse and neglect to occur, coordination is critical.

As with birth matching the medical profession is coordinating with CPS through data sharing, so much more can be accomplished on both the primary prevention and secondary prevention levels if more child welfare partners simply share the relevant data.

Home Visiting

Over the past 25 years, several reports have been published around CAN deaths and child welfare in general with the hopes of preventing child abuse and neglect. Governmental and non-governmental organizations independently study the subject matters and made recommendations. The Commission was provided a compendium of the recommendations from 25 reports since 1990, highlighting the 5 foremost of those reports, and citing the top 25 child welfare recommendations.

It was determined that the recommendation most elucidated of the foremost reports was that home visiting be made available for all families[10]. Unfortunately, home visiting for all families is not available. However, where home visiting is available, there seems to be evidence that it is an effective preventive child abuse and neglect strategy[11]. Testimony from the Commission hearings echoed these facts.

---

[10] Moving the Marker Forward 2015, Table 2 at page 7.
[11] Avellar, S., Paulsell, D., Sama-Miller, E., Del Grosso, P., Akers, L., & Kleinman, R. (2015). Home visiting evidence of effectiveness review: Executive summary. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. Retrieved from http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2015.pdf

The Dissenting Report Of The Honorable
Judge Patricia M. Martin
CECANF Commissioner

ONE SIZE DOES NOT FIT ALL

"Many researchers believe that discussions of race obscure the true contributing factor poverty, which affects roughly one in two American Indians and one in three African American and Hispanic families, but only one in nine white or Asian families (American Almanac Statistical Abstract of the United States, 1994)…Others have suggested to this Board that the problem is not poverty, but psychological stress caused by dealing with limited opportunities and the effects of racism. These important questions remain unanswered."

A Nation's Shame 1995

American Indian/Alaska Native Children

The Commission formed the American Indian/Alaska Native (AI/AN) subcommittee to examine child fatalities in Indian Country. Although it is widely known that data from the tribes is not always widely available, according to 2011-2013 NCANDs data, the rate of AI/AN child abuse and neglect fatality victims was nearly two times the rate of white children and, per 2014 NCANDS data, AI/AN children represented child abuse and neglect or maltreatment victims at a rate of one-and-a-half times that of white children.

The overarching theme from the testimony across the multiple Commission meetings was that child abuse and neglect fatalities of AI/AN children can be properly addressed only when tribal nations take responsibility and are allowed to take responsibility for their children. This can be achieved only as the U.S. federal system acknowledges and participates with Indian Country under a paradigm that views each individual tribe as a sovereign nation.

Specifically, the federal response to the question of child fatalities in Indian Country must accept the U.S. government's own description of Native American tribal nations as "domestic dependent [sovereign] nations within our borders." Therefore, the U.S. government is bound to operate with the tribes under the principle of a trust relationship. In addition, the federal government has a "duty to protect" the tribes, implying the necessary legislative and executive authorities to effect that protection. Further implied is the federal government's debt of care to these sovereign nations based on history and treaty.

Special attention must be paid to child fatalities due to abuse and neglect in Indian Country because of a particular and unique paradigm. In Indian Country, child abuse and neglect fatalities are not relegated to an examination of one age group of children, but considers all of the age groups. Thus, when speaking of child abuse and neglect fatalities in Indian Country, equal urgency is made regarding infants dying and teen suicides resulting from abuse and neglect.

Therefore, the recommendations to prevent child abuse and neglect fatalities must encompass strategies to address children from 0-18 years of age.

Throughout testimony during CECANF meetings in Burlington, VT, and Denver, CO, as well as a meeting dedicated to discussing tribal considerations in Scottsdale, AZ, the Commission heard from a wide range of speakers about the specific challenges in preventing child abuse and neglect fatalities including:

- Data Deficiency - the lack of data and data systems within many tribes to track key data around child abuse and neglect and child abuse and neglect fatalities.
- Jurisdictional Navigation - the multiple jurisdictional challenges when a child abuse and neglect fatality of an AI/AN child occurs on tribal lands and on nontribal lands.
- Inadequate Accessibility and/or Availability to Funding and Services - the numerous challenges that continue to persist around tribes being able to remain sovereign and at the same time access funding, training and technical assistance, and developmental opportunities that will promote parity between tribal child protection/child welfare agencies and state child protection/child welfare agencies.
- Impact of Historical Trauma and Poverty – Historically, AI/AN children have been exposed to the negative impact of colonization. Erosion of culture and a continued misrepresentation of tribal communities have traumatized generations of AI/AN children resulting in a cycle of hopelessness, thereby fostering generational exposure of children to violence (including exploitation and trafficking) and elevated substance abuse challenges in Indian Country. With few exceptions, AI/AN children experience poverty at an alarming rate. This poverty is one of the factors contributing to an environment wherein crises associated with child abuse and neglect fatalities are catalyzed.

The positive side of those challenges highlighted by speakers is the resiliency of the clan and family structures within tribes to maintain their sovereign tribal communities. Of great importance is the notion that the tribe is one family and that well-being of all the children is the responsibility of the family – the tribe. It is with that lens that several examples of work within specific tribes were highlighted through testimony. The following example stood out as sustainable and potentially effective in mainstream systems:

Eastern Band of Cherokee Indians' Multisystem Collaboration Example: The Eastern Band of Cherokee Indians has developed a multi-jurisdictional, multi-agency,

and multidisciplinary approach to child protection built on common goals and a common language across all systems and jurisdictions involved. This multisystem collaboration has focused on services and accountability, using a results-based accountability framework to measure and monitor progress and areas for continued development.

The Eastern Band also has developed an integrated child welfare team that has child protection, foster care, case managers, and behavioral health staff all working in one central place to promote teaming in working with families. To enhance that work, the Eastern Band is also leveraging Medicaid dollars to free up other resources to provide more in-home supports to families.

The Commission has set out to develop a set of recommendations around the needs of AI/AN children that (1) aligns with the CECANF National Strategy, (2) promotes an actionable and focused approach to address clearly identified challenges, and (3) develops an improved set of conditions in how tribes, states, and the federal government work together around the investigation, reduction, and prevention of child abuse and neglect fatalities.

Data Deficiency

Effective leadership and accountability in this area can be demonstrated when tribes, states, and the federal government recognize the sovereignty of tribes and the shared interests among tribes, states, and the federal government to protect all children both on tribal and nontribal lands and to ensure that families have the supports they need. Tribes, states, and the federal government should have a common goal for sharing data across tribal and state child protection/child welfare systems that would be supported by the provision of resources and support for a data infrastructure to help tribes collect and provide needed data.

Fatality data collected in tribal lands is woefully inadequate. Accordingly, a common refrain from those tasked with assessing deaths among Native American children is that "we don't know what we don't know because we don't have the data". Too often, critical yet generally easy to ascertain information related to child deaths simply is not recorded. For example, while the Bureau of Indian Affairs records deaths in Indian Country, there reporting instruments have no delineation of whether a death is a child or an adult. This data deficiency can be relieved by adopting the following steps:

RECOMMENDATION 4.1: Congress and the Administration should mandate that the Bureau

of Indian Affairs (BIA), at a minimum, immediately implement the practice of distinguishing child and adult homicide victims when reporting fatalities in Indian Country.

RECOMMENDATION 5.1: Congress and the Executive Branch should require the FBI to identify key data that tribes could track and that the BIA could collect. At a minimum, the FBI should ask BIA to use the National Incident-Based Reporting System (NIBRS) or request that BIA provide more detailed child-specific information. BIA and FBI data collection about AI/AN children and child fatalities should be coordinated to be complementary and comprehensive.

Jurisdictional Navigation

The notion that there must be a collective responsibility for safety in order to curtail the death of children in Indian Country is critical. No one side of the sovereign nations involved in this undertaking, be it the federal government, states, or a tribe, is able to adequately overcome the jurisdictional hurdles that continue to bar proper prevention and intervention strategies.

In most tribal lands and states, jurisdiction in child welfare and fatalities becomes a conundrum. Often, discrepancy arises as to which agencies and courts should intervene and adjudicate cases involving children without regard to tribal standing. As well, cases against perpetrators are often mishandled under the color of jurisdictional uncertainty, especially if they are non-Indian. However, this Commission received testimony from Indian Country where deliberate cooperation between tribes, states, and the federal government has been effectuated. The Eastern Band of Cherokees has been able to hammer out working relationships across jurisdictional lines in a multi-disciplinary paradigm which appears to be effective in combating child abuse and neglect fatalities. Therefore, we believe that further success can occur for all tribes by taking the following steps.

RECOMMENDATION 6.1: Increase reporting upfront to the Bureau of Indian Affairs (BIA) on tribal and state child welfare cases involving AI/AN children.

RECOMMENDATION 7.1: Congress should mandate the provision of training and technical assistance for tribes around collecting data and building data systems.

RECOMMENDATION 8.1: Federal policy should provide incentives for states and tribes to increase participation and deputation agreements and other recognition agreements between state and federal law enforcement agencies.

RECOMMENDATION 9.1: Coordination between and among jurisdictions should be mandated, facilitated, and incentivized.

RECOMMENDATION 10.1: The federal government should mandate the recognition of

tribal criminal jurisdiction in Indian Country in cases of child abuse and neglect, regardless of the perpetrator's race and/or ethnicity.

Impact of Historical Trauma and Poverty

Throughout the Commission's work, it has been well established that the historical trauma associated with the displacement of American Indians and Alaska Natives has resulted in high incidence of teen suicide, depression, disproportionate substance abuse, human trafficking and domestic violence on tribal lands. As well, this cadre of social epidemics has ravaged the fiber and stability of Indian youth. Efforts must be made to restore a positive self-awareness in Indian Country, especially among American Indian and Native Alaskan youth, in order to curtail the incidence of child abuse and neglect fatalities, including suicide.

The impact of historical trauma and poverty cannot be overstated. Yet, amongst Alaska Natives and in the Navajo nation, when cultural approaches have been utilized, and children have been reintroduced to their native culture, reductions in suicide and violence in general has been noticed.

Cultural considerations are very critical in Tribal lands. Traditional ceremonies, multi-shift employment and upward mobility efforts are too often overlooked when examining funding and service provision for tribal lands. Many times, service provision does not correspond with tribal members' ability to access the services because of cultural constraints. It is critical that the paradigm elevate these considerations to ensure the best possible approach to child welfare is provided in preventing child abuse and neglect fatalities.

Simply stated, the services must fit within a framework that is culturally appropriate for tribes. Assistance given to the tribes is unlike assistance given to states or to other countries. Assistance given to tribes are based on a duty of care and already existing treaties yet to be fully honored in spirit or letter. There is a federal duty to intervene on behalf of tribes with respect to child welfare and safety. One of the foremost demonstrations that the federal government can display is to commit to the revitalization of Native American culture to preserve the lives of children in Indian Country. To do so:

RECOMMENDATION 11.1: Congress and the Administration should address the ability within tribes to support child/family/tribal access to needed services, supports, early literacy services, home visiting, and education by, at a minimum, promoting access to services, supports and education outside of the standard 9 a.m. to 5 p.m. service hours.

RECOMMENDATION 12.1: Congress and the Administration should explore the

development and implementation of educational curricula connecting youth to their cultural traditions, particularly around native language renewal and positively presented Native American history, to be used at all levels of pre-collegiate education.

RECOMMENDATION 13.1: Congress and the Administration should mandate the implementation of service approaches that prioritize keeping children within their tribes as a primary alternative to out-of-home placement.

RECOMMENDATION 14.1: Conduct longitudinal research about the leading factors related to child abuse and neglect fatalities of AI/AN children, 18 and under. It may be possible to integrate a longitudinal research component in the Tiwahe Initiative (a partnership between HHS, DOJ, and DOI) currently being piloted in four tribes.

RECOMMENDATION 15.1: The federal government should promote and facilitate peer-to-peer connections around examples of well-formed efforts focused on AI/AN children and families.

"One mystifying issue is the large overrepresentation of African American families in known child abuse and neglect fatalities, which is twice or three times the rate seen in other racial groups. The data show a dramatic overrepresentation of African Americans in fatal abuse and neglect deaths, but there has been almost no study to understand this issue. Yet the numbers should deeply concern policymakers and the public: one study showed the homicide rate of African American infants studied over a 10-year period to be 25 per 100,000. This approaches the rate of violent death for African Americans (39 per 100,000), which, in contrast, is a widely discussed area of concern (Levine et al, 1994; Levine et a), 1995)."

A Nation's Shame 1995

Disproportionality

Child abuse and neglect fatality data available through NCANDS tell us that while African American children are approximately 15 percent of the child population nationally, they are 33 percent of the child abuse and neglect fatalities, which is approximately three times greater than white children (NCANDS 2014).

Over twenty years ago, the federal government commissioned the U. S. Advisory Board on Child Abuse and Neglect to produce a report about the state of child welfare in our country. The board found then that there was a glaring overrepresentation of African Americans in fatal abuse and neglect deaths with almost no study to understand the issue. That glaring overrepresentation still

remains. While research in this area has not flourished, we are now better able to understand some of the nuances that perpetuate disproportionality. As well, we are able to observe practices that may combat disparities.

> *"I think we need to look at abusive head trauma and why it is according to much of the research that abusive head trauma cases are misdiagnosed for white kids. I think that suggests that we really need to go back in and look at that data and it is possible that implicit bias could be contributing to that misdiagnosis of abusive head trauma with regard to white kids and that might give us information that will allow us to move forward."*
>
> Dr. Rita Cameron Wedding
> CECANF Testimony – New York

It could be that disproportionality is a double edged sword that directly disparately treats African Americans while inadvertently depriving Whites of proper assessments and diagnoses. Accordingly, the subcommittee studied disproportionality with this in mind and formed its recommendations with the intent that its recommendations would aid in the prevention of fatalities for children of every ethnicity and race in the United States.

The effect of disproportionality and disparities in the child abuse and neglect fatalities cannot be understated with regards to the impact on the affected communities. It is conceivable that such loss in the minority community may contribute to a cycle that ravages families, decimates neighborhoods, increases poverty, and produces an overall environment of hopelessness due to an overload of negative and/or unfair interaction with the child welfare system. As a result, mistrust of the system becomes established in the community disposition. Child abuse and neglect increases or goes unattended. Children in minority communities die at a disproportionate rate.

Attention must be given to the root causes of what can appear to be a systemic problem stemming from historically disparate treatment of minorities. It is undeniable that equality in other civil areas including education and criminal justice for minorities lags in progress. It is likely that such a systemic tragedy further spurs predisposition in the attitudes of players in the child protection systems. Law enforcement, courts, social workers and medical professionals alike often times demonstrate what can be characterized as bias when interacting with the minority community.

As the Commissioners heard testimony, discussions focused on some of the challenges to

combating the disproportionate number of child abuse and neglect fatalities in minority communities:

- Data Sharing and Assessing Risk – Disproportionality typically reaches the African-American community in more than one social context, although much information is available that can be utilized to produce the best health outcomes in the community. However, how risk is assessed in minority communities does not mirror non-minority risk assessments. This is largely due to implicit bias and a lack of cultural competence. Too often data from law enforcement, health, education, and other social services organizations and/or programs are unfairly presented and produce a climate that reduces the allocation of resources and services to disadvantaged communities and produces community distrust of the child protective system resulting in a concerted effort to avoid usage of the social services system by the community.
- The Impact of Racism – The impact of racism cannot be underestimated. Although racism remains a difficult subject to discuss, it is critical to understand that it is the basis for implicit bias. Implicit bias can impact decision-making related to minority children being overrepresented and possibly other children being underrepresented in the child welfare system. For example, it has been established that when an African American child is seen for a head injury in the emergency room, a CT scan is the protocol at a much higher rate than for a Caucasian child presenting the same symptomology. Thus, corresponding data would suggest a need to overcompensate intervention and prevention efforts when observing African American children and undercompensate when observing Caucasian children.
- Poverty – Minorities experience poverty at an elevated rate. Elevated poverty is one of the factors contributing to an environment wherein crises associated with child abuse and neglect fatalities are catalyzed. The formula for continued disparity in minority communities is a platform that consists of a lack of quality services, and a social services workforce that is often hamstrung with implicit bias, cultural incompetency, and improper data interpretation being imposed upon an economically disadvantaged community. Moreover, in concert with such an untenable platform available in impoverished communities, an escalation of trauma due to avoidance of the system perceived to be inadequate and unfair becomes the culture of that community, thereby disproportionately raising the documented incidents of child abuse and neglect fatalities.

Fortunately, the Commission had the opportunity to hear about two examples that illustrate focused work to address disproportionality related to child abuse and neglect fatalities:

Michigan's effort built an accountability and business case for addressing disproportionality and

promoting equity as a social justice issue. Bringing a broad group of stakeholders together, demonstration projects were implemented to address disproportionality, with an emphasis on training the workforce, partners, and mandated reporters, and formulating policy and programs that promote prevention and access to interventions that build strength and resiliency in individuals and families.

Sacramento County, CA's focused work on addressing child fatalities of African American children is an example of a community working to identify why the problem of disproportionality for child fatalities of African American children persisted for some 21 years without being addressed. This is also an example of mobilizing a broad range of stakeholders to address the issue. The entire community including faith based organizations, courts, educational professionals, hospitals, child care providers and law enforcement were enlisted to combat the travesty of child disproportionate fatalities.

> *"We have oftentimes identical risk factors for black families and white families but when the risk factors are identical, white families are more likely to get family and home support and black families are more likely to have their children removed. And families know that. So they're not going to stick around. They're not going to tell us things. They're not going to give us information, critical information that we need to have in order to save their children, to help them save their children."*
>
> Dr. Rita Cameron Wedding
> CECANF Testimony – New York

A climate of distrust of the very system that should be a tool to assist families in unification, health, and wholeness has been developed due in large part to the way information is processed and shared. Thus, African American families, particularly in emergent healthcare situations, avoid utilizing the social support system for fear of the professionals' bias. It is necessary to rebuild the trust in these communities. Disproportionately affected communities must be able to trust the system designed to protect its children. By taking measures to reduce bias and to improve screening methodology with the goal of child safety in the context of family unity and wholeness, trust will rebuild. Demonstrated systemic fairness must be presented to these communities in order to prevent further child abuse and neglect fatalities.

Continuing to address child welfare with a one size fits all mentality that ignores the necessity for diversity is simply untenable. The system will never be able to stop the preventable deaths of children due to child abuse and neglect if a serious and concerted effort is not made to remake it

both in policy and practice. Policies that ignore the multicultural nature of our society must be redressed. As well, professionals charged with effectuating child welfare and well-being must be re-oriented to understand that proper and effective implementation efforts to prevent child maltreatment, abuse, neglect, and fatalities must be conducted with a multicultural mindset.

"[S]ee poverty as a condition and not as a character flaw"

Dr. Renee Canady – CECANF Testimony, New York

Poverty - A Lack of Community Resources

The inadequate community platform perpetuated by poverty in minority communities is accentuated by the clear lack of quality services starting at the intake process, proceeding through the judicial adjudication, and finally ending in placements that ignore the possibility of reunification with family of any sort. Quality services (effective, culturally appropriate, and targeted) are needed to support children and their families disproportionately represented in child welfare and other child-serving systems. Efforts at the federal, state, and local levels need to address quality with the same emphasis as availability and accessibility.

When poverty is seen as a condition rather than an individual or group character flaw, true efforts can be made to eradicate this underlying hindrance to family preservation efforts. Because poverty is a condition of neighborhoods, quality of services provided, accessibility to services, quality of infrastructure, health equity, educational equity, and equal opportunity to earn livable income, it is essential that these issues be examined. Poverty first happens to a community and is then manifested in an individual. Poverty therefore is a lack of resources translated into a lack of quality social services, products, and opportunities.

Throughout the life of the Commission, emphasis has been made on having as many eyes on the children as possible. This train of thought is vital in communities already receiving disparate treatment and/or are demographically disadvantaged. Where we have seen potential improvement in outcomes related to disproportionately represented populations, there has been a direct correlation between an all hands on deck community response of mandatory reporters from various sectors including clergy, care providers, law enforcement, educators, and doctors.

In the African American community, historically, faith-based organizations have been an integral part of the social structure. This dynamic has not changed. Thus, when abuse and neglect happen in the African American community, it is probable that someone in a faith-based

organization had eyes on the victim. Yet knowing how to report, willingness to report and requirements to report have remained unclear.

Only now, social justice and consciousness demands have moved the faith-based community into partnerships requiring regulatory sophistication and government oversight. This is a positive development. However, while care providers, law enforcement, educators, and doctors have benefited from education and training in mandatory reporting, by in large, clergy have not – partly due to a lack of professional status. While 27 states require clergy to report child abuse and neglect, only 11 states require that clergy be registered with the state.

There is an opportunity to radically expand the mandatory reporting pool in the African American community. Just counting churches alone, there are approximately 69,738 faith-based organizations in the African American community. Statistics show that 53% of African Americans engage a faith-based organization on a weekly basis at a minimum. These numbers suggest the potential to gain thousands more eyes on kids.

RECOMMENDATION 16.1: Congress should mandate that all organizations receiving federal funding or benefits for the purpose of serving children have at least one responsible party who is registered in a federal registry, and that said party be trained in the nuances of mandatory reporting of child abuse and neglect. In the case of faith-based organizations, clergy should have the ability to report under the shield of anonymity.

RECOMMENDATION 17.1: Congress and the Administration should promote the standard that all CPS cases consider the total well-being (physical, mental, and emotional) of (1) the child, and (2) the nuclear family and shall proceed with the presumption of preserving the holistic health of the family in anticipation of reunification and/or kinship care where practicable.

RECOMMENDATION 18.1: Congress should encourage increased emphasis on teen pregnancy prevention, especially for young men and women in high poverty areas and those in foster care. There needs to be more attention given to young men in the development of effective teen pregnancy programs.

RECOMMENDATION 19.1: The Administration should bolster efforts to involve probation officers and parole officers in the multi-disciplinary outreach to monitor the safety of children where parolees and those on probation reside.

Combating Poverty-Strengthening Families

While the current system ostensibly seeks reunification as the ultimate goal of any removal, it seldom focuses efforts on refining the pathway to preserving the family structure. Specifically,

the clutter of poverty and poverty related perspectives manifested through a system wide attitude leaning towards removal of children is regularly the outcome for minority families encountering CPS.

Once a child is born and leaves the hospital with their family, the chance for primary protective services diminishes. Protective factors in the home are then the most important shield to abuse and neglect. This is particularly critical for children of underserved communities. In the unfortunate case that CPS becomes involved in the life of a family and child(ren), the Court becomes the champion for ensuring the safety of our children. Thus, serving as the fulcrum of the current system is the court.

Courts are the final authority on whether a family will be reconfigured, dismantled, or preserved. However, a general philosophy of how best to address child abuse and neglect fatalities has yet to be established in the field of jurisprudence. While the general default position with respect to family issues is "children first", the obvious starting point of any child protective services situation is a family and must focus on protective factors present in the home – especially in underserved communities.

Hence, and in light of the ostensible goal of reunification, it should logically follow that family interventions would be the first line of defense in protecting children and adjudicating child protection cases. Therefore, the courts must find their platform built on a philosophy of preserving families, thereby preserving communities. The court will then play an active role in weakening the influence of the poverty that contributes to the proliferation of systemic disparate treatment of minorities and poor whites alike. The courts have the positioning to provide some relief to families coming from communities dominated by poverty. To do so:

RECOMMENDATION 20.1: Congress should incentivize the establishment of Family Preservation Court or Intact Family Court[12] demonstration projects that feature a multi-

---

[12] **Intact Family Court – Through public/private partnerships develop place-based pilots focused on communities with disproportionate child abuse and neglect fatalities to address the needs of young children (5 years old and under) where there is a substantial risk of abuse or neglect. Elements of the Intact Family Court would include:**

- **Referrals from medical workers, law enforcement, clergy, or social workers**
- **Voluntary process for family to engage in**
- **Initial intake would include a physical for every child**
- **Guardian ad litem needed, instead of a lawyer for the child**
- **No lawyers engaged**
- **Assessment to provide focused coaching and supportive services to family**
- **Confidential process**

disciplinary team approach in order to promote the survival of healthy families and communities otherwise decimated by disproportionate incidence of child abuse and neglect and child abuse and neglect fatalities. This approach should not be limited to federal funds, but could be implemented through public/private partnerships.[13]

CONCLUSION

Humbly, this Commissioner has submitted this Dissenting Minority Report with the hope that The President and the Congress will look upon the Commission as a success. Often time, dissenting opinions are the key to discovering the balance between parties. Consenting, too often can mean business as usual and/or complete surrender. Dissent, more often than not, reveals the strength of points of agreement between parties.

In my humble opinion, I believe the reader of this report will find that where there is intersection between the Dissenting and Consenting reports, the strongest and most actionable recommendations that the Commission can sincerely make are presented in an effort to provide a National Strategy for Eliminating CAN fatalities.

Respectfully Submitted.

- **Social worker drives the Intact Family Court process and can still pursue more formal dependency process if necessary**
- **Court's role is expanded to be a resource both in the Intact Family Court, as well as in their current role in more formal dependency proceedings**

[13] The Intact Family Court will evaluate protective factors and provide pre-emptive supports to prevent child abuse and neglect fatalities. The process could have similarities among the pilots, but not be too prescriptive to address the unique needs in a specific community and provide targeted supports to families.

Summary of Recommendations

Mr. DAVIS. Judge Martin is a national expert on child welfare whom I have known for decades, and if she has concerns, then I think our Subcommittee should give serious consideration to them.

Ms. Willauer, given that timely access to treatment is related to child welfare reunification outcomes, can you tell us more about how you achieve quick access to services? And what are your recommendations to make this type of quick access available in more States and communities?

Ms. WILLAUER. Thank you for that question. I think it is the key to child welfare reform, quick access to parental substance use treatment.

So I think that there are a couple things. We need resources. We need treatment providers. Sometimes there is a 3- to 6-month waiting list in Kentucky, for example.

So, again, I think that I would reiterate what you are saying, and that is, for example, Regional Partnership Grants, taking them to a State level, providing States with the resources to be able to develop those resources so that individuals—so all families can get them. Right now, only pockets of families can get those resources. So it is critical.

Mr. DAVIS. Thank you.

Your testimony also emphasized the necessity to include fathers in family treatment, noting that this policy evolved over time. Can you expand on the importance of focusing on fathers in your program?

Ms. WILLAUER. Absolutely. Addiction affects the whole family, including moms, dads, kids, extended family. And if we do not include the fathers, then you are not holistically addressing the situation. We should include them in treatment, in decisionmaking. We should look at their families for support for placement for children. And we should look for gender-specific treatments for those dads.

Mr. DAVIS. Thank you very much.

Dr. Barillas, several of the other witnesses have described their promising approaches to address parental substance abuse and keep children safe. Are these interventions expensive in the short term?

Ms. BARILLAS. Evidence-based practice can be expensive in the short term. It requires fidelity to a model, which requires specific elements and training. It also requires evaluation, and I have found that a lot of times, when programs are funded, they are not funded for that evaluation piece. But in the long run, as you can hear from the various witnesses, these programs have a major impact and save us money.

Mr. DAVIS. So we follow the trend that an ounce of prevention is worth much more than a pound of cure——

Ms. BARILLAS. Yes, sir.

Mr. DAVIS [continuing]. If we provide it early on.

Ms. BARILLAS. Absolutely.

Mr. DAVIS. Thank you very much.

And, Mr. Chairman, I yield back.

Chairman BUCHANAN. Thank you.

I now recognize Mr. Reed for 5 minutes.

Mr. REED. Well, thank you, Mr. Chairman.

And thank you to the panel for your testimony. And each and every one of you has a great story, a great piece of information to help us on this issue.

So what I really want to get into is to ask you, on the day-to-day perspective of a frontline worker dealing with this issue, dealing with the people that are involved, we are trying to get to prevention. That seems to be a common theme that we are all testifying to in the remarks.

So, as we go down the path to prevention, what is the existing culture with those frontline workers in regards to prevention? Is it something they promote? Is it something they are committed to? Or are they more focused on the back end, dealing with the situation after the crisis has gone on?

Would anyone like to answer?

Ms. WILLAUER. I will speak to that. I was a frontline worker for 7 years.

I just think the frontline workers are overwhelmed. The caseloads are huge. They don't have the resources they need to do their work. It is not that they don't want to do prevention. They don't want to remove these children from the home. But sometimes, when your caseload is 30 families and you have nowhere to send parents to treatment, sometimes you feel like foster care might be a safer way to go, when we know that is not necessarily true.

Mr. REED. Any other input?

Mr. Glynn.

Mr. GLYNN. My organization works with 8,000 families at any given point, but this program here is the one that keeps me up at night. And it is the same for the child welfare agencies.

What we are asking is for a greater risk tolerance, right? We are asking that they keep babies, 0- to 3-year-olds, with parents who have an active substance abuse issue.

And so the model that will have to be adapted is one of shared risk, one in which we are in the home very often, three, four, five times a week, where we are on call 24/7. And we share that information with the child welfare workers. And, together, we have to make those decisions about is it safe and, when it is not, how do we remove the children.

Mr. REED. Okay. So that is great. So what you are envisioning is your organization picking up that risk on the front end—or sharing that risk with the child welfare system workers going forward.

Now, that being said, how do you then—we measure the success of that preventive measure that you are advocating for on the front end with your organization. What is the measurement that you would offer us as a guide in that culture?

Mr. GLYNN. I think, one, it should be placement; did the children stay within their biological or natural placement. And, two, for us, it is those tox screens. You know, how clean are the parents? Do they remain clean during periods of treatment, and what does it look like going out after?

Mr. REED. Okay.

And then from the child welfare workers' perspective, because some folks in D.C. think the ultimate solution is just more resources, more resources, and if you keep funding at higher and higher levels, you will cure this problem. One of the things I have

experienced here in the time I have been here, since 2010, is often that is not the best solution, nor will it lead to a solution. So what you have to do is reallocate the resources.

So, from a child welfare workers' reactive perspective, moving to a prevention, what things are they focusing on now on the front line that you would say is probably not the best use of resources and could be allocated more toward the front end to the prevention side of the equation?

Ms. Barillas, do you have any——

Ms. BARILLAS. Making——

Mr. REED. Or is every dollar being 100-percent efficiently deployed?

Ms. BARILLAS. No, no, I would not argue that. But what I would say is, you know, in the study we did in Texas, where we found that 26 percent of a caseworker's time is the only time they are spending with children and families because they are busy filling out 5 million forms——

Mr. REED. Amen.

Ms. BARILLAS [continuing]. Most of which are repetitive—you know, I know you all know nothing about that kind of paperwork—you know, instead of——

Mr. REED. And why are they filling out so many forms? What is causing that, from the frontline workers' perspective?

Ms. BARILLAS. It is caused by policy decisions that are made at the State level that are sending—we have this great idea, we are going to do structured decisionmaking, and we have this great idea, we are going to change visitation and make you fill out a form, and as part of that policymaking process there is no consideration of what implementation is actually going to look like on the front line.

Mr. REED. So is that a fair piece of input that I hear from you? When we move to the prevention side, make sure we don't duplicate that kind of administrative bureaucratic problem when we go to the prevention side?

Ms. BARILLAS. Oh, absolutely.

Mr. REED. And what would be the one reform or requirement or provision that we could put into that shift in policy that would accomplish that to the most successful end?

Ms. BARILLAS. Well, as I mentioned, considering in the implementation what is going to happen in the implementation process. There is a lot of this that can be done electronically or a lot that is already included in paperwork caseworkers have. They are literally duplicating the same information on five different forms.

Mr. REED. So data streamlined and data——

Ms. BARILLAS. Absolutely.

Mr. REED. I appreciate that.

And I am out of time. With that, I yield back.

Chairman BUCHANAN. Thank you.

I now recognize Mrs. Black for 5 minutes.

Mrs. BLACK. Thank you, Mr. Chairman. I want to thank you as a non-Committee Member for allowing me to sit on this Committee and also be able to ask questions.

Gosh, I don't know where to begin, just like the other Members of this Committee. This is such a big issue.

But where I do want to start—and if we could just walk down the line with this. Help me to understand how you come to know that someone needs assistance. Where do you get that first contact to say, we need to go and visit this family and become a part of helping them to turn the situation around?

Ms. Willauer, how about you?

Ms. WILLAUER. Yep. In the START program, families come to our attention after a report to the child welfare agency regarding some abuse or neglect. START gets involved right after that.

Mrs. BLACK. Okay.

Mr. Glynn.

Mr. GLYNN. The same is true for us.

Mrs. BLACK. Okay.

Ms. Barillas.

Ms. BARILLAS. In prevention, a lot of it is other service providers. So when families are receiving services from WIC or somewhere else and it is noticed that they need assistance, they will be referred to a prevention program.

Mrs. BLACK. Okay.

Mr. Lindert.

Mr. LINDERT. In our case in Florida, the families come to our attention as a result, primarily, of removal from their parents. However——

Mrs. BLACK. Primarily? I am sorry, I didn't catch that.

Mr. LINDERT. Removal from their parents.

Mrs. BLACK. Removal from their parents.

Mr. LINDERT. In some cases, it is also to serve the families in-home prior to removal.

Mrs. BLACK. Okay.

Mr. LINDERT. And in the other States where we are working, typically it is a result of a hotline call that has been made to the State's health welfare agency.

Mrs. BLACK. Okay.

So, again, going down the line, tell me what percentage of these moms that you come in contact with, what percentage of them are either single mothers or of a divorce, where they may have been married and no longer are.

Ms. WILLAUER. I don't have numbers on that, but I can tell you it depends on the region of the State.

Mrs. BLACK. Okay.

Ms. WILLAUER. And we do have a lot of single-headed households. But I can follow up with you.

Mrs. BLACK. Okay.

Mr. Glynn.

Mr. GLYNN. It would be an estimate, but it would be in the high 70 to 80 percent——

Mrs. BLACK. Okay. A high percentage.

Ms. Barillas.

Ms. BARILLAS. I would say the same, although I don't have the specific numbers right now.

Mrs. BLACK. Sure.

Mr. Lindert.

Mr. LINDERT. It is the same for me.

Mrs. BLACK. Okay.

So here is—I want to go back to what Congressman Reed was saying, and that is the prevention piece of this. And I will just tell you my experience as a registered nurse and also coming from the State of Tennessee, where I was on the Child and Family Services Committee.

I helped to bring a program into our State called Nurse-Family Partnership, where we had young mothers who were not wed or in some cases where they may have been but weren't getting support from that spouse, that we would interact with very early on to make sure that they understood that they were carrying a child and bonding with that child and making sure they got all the services that they needed that we could possibly give them. And that has been funded by the State of Tennessee and we have seen very remarkable, remarkable results there.

And so I am a big prevention kind of person. And I am glad to see every one of you are nodding your head on that, because, obviously, that really is the answer, if we could do that.

The evaluation piece is the next piece, that we didn't do a very good job in our State evaluating, because we saw a lot of children that were being removed from their homes, and the evaluations when I asked for the numbers and the statistics and so on—so if we could just go down the line again about evaluation. What are you using to evaluate each one of your programs?

Ms. Willauer.

Ms. WILLAUER. Can you say more on that? What are we using?

Mrs. BLACK. Well, what method are you using? Are you evaluating——

Ms. WILLAUER. Yes.

Mrs. BLACK [continuing]. On a regular basis? And what kinds of things are you evaluating when you get involved?

Ms. WILLAUER. Yes. So we are looking at all kinds of factors, what makes our program work. We are looking at child removals. We are looking at parental sobriety, reunification, recurrence, reentry into foster care, different designs of program evaluation. But it is critical that we have all of that.

Mrs. BLACK. And you are evaluating what works and doesn't work.

Ms. WILLAUER. Absolutely. We are doing a randomized control trial in Louisville, Kentucky, on START——

Mrs. BLACK. Very good.

Mr. Glynn.

Mr. GLYNN. The University of Yale provides oversight and evaluation to all the service providers.

Mrs. BLACK. Excellent.

Ms. Barillas.

Ms. BARILLAS. In Texas, we have actually really struggled with that, and it was only a couple of years ago, when our Prevention and Early Intervention Division got a new director, that we started really looking. Because, for the most part, people were using pre- and post-tests, which really can only tell you so much. So, as there was a push for more evidence-based practice, you see more, for example, like, randomized control trials——

Mrs. BLACK. Good. Yes.

Yes?

Mr. LINDERT. We are working with Casey Family Programs to evaluate the implementation in four States, and they are using an interrupted time series design. Although the evaluation is just about to begin.

Mrs. BLACK. Excellent.

And I just will finish up by saying that if you don't measure something you can't tell whether it is working or not. And I think that is one of our problems, Mr. Chairman, is that we spend a lot of money on a lot of different programs, but when you ask about their evaluations and how they are measuring the success, what you see is you are spending a lot of money and you are getting a lot of information that isn't valid, that you don't have the real statistical information to show that it is working.

And so I think every dollar that we expend from the Federal Government should be required to have an evaluation tool where we can say that money is actually working. And I will go back to that "ounce of prevention is worth a pound of cure." That is really where it is good to be spending most of the money, on these kinds of programs that we know work.

So thank you for the work that you do. It is God's work. Thank you.

I yield back.

Chairman BUCHANAN. Thank you.

Let me just ask you—you know, everybody has a family member or somebody they know, and it just seems to me—and everybody has touched on it—is the whole investment seems to be, especially with children, the prevention piece.

And I don't know, I would like to get all of your thoughts just quickly on it. But, you know, at what level, what grade level, do you need to start working with children? You know, you think high school, but then you hear all these stories that you have to get down to 3rd and 4th grade. It seems that is the investment we have to make in an aggressive way.

And the reason I say that is because I have seen it in my own family, where someone ends up having a problem, and then to move them back off that problem is huge, the toll it takes on a family and the expense. And many times, I don't know what the rate is, but they have to be on guard the rest of their life, many times, because the drug owns them.

So I guess, as it relates to children, what is your experience, your thoughts about how early in our school systems and everything—parents—do we need to be investing with these children in terms of educating them and making sure they understand if they make a bad choice it is tough to come back from that?

Ms. Willauer, let's just go down the row real quick.

Ms. WILLAUER. I guess I would just say it starts at birth. It starts with the family. There are early intervention services and early childhood services that can help with bonding and attachment. So it begins there, and I think there are opportunities all the way through the lifespan of a child's life.

Chairman BUCHANAN. Mr. Glynn.

Mr. GLYNN. I would agree that, you know, what we know about brain development really does push us to say we have to invest more in the 0 to 5 years of development, and that will help to cre-

ate the executive functions that you are looking for to prevent some of the decisions that will be made later on.

Chairman BUCHANAN. Ms. Barillas.

Ms. BARILLAS. You stole my answer.

Yeah, absolutely, the brain development is critical to giving children the skills they need to make those decisions. But I also agree, if children are going home to an environment that is full of these negative influences, then it is not going to matter what happens in school or in another program.

Chairman BUCHANAN. Mr. Lindert.

Mr. LINDERT. I agree with all of the comments.

I would also add that when we are thinking about children who have come to the attention of the child protection system, we have to prioritize early childhood and, in particular, infancy. The majority of maltreatment fatalities occur within the first 3 years of life, a significant amount of those in infancy. And child welfare agencies need to approach early-childhood cases differently than we approach cases on teenagers and at other points throughout the lifespan.

That is a recommendation of the Commission. It is also something I have seen in our systems of care and as a frontline worker myself.

Chairman BUCHANAN. I would like to thank our witnesses for appearing before us today. You have given us a lot to think about as we try to improve our child welfare system to protect more children from harm.

Please be advised that Members will have 2 weeks to submit written questions to be answered later in writing. Those questions and answers will be made part of the formal hearing record.

With that, the Subcommittee stands adjourned.

[Whereupon, at 4:12 p.m., the Subcommittee was adjourned.]

[Submissions for the Record follow:]

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

June 1, 2016

Testimony for the record on behalf of the
American Academy of Pediatrics

Comments before the
U.S. House Committee on Ways and Means Committee Human Resources Subcommittee

"The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm"

American Academy of Pediatrics • Department of Federal Affairs
601 13th Street NW, Suite 400 North • Washington, DC 20005
Tel: 800.336.5475 • E-mail: kids1st@aap.org

American Academy of Pediatrics
Testimony for the Record
U.S. House Ways and Means Committee Human Resources Subcommittee
June 1, 2016

Thank you Chairman Buchanan, Ranking Member Doggett, and Members of the Human Resources Subcommittee for the opportunity to provide testimony for the record on this important hearing on parental substance use and child protection.

The American Academy of Pediatrics (AAP) is a non-profit professional organization of 64,000 primary care pediatricians, pediatric medical sub-specialists, and pediatric surgical specialists dedicated to the health, safety, and well-being of infants, children, adolescents, and young adults. The AAP develops its policy on the health needs of children in foster care through its Council on Foster Care, Adoption, and Kinship Care. This group comprises preeminent national experts on the intersection of child welfare and health, with a rich understanding of the how to address child trauma and support children involved with the child welfare system.

The ongoing opioid epidemic has substantial negative effects on children and families. Parental substance abuse is one of many adverse childhood experiences, in addition to maltreatment and poverty, that can contribute to toxic stress. In turn, toxic stress can lead to poorer health, developmental, social, and economic outcomes across the life span. Federal policy that supports at-risk families through health and social interventions is an important means to promote resilience and buffer the effects of adversity, including parental substance use.

The impending need to reauthorize Title IV-B of the Social Security Act affords substantial opportunities for the Committee on Ways and Means to consider and craft comprehensive policies to improve the linkages between health and child welfare services and contribute to better child wellbeing. Ameliorating the negative child health impact of parental substance use will be a critical component to this effort. This testimony outlines broad aspects of federal policy change that we respectfully submit for your consideration to address this ongoing problem and improve health outcomes for vulnerable children.

Advancing the Important Policies of the Family First Act

As you consider how to improve the ways in which the child welfare system serves children affected by parental substance use, we respectfully encourage you to incorporate the critical policies of the *Family First Act* into these policy discussions. The AAP strongly supports the *Family First Act* for the improvement it would create in balancing incentives to states by allowing them to use the best lessons from Title IV-E waivers and provide time-limited services to children at-risk for entering foster care and their caregivers to prevent entry into foster care. Parenting skills training, mental health services, and substance abuse treatment are targeted categories of services that aim at key drivers of family crisis and disruption, including parental substance use. Importantly, these services target both children and their caregivers, offering an opportunity to meaningfully address the reasons a child may otherwise enter foster care. In addition to the prevention policies, the AAP also supports the bill's new requirements to assure the appropriateness of congregate care placements. We urge you to use the current child welfare policy discussions as an opportunity to concurrently advance the bipartisan policies of the *Family First Act*.

Promoting Safe and Stable Families

The Promoting Safe and Stable Families program provides essential funding for states to engage in services that strengthen family capacity to care for their children and help families in crisis remain together. This program supports four key service categories: family support; family preservation; time-limited reunification; and adoption promotion and support. Children fare best when they are raised in families equipped to meet their needs. These services help maintain intact families during challenging times and are a critical means to preventing the need for out-of-home placements for reasons such as parental substance use. These investments have also complemented work under state Title IV-E waivers, which are due to expire in 2019. Given the experience and evidence to support the critical work states provide through IV-B, we recommend increasing IV-B resources and also considering how to best align these programs with the policies of the *Family First Act*.

Regional Partnership Grants

The Regional Partnership Grants under Promoting Safe and Stable Families fund effective multi-disciplinary interventions designed to address the impact of parental substance abuse on the child welfare system. These are important programs that support comprehensive family-centered services to treat substance abuse and keep families together where possible and appropriate for the needs of children. Given the successes of these programs and the growing impact of the opioid epidemic on families and the child welfare system, we suggest expanding this program to reach additional communities. It will be critical to continue the program's focus on the whole family to ensure that all children receive support and services for needs arising from parental substance abuse. Neonatal Abstinence Syndrome (NAS) incidence is increasing, and the AAP suggests ensuring that approaches to address NAS include consideration of the needs of additional children in the home, to support the healing of the whole family.

Medical Directors of Child Welfare Agencies

The health and well-being of children involved in the child welfare system is of critical importance to their long-term health and developmental outcomes. This is particularly true for children who have experienced deleterious effects from parental substance use. Child welfare agencies oversee important aspects of the coordination and provision of health services to children, and medical professionals can play an important role in ensuring that these services are of high quality and are optimally coordinated. A means through which some states, such as Illinois and Massachusetts, have developed an intentional infusion of this expertise into their systems is to have a pediatrician serve as the medical director of their child welfare agency. The experience of those states that have used this model demonstrates improved coordination of care, reduced costs, and better understanding of health and well-being for the child welfare staff working with the medical director.

Despite the promise of this model and the efforts of the AAP to ascertain the extent to which states are employing physicians as child welfare medical directors, there is no existing inventory of which states use medical directors and in what capacity. We suggest the development of a U.S. Government Accountability Office study to survey all child welfare agencies to assess

whether they are using physician medical directors, the structure in which those medical directors work, and the state's perception of the medical director's impact on organizational effectiveness and child health outcomes. This information will help improve our understanding of how these positions can be most effective, and will be important in ensuring the effective inclusion of a child health provider perspective when overseeing children with complex experiences of trauma in the child welfare system, including parental substance use.

Court Improvement Program

The judicial system makes critical decisions about children's permanency plans, health services, and other services affecting child health and wellbeing. The Court Improvement Program is an important policy tool for ameliorating the judicial experience of families in crisis. One addition to this program that we suggest is an expansion to expressly allow states to use the program funds to provide training on child trauma and child development to judges, attorneys, and law enforcement personnel involved with the courts serving the child welfare population. This training should be evidence-based or evidence-informed to ensure its effectiveness.

Access to expanded training of this kind would ensure that decision-makers within the courts better understand the experience, needs, and behavior of children and parents in the child welfare system, including those affected by substance use. This will lead to more effective placement and permanency decisions and greater assurance of access to appropriate treatment services. This would also serve as a logical outgrowth of the Court Improvement Program, as it would facilitate improved court processing of complex cases and result in better outcomes, while allowing states to tailor the programs to the needs of their particular populations. In a related effort, we also suggest updating the requirements for IV-B funds used to assess and improve foster care court proceedings, in order to determine the extent to which states use these funds for training on child trauma and child development. This will enable monitoring of how states are pursuing this type of training.

Health Oversight and Coordination Plans

As a component of their Title IV-B child welfare services plans, states are required (under 42 U.S.C. § 622(b)(15)(A)) to develop Health Oversight and Coordination Plans (HOCPs) that outline how states ensure children in foster care receive needed health services. This requirement came into effect under the *Fostering Connections to Success and Increasing Adoptions Act of 2008* (P.L. 110-351) and was further updated by the *Child and Family Services Improvement and Innovation Act* (P.L. 112-34). As part of their HOCPs, states must include in the Child and Family Services Plan an enumeration of each of the following elements:

- a schedule for initial and follow-up health screenings that meet reasonable standards of medical practice; (The AAP has clear guidance around this and that guidance has been adopted by many states, but not by others.)
- how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home;
- how medical information for children in care will be updated and appropriately shared, which may include the development and implementation of an electronic health record;

- steps to ensure continuity of health care services, which may include the establishment of a medical home for every child in care;
- the oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
- how the State actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children in foster care and in determining appropriate medical treatment for the children; and
- steps to ensure achievement of the components of the transition plan development process required under section 475(5)(H) to address the health care needs of children aging out of foster care, including: the requirement to include options for health insurance; the requirement for information about a health care power of attorney, health care proxy, or other similar document recognized under State law; and the requirement to provide the child with the option to execute such a document.

The AAP strongly supported the creation of HOCPs, as this is a critical means through which to improve child health and wellbeing. Unfortunately, implementation of this aspect of the law has not been effective for two key reasons: 1) states do not report comparable information or do so in a comparable structure, making it difficult to compare state progress or draw out best practices and challenges; and 2) sentinel evidence suggests that state adherence to HOCPs is not effective.

Pediatricians have reported, for several years, discrepancies between their states' plans and what they see for the children in foster care for whom they provide care. In 2015, the U.S. Department of Health and Human Services (HHS) Office of the Inspector General (OIG) released the report "Not All Children in Foster Care Who Were Enrolled in Medicaid Received Required Health Screenings". The OIG report examined the provision of health screenings to children in foster care in four states: California, Illinois, New York, and Texas. The report found that in those four states, nearly one-third of children in foster care enrolled in Medicaid did not receive at least one health screening, and over one-quarter received at least one screening late. The provision of initial and follow-up health screenings is one required element for state HOCPs, but the evidence of this discrepancy continues to raise concerns about states' fidelity to their HOCPs.

We believe that states could more effectively implement their HOCPs with additional resources and clear guidance and oversight from HHS on HOCP development and reporting. In particular, new guidance from HHS offering a model for HOCP development and structure and background resources would provide states a clear framework within which to prepare their plans and make it easier for HHS to assess and oversee HOCP development. We also believe the provision of additional resources to support plan development and implementation, as well as oversight, are critical. This would promote lower overall costs through better coordinated and managed health services for this vulnerable population. An increased federal matching rate reimbursement for meeting certain HOCP benchmarks could also provide an incentive to states to more effectively manage health services for children in foster care. Some states utilize

the *Bright Futures* guidelines; this resource could be used to help develop such HOCP benchmarks and plan development.

In addition, given ongoing concerns regarding potentially inappropriate prescription of psychotropic medication to children in foster care, we recommend the addition of a new required element to state HOCPs: How the state ensures access to evidence-based trauma-informed psychosocial services. This element would serve a complementary role to the psychotropic medication oversight requirement and signal to states the importance of expanding non-pharmaceutical treatment options. Pediatricians continue to stress that if services are truly meant to support family reunification, the services must take a two-generation approach, with significant attention to the trauma history and trauma reactions of the parents. We will achieve greater success among biological families if we address those underlying issues.

Importance of Evidence-Based Services

The AAP strongly supports the use of evidence-based services for children and families. We suggest prioritizing and emphasizing the use of evidence-based services wherever possible in child welfare, including when serving children who have experienced parental substance use and their caregivers. In addition, we suggest providing support for the development of an inventory of those services. While we understand that individual communities may not have the necessary supply of evidence-based services to meet demand, we urge caution in the allowance of programs that are not at least evidence-informed or promising practices. It is possible that services without an evidentiary basis could have a harmful effect on children, further exacerbating the already significant trauma to which this population is exposed. We also encourage collaboration between child welfare and state Medicaid agencies in identifying and making available services for children and families under this legislation. We also suggest the inclusion of funding for innovative means of making evidence-based programs more broadly accessible, such as through telehealth. This will be particularly important for rural areas or under-served areas in large cities. It is important to ensure that the duration of services children and families receive provides sufficient dosage of an evidence-based intervention to generate the evidence-based treatment effect. Clear, timely, and instructive HHS guidance on all of these criteria will be essential to ensuring the safety, quality, and efficacy of these services.

Consent for Health Services

The issue of consent for medical services for children once they enter foster care can act as a barrier to timely assessment and receipt of appropriately tailored services and psychosocial interventions targeting children and their caregivers. Timely access to these services can ultimately reduce the length of stay in out-of-home care. Currently, there is variability in who may provide consent for children as they enter care, which can lead to children not receiving needed services in a timely manner. While there is understandably a balance to strike in respecting the appropriate exercise of parental rights, lack of parental consent to medical care during extreme family crisis should not preclude a child from accessing care. In particular, we believe that child welfare agencies should have the authority to consent for comprehensive health assessments when children enter care, as well as any services the assessing professionals finds

are indicated for that child. This can be particularly important in instances of parental substance use.

For example, if a young child presents to the child welfare system with a case of lice, but the parent will not consent to medical treatment of that lice, that young child may have to spend days in a shelter because foster homes will not take children until they are treated. This, for an already traumatized child, is an unnecessary and devastating stop-over, and one that could be avoided by allowing the child welfare agency to consent to care on behalf of the child pending adjudication of the case. Even routine problems, such as head lice, can become a crisis for the child if untreated. Entry into foster care is a critical window in which timely intervention can help begin to address a child's trauma and related health needs, improving their well-being and likelihood of permanency. This is also an important means to identifying potential services for serving children and their caregivers together. Treatment within the parent-child dyad can be an effective means to serve this vulnerable population, especially for very young children.

Recruitment and Retention of Foster Families

When maintaining a child in their home is not safely feasible, it is critical to have a sufficient supply of high-quality family foster homes available to care for children. Subpart 1 of IV-B includes a requirement that states include in their child welfare services plan how they will "provide for the diligent recruitment of potential foster and adoptive families that reflect the ethnic and racial diversity of children in the state for whom foster and adoptive families are needed." Given the need to expand recruitment broadly and to also better support and retain foster families and kinship caregivers, we recommend updating this requirement to require "diligent recruitment and retention of potential foster, kinship, and adoptive families, including efforts to:

- Ensure that foster, kinship, and adoptive families reflect the ethnic and racial diversity of children in the state for whom foster, kinship, and adoptive families are needed;
- Meet the placement needs of LGBTQ children and ensure that LGBT families do not face discrimination in serving children;
- Meet the placement needs of children with special health care needs;
- Ensure availability of placements for adolescents, including pregnant or parenting adolescents; and
- Provide evidence-based or evidence-informed child development, parenting skills, and trauma training to all foster, kinship, and adoptive families as a requirement for licensure or re-certification."

We recommend these changes to ensure that child welfare systems effectively recruit and retain foster, kinship, and adoptive families that can serve the needs of their population. In addition, we recommend expanding resources to states to support recruitment and retention. Transformation of the foster care system to be truly trauma-informed and designed to meet children's needs will necessitate effectively training and reimbursing families for quality care.

Conclusion

Thank you again for the opportunity to provide testimony for the record. The AAP looks forward to the opportunity to work with you as you consider these important policy issues. If you have any questions, please do not hesitate to contact Zach Laris in the Washington, D.C. office at 202/347-8600 or zlaris@aap.org.

Children's Hospital of Wisconsin

Community Services
620 South 76th Street, Milwaukee, WI 53214
(414) 453-1400
Fax: (414) 453-2538

"The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm"
Human Resources Subcommittee Hearing
Statement for the Record
Amy Herbst, Vice President, Child Well-Being
Children's Hospital of Wisconsin

Chairman Buchanan and Ranking Member Doggett, thank you for holding this important hearing on protecting children from harm.

Children's Hospital of Wisconsin (Children's) is the region's only independent health care system dedicated solely to the health and well-being of children. We serve children from every county in the state of Wisconsin. Children's, with hospital locations in Milwaukee and Neenah, is recognized as one of the leading pediatric health care centers in the United States. It is ranked in nine specialty areas in U.S. News & World Report's 2015-16 Best Children's Hospitals report.

In addition to offering high quality, specialized pediatric medical care, Children's is the largest not-for-profit, community-based child and family serving agency in Wisconsin. Through our Community Services work, we provide a continuum of care to more than 15,000 children and families annually. This includes family preservation and support, child and family counseling, child welfare, child advocacy and protection; and foster care and adoption services.

Children's is one of two non-profits that provide all of the case management, out-of-home care and intensive home counseling services in Milwaukee, where a third of the state's foster care population resides. We are also the largest provider of treatment foster care in the state, contracting with 33 of 72 Wisconsin counties, and are proud to report the best optimal outcomes when it comes to reunification, adoption or guardianship. Additionally, Children's has partnered with the State through our Children's Community Health Plan—the largest Medicaid Health Maintenance Organization in the state—to implement a medical home program for children in foster care in six southeastern Wisconsin counties.

We are committed to improving the health and well-being of children and families, now and over the trajectory of their lives. That is why we serve the holistic needs of a child and family through comprehensive, coordinated systems of care that address the physical, mental and social well-being of children.

We appreciate the focus on the heroin epidemic and parental substance abuse as we see firsthand the devastating impact of these issues on children's health and well-being. In 2014, 27 percent of children entering foster care in Wisconsin had caregiver drug or alcohol abuse as a contributing factor to their removal from the home, a six percent increase from 2011. At Children's, 60 percent of children entering our foster care program in 2015 had a parent screen positive for alcohol or drug abuse, which is rarely the sole challenge for a family involved with child welfare. Often these parents also struggle with housing instability, domestic violence and mental health issues stemming from the trauma of their own adverse childhood experiences.

Furthermore, we know through empirical research that children who experience neglect, violence or other adverse situations are increasingly likely to face a lifetime of complicated physical and emotional health

Children's Hospital of Wisconsin

challenges. For example, children who have experienced maltreatment are 25 percent more likely to have mental health problems, low academic achievement and substance abuse,[1] as well as more likely to exhibit low self-esteem, aggression toward others and risky sexual behaviors.[2]

While there are a number of evidence-based interventions, such as Parent Child Interaction Therapy, that can be employed to mitigate the impact of maltreatment, more must be done to provide access to these services for high-risk families. Importantly, as a result of our work and evidence-based research, we believe it is important to intervene with high-risk families as early as possible in order to ensure a healthy trajectory for children and families and avoid costly foster care placements.

At Children's we have invested in several programs aimed at doing just that. Our *Strong Families, Thriving Children* work is a comprehensive child and family well-being model—customized to meet each family's unique needs— which focuses on healthy developmental functioning combined with a nurturing environment that helps children thrive into adulthood.

This approach consists of evidence-based interventions and tailored plans; emphasis on child development outcomes; and strength-focused comprehensive functional assessments. It leverages new interventions designed to break the cycle of maltreatment, utilizing more comprehensive trauma assessments of both children and adults that pinpoint priority areas for our services, individualized plans and a more comprehensive approach to supporting families we serve.

In 2014, we provided parenting training and support to over 4,000 individuals at our Family Resource Centers located throughout the state; we served over 400 individuals through our Community Response program that provides service coordination and family support to families at risk for child abuse and neglect; and served over 600 families through our Home Visiting Program that provides individualized, home-based parenting education and support.

We are encouraged by statements made at the hearing that the Ways & Means Committee is interested in "shifting foster care funding into services that help prevent abuse and neglect." We strongly support changes to the child welfare financing model that currently favors one intervention, foster care, to one that provides more flexibility and funding for targeted, evidence-informed, preventive services for children and families.

To that end, Children's strongly supports the Senate Finance Committee's proposed Family First Act provisions that would allow funds under Title IV-E of the Social Security Act to be used for the first time for evidence-based prevention services to help keep children at risk of placement in foster care safely at home with their parents or with kin. We recruit and provide kin placements and believe family connections are important for the child's long-term well-being.

---

[1] Barbara Tatem Kelley, Terence P. Thornberry, Ph.D., and Carolyn A. Smith, "In the wake of childhood maltreatment", *Office of Juvenile Justice Bulletin (1997)*

[2] J Briere and M Runtz, "Differential adult symptomatology associated with three types of child abuse". *Child Abuse & Neglect (1990),* 14, 357-364.

Children's Hospital of Wisconsin

Finally, we firmly believe that in order to ensure the healthy functioning of children and adults, and to make the best use of our federal and state dollars, outcomes related to safety and permanency are not enough. More must be done to prioritize assessments, interventions and measures that address child well-being and better position children to thrive into adulthood.

The Family First Act makes progress towards this goal by focusing on evidence-based interventions, assessment tools and requiring the Secretary to assess the extent to which programs and services improve child well-being. Children's believes that better defining child well-being and integrating measures into the child welfare system are critical towards achieving better outcomes for children, society and taxpayers.

We strongly support your work to improve the lives of at-risk children and families and hope to serve as a resource and partner as the Committee works to advance legislation.

Written Testimony of Donna Butts, Executive Director, Generations United

**"The Heroin Epidemic and Parental Substance Abuse:
Using Evidence and Data to Protect Kids from Harm"**

**Ways and Means Human Resources Subcommittee Hearing
Wednesday, May 18, 2016, 2:00 PM**

Generations United is pleased to submit this written testimony to the Ways and Means Human Resources Subcommittee. We applaud Chairman Buchanan, Ranking Member Doggett and other members of the Subcommittee for their leadership in holding this hearing addressing parental substance abuse and the opioid epidemic with the goal of protecting children from harm.

Consistent with Generations United's mission and our longstanding work through our National Center on Grandfamilies, we will focus our testimony on "grandfamilies" and the value of prevention services for all three generations in these families -- parents, children, and caregivers. Prevention services, as proposed by the Family First Act, help protect children from harm. With these types of vital services extended to those children who are at imminent risk of entering the foster care system, children may be able to remain safely in their families and consequently may not need to enter the system. But, if they do, the families will also get services and supports that may help the children reunify safely with parents or keep the grandfamily together.

Grandfamilies

2.5 million children are raised by grandparents, aunts, uncles, siblings and other extended family and close family friends who step forward to care for them when parents are unable.[i] Although data is limited, we know that parental substance abuse is the primary reason these grandfamilies come together.

With the recent increase in heroin abuse and opioid addiction, more grandparents and other relatives are raising these children than ever. Across the country, over 2.6 million grandparents are responsible for their grandchildren.[ii] The anecdotes are overwhelming: "At the time of the custody hearing, both my daughter and the children's father were in jail on drug-related charges. I remember the judge asking me how long I thought it would be before the children's parents would be capable of taking care of their children. I optimistically said, 'Oh, about six months, your honor.' Well, here we are more than 20 years later. … It can be a third of your life caring for grandkids when addiction is in the picture."[iii]

Most of these grandfamilies are outside the child welfare system. They are often struggling with little or no support. For the over 113,000 children who are raised by grandfamilies in foster care, more support is available.[iv] However, even in the system, there is limited help for

relative caregivers to raise the children, parents to address their substance abuse, mental health or other issues so they can parent again, and children to get the trauma and other services they need.

Children Fare Well in Grandfamilies

As a society, it behooves us to support these grandfamilies, because research confirms that the children do well in these families. Compared to children in non-relative care, children in the care of relatives experience:

- ***Increased stability***
  - Fewer placement changes [v]
  - Fewer school changes[vi]
- ***Higher levels of permanency***
  - Less likely to re-enter the foster care system after returning to birth parents[vii]
  - Relatives are willing to adopt or become permanent guardians when reunification with parents is not possible. In fact, 32% of children adopted from foster care are adopted by relatives.[viii]
- ***Greater safety***[ix]
- ***Better behavioral and mental health outcomes***[x]
- ***More positive feelings about placements***[xi]
  - More likely to want current placement to be permanent home
  - Less likely to try to run away
  - More likely to like who they live with (93% vs. 79% for non-relative foster care, 51% for group care)
  - More likely to report they "always felt loved"[xii]
- ***Increased likelihood of living with or staying connected to siblings***[xiii]
- ***Greater preservation of cultural identity and family and community connections***

Services to Grandfamilies Improves Outcomes for Children

Research shows that when caregivers in grandfamilies are offered supportive services -- such as mental health care and kinship navigator programs that help link relative caregivers to a broad range of supports --_ the social and mental health outcomes for these children are even better than for other children being raised by relatives not receiving services.[xiv]

Family First Act

Providing prevention services

The proposed Family First Act would make great strides in protecting children from harm by offering prevention services and supports for children who are "candidates for foster care" being cared for by relatives. Under the proposal, for the first time, states will be able (but not required) to use Title IV-E funds for prevention services for families of eligible children in grandfamilies. Eligible children would be children who are candidates for foster care, identified by the state as being at imminent risk of entering or re-entering foster care, but who can safely

remain at home or with a kinship caregiver if provided services. Parents or kin caregivers of children at imminent risk of entering foster care could also get services.

The services are of the type that have been shown to improve outcomes for children: mental health care, substance abuse prevention, individual and family counseling, in-home parent skill-based services, access to kinship navigators, and short term financial assistance to kinship families.. All of these services are intended to support parents, kinship caregivers, and children so that children will not be harmed and can remain with family, whether it is their parents or other relatives.

The Act is carefully crafted to ensure that each child has a prevention plan that lists the services or assistance needed and identifies the permanency goal for the child, how services are tied to the placement and permanency goal, and are trauma-informed.

Addressing barriers to licensure of relatives

More than half of children placed with relatives under state supervision are in unlicensed homes, and consequently receive no or very little ongoing support.[xv] If children end up needing to enter foster care, some of them may need the ongoing financial support and services of the system and the pathway to permanency through the Guardianship Assistance Program (GAP). These supports, services and GAP are only available to those children whose relatives are licensed. GAP, which is a federal option created by the Family Connections to Success and Improving Adoptions Act of 2008 (Fostering Connections Act), is now in 39 jurisdictions and allows children with a licensed relative foster parent to exit the system with ongoing financial support.

Unfortunately, becoming a licensed foster parent -- who is eligible for these services and supports -- is often not an option for some relatives due to barriers caused by state licensing standards. Standards that often go well beyond what is required by Federal law and are often nonsensical because they are based on litigation or middle class notions of what is suitable. For example, some standards prohibit certain breeds of dogs or require caregivers to own a car. To address these barriers, the proposed Family First Act directs HHS to release regulations on national model licensing standards, like those Generations United created with the American Bar Association and the National Association for Regulatory Administration. States must describe in their state plans how their practices deviate from the national standards. (Our Model Family Foster Home Standards are available at www.grandfamilies.org).

Adoption and Legal Guardianship Incentive Program

The Adoption and Legal Guardianship Incentive Payments Program, funded under Title IV-E of the Social Security Act, recognizes states for improved performance in helping children exit foster care to permanent homes through both adoption and guardianship. Guardianship is an important permanency option for children in relative care who wish to remain permanently with a relative without terminating the parental rights of their parents. The incentive program was revised and reauthorized through FY2016 in the Preventing Sex Trafficking and Strengthening Families Act of 2014. We urge reauthorization of that the incentive program for

an additional three to five years. It is important to maintain the changes made to the program in 2014 (i.e. the addition of incentives for exits to guardianship, determining incentives based on improvements in rate rather than numbers, etc.) because more states received incentives under the new incentive structure than from the former incentive program and more states earned larger incentive awards with the new incentive structure.

Family Connection Grants

Finally, two rounds of Family Connection Grants, authorized by the Fostering Connections to Success and Improving Adoptions Act of 2008 (Fostering Connections Act), have funded several kinship navigator programs, which have resulted in many positive outcomes for grandfamilies. According to the 2013 Report entitled 2009-Funded Grantees Cross-Site Evaluation Report - Final, positive outcomes for those receiving kinship navigator services included:

- Kinship caregivers receiving navigator services achieved identified safety goals for their families.
- The children in the care of kinship caregivers had higher rates of permanency through legal guardianship and reunification with parents.
- Well-being results showed that kinship navigator programs were successful at ameliorating the needs of grandfamilies.

The five year evaluation of Florida's 2012 kinship navigator grant was recently published and shows further compelling results for its 2956 participants[xvi]:

- 99 percent of participants' children did not enter the child welfare system at the 12 month follow-up, showing placement stability and child safety.
- Cost of the program is less than half the costs associated with adjudicating a child dependent. Non-relative foster care is 6 times and residential group care is more than 21 times as expensive as the navigator program.

Unfortunately, the grants expired in 2015, and most states have not established kinship navigator programs leaving many grandfamilies without access to these important programs that can link them and their families to services like substance abuse prevention and counseling.

Conclusion

All of these services and supports improve outcomes for the children, as the research confirms. But, even more compelling, is the proof from the caregivers themselves. As one grandmother raising a child of a parent who is addicted to heroin put it, my grandson's teacher "said he was the saddest boy she's ever taught. At that, I said, 'I'm not enough for him anymore — I have to take him to therapy.' I found a wonderful therapist; things have turned around."[xvii]

Thank you for the opportunity to offer written testimony for this important hearing. Please direct questions regarding this testimony to Jaia Peterson Lent, Generations United's Deputy

Executive Director, at jlent@gu.org or 202-289-3979 or to Ana Beltran, Generations United's Special Advisor at abeltran@gu.org.

About Generations United

Generations United is the national membership organization focused solely on improving the lives of children, youth, and older people through intergenerational strategies, programs, and public policies. Since 1986, Generations United has been the catalyst for policies and practices stimulating cooperation and collaboration among generations. We believe that we can only be successful in the face of our complex future if generational diversity is regarded as a national asset and fully leveraged. For almost twenty years, Generations United's National Center on Grandfamilies has been a leading voice for issues affecting families headed by grandparents or other relatives.

---

[i] Generations United. (2015). *The state of grandfamilies in america*. Washington, D.C.: Author.

[ii] Ibid.

[iii] Seelye, K. (2016, May 21). Children of heroin crisis find refuge in grandparent's arms. *The New York Times*. Retrieved from http://www.nytimes.com

[iv] See endnote i.

[v] Helton, J. (2011). Children with behavioral, non-behavioral, and multiple disabilities, and the risk of out-of-home placement disruption. *Child Abuse & Neglect* 35, 956-964.

Testa M., Bruhn C., & Helton J. (2010). Comparative safety, stability, and continuity of children's placements in formal and informal substitute care. In M.B. Webb, K. Dowd, B.J. Harden, J. Landsverk, & M.F. Testa (Eds.). *Child Welfare and Child Well-being: New Perspectives from the National Survey of Child and Adolescent Well-Being* (pp. 159-191). New York: Oxford University Press.

Zinn, A., DeCoursey, J., Goerge, R.M., & Courtney, M.E. (2006). A study of placement stability in Illinois. Chapin Hall. Retrieved from https://www.chapinhall.org/sites/default/files/old_reports/280.pdf

Chamberlain, P., et al. (2006). Who disrupts from placement in foster and kinship care? *Child Abuse & Neglect 30,* 409–424. Retrieved from http://www.mtfc.com/2006_chamberlain_et%20al_a_Who_Disrupts.pdf

Testa, M. (2001). Kinship care and permanency. *Journal of Social Service Research 28*(1), 25–43.

[vi] U.S. Department of Health & Human Services, Administration for Children & Families. (2005). *National Survey of Child and Adolescent Well-Being (NSCAW) CPS Sample Component Wave 1 Data Analysis Report, April 2005*. Washington, D.C.: U.S. Department of Health & Human Services, Administration for Children & Families. Retrieved from http://www.acf.hhs.gov/sites/default/files/opre/cps_report_revised_090105.pdf

[vii] Falconnier, L.A., et al. (2010). Indicators of quality in kinship foster care. *Child Welfare and Placement 91*(4).

[viii] U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2015). The AFCARS report: Preliminary FY 2014 estimates as of July 2015 (No. 22). Retrieved from http://www.acf.hhs.gov/sites/default/files/cb/afcarsreport22.pdf

Testa, M. & Shook, K., Cohen, L., & Woods, M. (1996). Permanency planning options for children in formal kinship care. *Child Welfare 75*(5).

[ix] Public Children Services Association of Ohio. (2012). Ohio's fostering connection grant: Enhanced kinship navigator project-Final progress report. Retrieved from http://www.kinshipohio.org/Resources/2012/OhioKinshipFinalProgressReport.pdf

Testa, Bruhn, & Helton. (2010). Comparative safety of children's placements in formal and informal substitute care.

Winokur, M., Crawford, G., Longobardi, R., & Valentine, D. (2008). Matched comparison of children in kinship care and foster care on child welfare outcomes. *Families in Society 89*(3), 338-46.

Johnson, K. (2005). A retrospective support assessment study of foster and relative care providers. Madison, WI: Children's Research Center. Retrieved from http://www.nccdglobal.org/sites/default/files/publication_pdf/fcrp_support_assmnt_sept05.pdf

[x] Garcia, A., et al. (2014). The influence of caregiver depression on children in non-relative foster care versus kinship care placements. *Maternal and Child Health Journal 19*(3), 459-467.
Cheung, C., Goodman, D., Leckie, G., & Jenkins, J.M. (2011). Understanding contextual effects on externalizing behaviors in children in out-of-home care: Influence of workers and foster families. *Children and Youth Services Review 33*, 2050-2060.
Fechter-Leggett, M.O., & O'Brien, K. (2010). The effects of kinship care on adult mental health outcomes of alumni of foster care. *Children and Youth Services Review 32*, 206-213.
Winokur, M., Holtan, A., & Valentine, D. (2009). Kinship care for the safety, permanency, and well-being of children removed from the home for maltreatment. *Campbell Systematic Reviews 1*. Retrieved from http://www.campbellcollaboration.org/lib/project/51/
Rubin, D.M., et al. (2008). Impact of kinship care on behavioral well-being for children in out-of-home care. *Archives of Pediatric and Adolescent Medicine 162*(6), 550-556.
U.S. Department of Health & Human Services, Administration for Children & Families. *NSCAW.*
[xi] U.S. Department of Health & Human Services, Administration for Children & Families. *NSCAW.*
[xii] Wilson, L. & Conroy, J. (1996). Satisfaction of 1,100 children in out-of-home care, primarily family foster care, in illinois' child welfare system. Tallahassee, FL: Wilson Resources. Retrieved from http://www.eoutcome.org/Uploads/COAUploads/PdfUpload/SatisfactionInIllinoisChildWelfare.pdf
[xiii] Rolock, N. & Testa, M. (2006). *Conditions of children in or at risk of foster care in Illinois*. Urbana, IL, Children and Family Research Center. Retrieved from http://cfrc.illinois.edu/pubs/rp_20150101_ConditionsOfChildrenInOrAtRiskOfFosterCareInIllinois2013MonitoringReportOfTheB.H.ConsentDecree.pdf
Wulczyn, F. & Zimmerman, E. (2005). Sibling placements in longitudinal perspective. *Children and Youth Services Review 27*, 741-763.
Shlonsky, A., Webster, D., & Needell, B. (2003). The ties that bind: A cross-sectional analysis of siblings in foster care. *Journal of Social Service Research 29*(3), 27-52.
[xiv] Cooper, L. & Littlewood, K. (2015). KIN Tech research brief: Benefits, safety, outcomes and cost. Florida: The Children's Home, Inc.
Child Welfare League of America. (2015). Kinship navigators: Profiles of family connections projects from 2012 to 2015. Washington, DC: CWLA Press.
Sakai, C., et al. (2014). Mental health beliefs and barriers to accessing mental health services in youth aging out of foster care. *Academic Pediatrics 14*(6), 565–573.
U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau. (2013). Family connection discretionary grants: 2009-funded grantees cross-site evaluation report- final. Retrieved from http://www.nrcpfc.org/grantees_public/2009/fam%20conn%202009%20cross-site%20final%20report%206-17-13.pdf.
The Children's Home Society of New Jersey. (2012). ACF-OGM SF-PPR final report. Trenton, NJ: The Children Home Society of New Jersey.
Public Children Services Association of Ohio. (2012). Ohio's fostering connection grant
Crum, W. (2010). Foster parent parenting characteristics that lead to increased placement stability or disruption. *Child and Youth Services Review 32*, 185–190.
Houston, D. & Kramer, L. (2008). Meeting the long-term needs of families who adopt children out of foster care: A three-year follow-up study. *Child Welfare 87*, 145–170.
Garcia, et al. The influence of caregiver depression on children in non-relative foster care versus kinship care placements.
Casey Family Programs. (2005). Casey Family Programs kinship caregiver navigator pilot: Final pilot evaluation report (July 1, 2004 through February 18, 2005). Seattle, WA: Casey Family Programs.
[xv] Annie E. Casey Foundation. (2012, May). Stepping up for kids: What government and communities should do to support kinship families. Retrieved from: http://www.aecf.org/resources/stepping-up-for-kids/
[xvi] Littlewood, K., Kinship Services Network Program: Five year evaluation of family support and case management for informal kinship families, Children and Youth Services Review (2015), http://dx.doi.org/10.1016/j.childyouth.2014.10.008
[xvii] See endnote iii.

NEW YORK STATE | Office of Children and Family Services

ANDREW M. CUOMO
Governor

SHEILA J. POOLE
Acting Commissioner

May 31, 2016

The Honorable Vern Buchanan
Chairman
House Ways & Means Committee Subcommittee on Human Resources
1102 Longworth HOB
Washington D.C. 20515

Dear Chairman Buchanan:

Thank you for the opportunity to offer testimony by submission to the record on the recent hearing regarding the heroin epidemic and child welfare. Your opening remarks made reference to a Senate proposal which I believe is the "discussion draft" legislation intended to improve the nation's foster care system. As Acting Commissioner of the New York State Office of Children and Family Services (OCFS), I oversee the administration of child welfare services for New York State. I have provided the Senate Finance Committee, Senator Wyden and several national and statewide advocacy groups our position on this proposal. I am still concerned that some of the provisions in the Senate proposal including those that limit federal funding for foster care may have detrimental consequences for the New York State's program that will ultimately affect the children it serves.

Like your home state of Florida, New York is also large and diverse. However, we are a state supervised and county administered child welfare services system, which is divided into 58 local social services districts. One district encompasses the five boroughs comprising New York City, and the other districts correspond to the 57 counties that make up the rest of the state, and one federally-recognized tribe. The districts' compositions vary widely with respect to their percentages of urban, suburban and rural areas and their available economic opportunities, resulting in diverse populations with differing needs. Consequently, the state gives its local social services districts as much flexibility as possible to provide child welfare services in a manner that works best for their particular populations. It is important that any new federal child welfare laws afford similar flexibility to the states and their localities.

New York has been providing preventive services to children and families for a long time. In 1979, New York enacted a statewide preventive services program designed to prevent the placement of children in foster care and to enable children in foster care to return home sooner. The state law preceded the enactment of federal Title IV-B funding in 1980. New York has consistently devoted significant state and local funds to preventive services in addition to using other available federal funding for such purposes, including Title IV-E candidacy funding. Our continuous focus has been to reduce the number of out-of-home placements to only those that are absolutely necessary to protect the children. As a result, the total foster care population in New York State has decreased from 53,902 in 1995 to 17,452 in 2015 despite some upward trends with opioid abuse, overall we are continuing on a downward track.

The children and youth currently in foster care out of home placements in New York primarily are hard-to–place or have special needs. The goal of preventive services for these children and youth is to safely reunite them with their families or find other placements for them. New York's Title IV-E waiver demonstration project is focused on reducing the number of foster care placements even further through the increased options available under the waiver's flexible funding structure.

New York may be unique in the approach it has taken in providing preventive services to reduce out-of-home placements. It is our understanding that many states do not invest in preventive programs at all. Therefore, while we applaud your efforts to encourage more states to focus their work on reducing foster care through preventive services, we have serious concern about the proposal's one-size fits-all approach.

Regarding the heroin/opioid epidemic, I must first state for the record that the states' child welfare administrators are not charged with the responsibility for substance abuse screening and treatment. These programs are operated by the states' departments of health. Therefore, federal funding should not be shifted from necessary child welfare programs to health programs, which could potentially cause a shortfall in child welfare programs and services. This would seem to be counterproductive. Considering also that the bill language of the Senate proposal is still unavailable and the poor Congressional Budget Office (CBO) score given to it, we certainly urge the committee to recommend that the heroin/opioid issue be handled within another legislative vehicle that is appropriately funded.

The Wyden/Hatch Senate proposal is more aligned to a funding scheme for preventive services. New York proposes that this draft be amended to make both Part 1 and Part 2 optional for states as there are many states like New York that commit robust resources to preventive funding. As previously stated, New York State has made numerous comments on the Wyden Hatch proposal. I can certainly provide you with our letters should you be interested in reading them. As far as Part 1, since it is optional, I will not get into the details at this time. However, Part 2 of the proposal is mandatory in its current form and will provide unintentional detrimental effects for children, families and the states' child welfare programs.

It is Part 2 of the Wyden Hatch Senate proposal that is particularly alarming. This provision essentially takes the decision of children's placements out states' authority and narrowly defines those placements for which the federal government would provide Title IV-E reimbursements to the states. The second part of this proposal would eliminate almost all funding for congregate care. The provision paints all congregate care placements with the same broad brush and is considered not acceptable to children of certain ages. It would establish a national definition of foster family homes. It would involve the courts deciding if placements are acceptable and sets time frames on when the courts should be reviewing placements of foster children in congregate placements. In New York, the busy court calendars would not have the time to conduct these sorts of reviews. Additionally, the provision is asking judges to be expert social workers. Nowhere in this bill is consideration for hospitalized children, unaccompanied alien children (UAC), and children placed in juvenile justice facilities. These children and youth are not in a one-size-fits-all category; their care must be considered and funded. In this portion of the proposal, the ACF Secretary will decide what facilities would be considered acceptable Qualified Residential Treatment Programs (QRTPs) eligible for federal funding for these specific vulnerable populations hang in the balance. A brief fiscal forecast indicates that this could cost NYS up to $600 Million.

Even with the eventual release of bill language to clarify some of the concerns and questions we have, there is also the uncertainty of rule promulgation. We are still awaiting federal guidance

required under the Preventing Sex Trafficking and Strengthening Families Act, rules form the sex trafficking legislation passed in 2014 (PL 113-183). As you well know, rule promulgation is a lengthy process and with the upcoming change in administration, this would add another level of scrutiny to the work left by the current administration. We, in New York believe that the entire Wyden/Hatch bill should be left up to the states via optional participation.

Preventing out of home placements is a priority for all states. The heroin/opioid trend is not the only factor that could place children in foster care settings. On the same note, not all prevention services are related to any sort of abuse of substances. The heroin/opioid problems and foster care should be addressed on their own merits while flexible, robust federal funding for preventive child welfare services stand alone.

Thank you for this opportunity.

Sincerely,

Sheila J. Poole
Acting Commissioner

This statement for the record, in support of the Honorable Karen Bass' webinar presentation "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm," is submitted by witness Dr. Kathryn Icenhower, Chief Executive Officer of SHIELDS For Families, 11601 S. Western Ave., Los Angeles, CA 90047, tel 323-242-5000, fax 323-242-5011.

Sophie's Choice: Stop Making Substance Abusing Women Choose Between their Children and Treatment

Too often, parents seeking substance abuse treatment are forced to make a 'Sophie's choice' between two life-changing options: enter treatment and risk removal of their children from their home, or avoid treatment and continue to suffer, in isolation, the deleterious effects of addiction. Either option puts the children of substance-abusing parents at great risk. Children of people who abuse substances are likely to have a range of developmental, behavioral, and emotional difficulties (Substance Abuse and Mental Health Services Administration (SAMHSA), 2007). These children incur exceptional risk due to genetic, prenatal, and environmental influences include physical illness and injury, emotional disturbances, educational deficits, and behavior problems (Johnson and Leff, 1999; Metsch et al., 1995). These problems are often compounded when children are removed from their parents' homes and placed in foster care, which is known to produce poor social outcomes, such as high delinquency rates, high teen birth rates, and lower earnings (University of Pennsylvania Collaborative on Community Integration).

Integrating children into parental substance use treatment changes the treatment dynamic and offers an integrated way of addressing the needs of families with multiple problems (SAMHSA, 2007). Family-centered treatment offers a solution to tackling the challenges of

addressing substance use disorders among pregnant and parenting women, as well as to ameliorating the effects such disorders have on children. Family-centered treatment results in improved treatment outcomes for individual women as well as improved outcomes for children and other family members, including decreased incidence of developmental delays, improved school success and school readiness, reductions in costs for substance-exposed births, and treatment outcomes in both substance abuse and mental health settings (SAMHSA, 2007).

With these issues in mind, SHIELDS for Families (SHIELDS)' approach to family-centered treatment is distinguished by a simultaneous focus on supportive residential housing that allows the entire family to live together, as well as comprehensive, multidisciplinary youth services. Incorporated in 1991, SHIELDS is a comprehensive, community-based non-profit organization dedicated to developing, delivering, and evaluating culturally sensitive, comprehensive service models that empower and advocate for at-risk families in South Los Angeles. SHIELDS' programs are built on the premise that substance use disorders are family diseases, and that the delivery of comprehensive services can transform families into healthy, functioning entities able to break the intergenerational cycle of substance use and related consequences. To this end, SHIELDS currently employs over 380 full time employees, with an annual budget of over $30 million to serve over 10,000 families annually in 39 programs, including the Exodus Family-Centered Day Treatment program, the Heros and Sheros Youth Program, and adjunct components that provide critical supportive services.

Stable housing can often make the difference between success and failure in substance use disorder treatment. For women, particularly those with children, housing represents more than just shelter: it is a crucial support for recovery; it represents safety both for a woman and for her children, and a lack of housing support negatively affects all other domains of family well-

being (SAMHSA, 2007). Residential facilities that allow the entire family to live together offer multiple benefits. Residential facilities empower families by offering the structure, meals, and safe housing that many children and adults affected by substance use disorders need (SAMHSA, 2007). Keeping the entire family together provides opportunities for fathers and extended family members to be involved in the child's upbringing, as well as provides opportunities for staff to engage with the family in "teachable moments" to provide support as they build healthy relationships and life skills. Furthermore, it increases the likelihood that women will emerge from treatment with successful outcomes, since they are motivated and bolstered by the support of their families.

Originally funded through the SAMHSA Center for Substance Abuse Treatment's (CSAT) perinatal initiatives in 1994, SHIELDS' Exodus program utilizes a unique model in which comprehensive family-centered treatment, follow-up and related social services are provided to women and their families on-site at a SHIELDS-owned housing complex. While undergoing treatment for substance use disorders, women are able to reside on the property in either individual apartments or in lodgings that accommodate the entire family. In addition to evidence-based substance use disorder treatment, the Exodus program offers counseling, child development, vocational, mental health, medical care, family support and family reunification services. After completion of treatment services, which typically last 12-18 months, families are able to remain in their housing for a transitional period of up to one year, allowing for adequate time to develop the supportive systems necessary for ongoing recovery and family maintenance.

Since implementation, the Exodus program has seen tremendous successes in treating substance abuse disorders, increasing family reunification rates, and improving critical indicators of health for both women and children. Throughout the history of the program, completion rates

have never been less than 70%, and in the past seven years, an average of 81% of our families have successfully completed all phases of our treatment services. The rates of family reunification, defined as when children in temporary out-of-home care return to their families of origin, have averaged 85% since implementation. Furthermore, over the past five years, our model of services has facilitated improvements in maternal and infant health indicators. The total rate of substance-exposed births has been less than 4%; less than 5% of newborns were born at a low birth weight, and none at a very low birth weight. 100% of our children ages 0-5 now have established, permanent medical homes, and 90% of all children have scored in the normal range on relevant developmental assessments.

As discussed above, children of substance-abusing parents represent a special population at risk of alcohol and drug abuse. These children are more likely to be placed for adoption or foster care, and to have behavioral and educational problems, and are more likely to be overrepresented in the foster care system and the juvenile justice system. Furthermore, teenagers are more likely to use drugs if their father, mother, or older siblings also used drugs, indicating that even low levels of use by parents could influence drug experimentation by teenagers (Gfroerer, 1987).

SHIELDS' Heros and Sheros program is a prevention and treatment program specifically designed to serve the children of the low income families enrolled in our substance abuse programs. Heros and Sheros consists of five youth programs that provide prevention and early intervention services and mental health services for children ages 6-18. Two of the sites are located at SHIELDS' substance abuse programs, including Exodus; one is at the Jordan Downs Housing Development (Jordan Downs Family First); two others are charter schools (College Bridge Academy) in Watts and Compton. SHIELDS utilizes a "community ecosystems"

research-based approach to alcohol and drug prevention, which emphasizes problems as a function of the larger whole rather than as pieces existing in isolation. In order to identify needs specific to our target population in South Los Angeles - primarily African-American and Hispanic youth, particularly children of substance abusers - the program provides a comprehensive assessment upon enrollment and develops a detailed service plan to monitor youth progress and development. These assessments look beyond the individual to consider how family, social and community experiences shape an individual by decreasing risk factors and increasing protective factors in five specific domains: Individual, Family, School, Peers, and Community.

The core program components of Heros and Sheros include (1) individual and group counseling, designed to provide mentorship and guidance for youth, provided by both an on-site therapist and a family counselor a minimum of once per week and in two-hour weekly peer counseling group sessions; (2) case management services designed to ensure the coordination of comprehensive services, advocacy for family needs, and linkage and referral to supports within SHIELDS and the community; (3) social and life skills training designed to improve youth problem-solving and decision-making skills as well as cultural activities designed to reinforce positive cultural identity, pride, and an understanding of other cultures; (4) educational classes and tutoring provided through SHIELDS' College Bridge Academy, a grade 9-12 charter school, as well as after-school tutoring in both academic subjects and computer literacy designed to improve youth academic performance, and (5) recreational activities, including a weekend camp held six times a year, sports, arts and crafts, field trips to local landmarks and events, and dance and musical performances.

Blending these youth services with parental substance abuse treatment has proven an effective way to equip families in our community with the skills and knowledge necessary to decrease the incidence of substance abuse, succeed in vocational and educational pursuits, and improve family cohesion. In the past year, over 91% of our youth increased their knowledge of alcohol and drug (ATOD) issues through developing community campaigns that focus on anti-drug messages, by participating as speakers in community and agency events, and through sharing their own stories about the destructive influence of drug addiction in onsite counseling groups as well as public settings. Over the past five years, over 76% of our children have improved both their attitudes towards school as well as attendance and grades. Finally, perhaps most importantly, in the past year, 76.1% of our parents demonstrated improved family cohesion as measured by the closure of child protective services cases, referrals and re-referral for child abuse and neglect, and level of participation in treatment.

Organizations seeking to implement family-centered treatment are faced with a unique set of challenges, and for many, successful treatment of the family as a unit requires a paradigm shift away from traditional treatment methods. The service-delivery experience at SHIELDS has demonstrated that providing comprehensive, family-centered services requires a certain kind of organization: one that operates and feels like "family;" where conditions are created that make staff want to remain in the long-term; where decisions are made in multidisciplinary teams; where mechanisms are in place to give clients a voice; where collaborations with other service providers are a fundamental way of doing business, and where funding streams are blended to create a cohesive programmatic experience for clients. These organizational practices create a stable yet flexible and responsive organization that keeps clients' needs and experiences front and center.

Staff and clients alike describe SHIELDS as a place that feels like family. What this means is that *people's experiences matter* and *relationships have value*. Our program model fosters this culture in a number of ways. Women are treated in the context of their families, based on the conviction that her health and the health of her children and family are interdependent. Clients are active participants in our intake and assessment process, and given ample opportunity to describe what they see as their primary issues and concerns and lead the conversation about how to address them. Staff at all levels—right up to the Chief Executive Officer—maintain an open-door policy so they are accessible to clients and workers alike. The Client Council is a formal vehicle for giving clients' experiences a shaping role in the organization. As an organization, SHIELDS is in a constant process of *becoming*, that is, being shaped by the experience of the people who work there and the people they serve.

SHIELDS has created organizational conditions that lead to high staff satisfaction and retention by offering its staff the same kind of support and promotion it offers clients, resulting in a more experienced, contented staff with the power to build stable relationships with clients. This is achieved through a variety of organizational policies and strategies aimed at making the atmosphere of empowerment and respect organizationally pervasive. First, SHIELDS offers a higher level of compensation (in salaries and benefits) as compared to the industry standard. Compensation includes 14 paid holidays a year, a week-long sabbatical between Christmas and New Year's, and generous vacation accruement. Second, SHIELDS promotes personal and professional growth and development and encourages staff to further their education. SHIELDS' educational-leave policy allows staff to use three hours of paid time per week toward schooling, and a partnership with a local California State University offers staff (and clients) the chance to get their degrees while getting clinical hours within the organization. Finally, SHIELDS has

made it an organizational priority to both hire staff that were once clients, and to promote staff from within the organization. Approximately 20 percent of our staff were once clients. It is not unusual for a staff member to have been with the organization for many years, starting at an entry-level position and working over time in many programs and capacities.

Providing comprehensive services for every member of the family would not be possible without a multidisciplinary team overseeing all aspects of client care. This approach ensures that in every decision, all members of the family and all aspects of the client's recovery are taken into consideration. This approach requires implementing both an intake and review team as well as multidisciplinary case conferences. At SHIELDS, staff representatives from all the programs meet weekly to review client intake and assessment forms and decide together which program is the best match for each client and her family members. Case conferences, attended by all staff involved in the client's treatment, are also held weekly, and provide an opportunity to talk about the family's progress and address any outstanding concerns. The open lines of communication among staff of the various program components ensure that individual family members are always regarded as part of a unit.

At SHIELDS, clients are empowered to have a voice, not only in their own assessment and treatment processes, but in how and which programs and services are delivered. The Client Council is a segment of the client population whose purpose is to represent all clients in treatment, and to help build, shape, and formulate some of the program policies as they relate to daily client procedures and rules as well as to cultural sensitivity and responsiveness of the program. The Council meets weekly, and clients elect an executive board and manage the meetings. Issues, recommended changes, and concerns are presented to the program administrative staff. Representatives from the Client Council also are elected to represent the

program on the SHIELDS Consumer Advisory Board, which assists with policy development and agency-wide activities. The Client Council ensures that the experience of clients is always central in determining the direction of the organization.

Any one organization would have difficulty providing for the wide range of needs of a client and her children and family. The most practical and effective way of providing a comprehensive set of services along the spectrum of care is to partner with other organizations—public, nonprofit, and private. SHIELDS engages community partners at every level and in every program component. Treatment and housing case managers work closely with child welfare case managers for clients who have open cases, creating joint treatment plans, engaging child welfare dollars to help fund client housing costs, and ensuring that clients are using the Exodus program effectively to meet the reunification requirements of child welfare. The educational and component of the Exodus program offers basic literacy, high school equivalency, and computer classes through its partnership with the Los Angeles and Compton Unified School Districts. Vocational training is provided in partnership with a wide range of private employers, many of whom accept clients with criminal histories and guarantee job placement for any client who has received the SHIELDS certification. Building collaborations is not only an effective strategy for providing comprehensive services to the entire family, it also builds capacity in the community. SHIELDS makes a point of not duplicating services with other local service-providing agencies, and instead brings those service providers on board for collaboration.

One of the primary challenges of providing comprehensive services for the entire family along the spectrum of care is that the funding streams available to service providers are *categorical* rather than *comprehensive*. In this funding environment, the solution is this: service-delivery organizations committed to providing comprehensive services must *blend* categorical

funding sources. The challenge for providers is to piece together a seamless pathway of services from various funding sources. At SHIELDS, for example, treatment funding comes from the Los Angeles County Office of Substance Abuse Prevention and Control, while mental health services at Heros and Sheros comes from the County Department of Mental Health Services. Housing is funded primarily by the rental income for program spaces, while funding for child development activities comes from the County Health Department. The mother's educational classes are made possible by a partnership with the L.A. Unified School District, while the youth participates in a charter school funded by a State grant in partnership with a local educational non-profit. The work of piecing together funding is ongoing. Over time, funding sources shift as policy priorities change, as do families' needs. Service-providing agencies must continue to be creative in finding and blending funding sources to provide for a changing array of services.

These strategies can eliminate the need for mothers seeking substance abuse treatment to be forced into making a 'Sophie's choice' between their own well-being and that of their children. As demonstrated by SHIELDS' successes, implementing a family-centered treatment program results in improved treatment retention/outcomes for individual women as well as improved outcomes for children and other family members. When family-centered services are delivered according to these service-delivery strategies—with comprehensive services, on-site services and programs, culturally competent services, community-based programming, relationship-centered treatment, and client-centered treatment—a program ensures successful outcomes not only for current clients but also for future generations.

Written Testimony
Of
The American Congress of Obstetricians and Gynecologists
Submitted by:
Hal C. Lawrence, III, MD, FACOG
Before the
House Ways and Means Subcommittee on Human Resources
Regarding
The Heroin Epidemic and Parental Substance Abuse:
Using Evidence and Data to Protect Kids from Harm
May 18, 2016

Chairman Buchanan, Ranking Member Doggett, and distinguished Members of the Subcommittee on Human Resources, thank you for giving the American Congress of Obstetricians and Gynecologists (ACOG), representing more than 57,000 physicians and partners in women's health, the opportunity to submit written testimony in response to your May 18, 2016 hearing titled "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm." We appreciate the thoughtful way that the Subcommittee approached this sensitive topic. I hope you will view ACOG as a resource and trusted partner as you continue to examine this issue.

I am the Executive Vice President and Chief Executive Officer at ACOG and in this capacity am keenly aware of the increase in opioid dependence and its impact on the women we serve and their families. My testimony will focus on the need for greater access to evidence-based treatment for pregnant and parenting women and its positive impact on family preservation.

The instance of opioid use disorder has risen dramatically over the past few years. Especially important are pregnant and parenting women with opioid dependence and their children. The unplanned pregnancy rate among women with an opioid use disorder is 86%, a number that far surpasses the national average of 46%.[1] Not only does that speak to the need for increased access to contraception among women with opioid addiction, but also elucidates the fact that many of these women were not expecting to be pregnant.

All pregnant women are concerned for the health of their baby-to-be and are motivated to change unhealthy behaviors. From population level data, we know the natural history of substance use during pregnancy – most women who use substances including opioids quit or cut back. Those who cannot stop using, by definition, meet criteria for having a substance use disorder. In other words, continued substance use in pregnancy is pathognomonic for addiction, a chronic, relapsing brain disease.

Evidence-based treatment for pregnant and breastfeeding women with substance use disorders includes the use of medication-assisted treatment (MAT) such as methadone and buprenorphine. When treating pregnant women with opioid addiction, in most instances withdrawal or detoxification is not clinically appropriate. Medically supervised tapered doses of opioids during

[1] Heil S, Jones H, Arria A, et al. "Unintended pregnancy in opioid-abusing women." J Subst Abuse Treat. 2011 Mar, 40(2): 199-202.

pregnancy often result in relapse to former use within a short period of time, adding increased risk to the fetus and increasing the mother's risk for overdose postpartum. Abrupt discontinuation of opioids in an opioid-addicted pregnant woman can result in preterm labor, fetal distress, or fetal demise.[2]

Tragically, drug overdose is now the number one cause of maternal mortality in a growing number of states. Threats of incarceration, immediate revocation of child custody, and other punitive responses drive pregnant and parenting women away from seeking vital prenatal care and addiction treatment. Alternatively, non-punitive public health approaches to treatment have resulted in better outcomes for both moms and babies. Immediately postpartum, women who bond with their babies, including via breastfeeding, are more likely to stay in treatment and connected to the healthcare system.

Substance use disorder treatment that supports the family as a unit has proven effective for maintaining maternal sobriety and child well-being. However, in 2015 the Government Accountability Office found that "the program gap most frequently cited was the lack of available treatment programs for pregnant women…"[3] While there are in-patient treatment programs specific to this population, including programs that allow women to bring their minor children, the demand far surpasses the supply. In addition, many of these women are the sole caregiver or breadwinner in their families and would benefit from increasing the availability of out-patient treatment options that are responsive to their complex obligations.

The Improving Treatment for Pregnant and Postpartum Women Act (HR 3691), passed by the House of Representatives on May 11th, has the potential to improve access to evidence-based treatment. This bipartisan and bicameral legislation reauthorizes residential treatment programs for pregnant and postpartum women and creates a pilot program to enhance flexibility of state funds to improve access to care, including nonresidential services. The legislation is due to be conferenced by the House and Senate in the coming days, but its positive impact will be stunted if it is not authorized at the introduced level of $40,000,000. I therefore strongly encourage you to support this legislation at the authorized level.

As Chairman Buchanan said in his opening statement, strong families make for a strong community. Empowering opioid dependent pregnant and parenting women with access to evidence-based family-centered treatment will improve outcomes for both mothers and their children and foster family preservation. Thank you again for the opportunity to submit written testimony, and for your thoughtful approach to this issue. I hope that you will consider ACOG a trusted partner in this space and will let us know if we can provide any additional assistance.

---

[2] Opioid abuse, dependence, and addiction in pregnancy. Committee Opinion No. 524. American College of Obstetricians and Gynecologists. Obstet Gynecol 2012;119:1070–6.

[3] U.S. Government Accountability Office. (2015, February). Prenatal Drug Use and Newborn Health: Federal Efforts Need Better Planning and Coordination. (Publication No. GAO-15-203). Retrieved from http://www.gao.gov/products/GAO-15-203

PREMIER TRANSFORMING HEALTHCARE TOGETHER®

Statement for the Record

Submitted by

The Premier healthcare alliance

The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm

House Ways and Means Human Resources Subcommittee

May 18, 2016

The Premier healthcare alliance appreciates the opportunity to provide a statement for the record on the House Ways and Means Committee hearing, titled "The Heroin Epidemic and Parental Substance Abuse: Using Evidence and Data to Protect Kids from Harm." Premier is a leading healthcare improvement company, uniting an alliance of approximately 3,600 U.S. hospitals and 120,000 other providers to transform healthcare. With integrated data and analytics, collaboratives, supply chain solutions, and advisory and other services, Premier enables better care and outcomes at a lower cost. Premier, a Malcolm Baldrige National Quality Award recipient, plays a critical role in the rapidly evolving healthcare industry, collaborating with members to co-develop long-term innovations that reinvent and improve the way care is delivered to patients nationwide.

We applaud the leadership of Chairman Buchanan and Ranking Member Doggett for holding this important hearing today that builds on the House's action last week to approve much-needed legislation to address the opioids epidemic that is hitting so many of our communities and the patients that our Premier alliance members serve. We appreciate the House Ways and Means Committee's leadership in urging the Centers for Medicare & Medicaid Services (CMS) to remove barriers to providers' access to substance use data in order to support insight and innovation in healthcare delivery. Empowering the providers who are on the front lines of care delivery with the information they need to diagnosis and effectively treat patients who use opioids and other controlled substances is absolutely central to these national efforts. Standing in the way of this is a 40 year-old law that essentially makes it impossible for providers to identify patients with substance use disorders, which are often associated with behavioral health issues. This creates blind spots that limit the delivery of informed, coordinated care, as well as substance

13034 Ballantyne Corporate Place T 704.357.0022
Charlotte, NC 28277 F 704.357.6611

444 North Capitol Street, N.W. T 202.393.0860
Suite 625, Washington, DC 20001 F 202.393.6499

PREMIERINC.COM

use treatment and addiction counseling. These outdated regulations run counter to new, innovative delivery care models, such as ACOs and bundled payments, that require a holistic knowledge-base and approach to improving health outcomes. The Premier healthcare alliance and a wide range of other organizations, including those representing patients, hospitals, physicians, Medicaid directors, the mental health community and others, are calling on Congress to allow healthcare providers engaged in these care models access to their patients' Medicare, Medicaid and CHIP data on substance use in a way that maintains strong patient confidentiality.

Providers are "flying blind" when it comes to substance use, putting patients and their families at risk and stymieing care coordination

CMS provides participating providers of Medicare ACO and bundled payment organizations with monthly Medicare Parts A, B and D claims under data use agreements that include criminal penalties for misuse. However, a 1970s rule governing the confidentiality of drug and alcohol treatment and prevention records (42.C.F.R. Part 2 (Part 2)) that predates HIPAA and its robust patient confidentiality protections prevents CMS from disclosing or allowing the use of patients' information on substance use without complex and multiple patient consents. Thus, CMS has interpreted this to require the agency to remove claims where substance use disorder is a primary or secondary diagnosis before sending data to researchers or providers who are part of ACOs, bundled payment and other alternative payment models. Removing this data translates to providers missing roughly 4.5 percent of inpatient Medicare claims and 8 percent of Medicaid claims[i], despite being accountable for the outcome of their patients' health and cost of care.

This poses a serious safety threat to patients with substance use disorders considering the potential for drug contraindications and co-existing medical problems. As this hearing brings into focus, it also poses a threat to the family members of those who are struggling with substance use disorders. The lack of data to cue physicians, hospitals and other providers that patients may suffer from substance use disorders means these patients will not benefit from efforts to improve care and efficiency in care coordination models in the same way as other patients, whose comprehensive medical information is available to their providers. This could result in patients being denied critically needed treatment and other social support services because of a decades-old law that does not reflect current models of care, nor account for the strong patient confidentiality protections subsequently put in place by HIPAA.

Moreover, this outdated law creates a costly administrative burden for the government by requiring CMS to scrub substance use data from medical records before transmitting to ACOs and bundled payment organizations. At a time when we are looking to inject more efficiency into our healthcare system, this adds complexity and costs to the system, in addition to laying on the line patient safety and care coordination needs.

To the extent that we start scaling alternative payment models and moving to multi-payer models, including those in the Medicaid program, these problems will only compound.

A broad range of stakeholders support opening up substance use data for our healthcare providers to analyze and improve care in the communities they serve

Premier has joined a broad array of other organizations in calling on Congress to ensure that the Medicare, Medicaid and CHIP data feeds sent to providers that are participating in alternative payment models include all claims, including those involving substance use disorder. House Leadership and Committee members have received multiple coalition letters (May 12 stakeholder letter, May 10 stakeholder letter) to this effect. Also as part of the Health Care Transformation Task Force, a consortium of private sector stakeholders committed to accelerating the pace of delivery system transformation, and the National Coalition on Health Care, an alliance of leading national healthcare consumer, labor and business groups, we are urging Congress to amend Part 2 regulations to allow participants of alternative payment models access to these data to promote effective valued-based care. In addition, the National Association of Medicaid Directors sent a letter to House leadership on the need to amend privacy laws to fully address the opioid crisis, and ensure individuals with substance use disorders receive integrated care delivery and benefit from patient-centered models.

We thank the Subcommittee again for holding this critical hearing today. If you have any questions or comments, please contact Duanne Pearson, Director of Federal and Affairs, at duanne_pearson@premierinc.com or 202.879.8008.

---

[i] http://www.nejm.org/doi/full/10.1056/NEJMp1501362

○