

WRITTEN TESTIMONY

of the

AMERICAN PUBLIC HUMAN SERVICES ASSOCIATION

and its affiliate the

NATIONAL ASSOCIATION OF PUBLIC CHILD WELFARE ADMINISTRATORS

Submitted to the

HOUSE WAYS AND MEANS COMMITTEE

SUBCOMMITTEE ON HUMAN RESOURCES

HEARING ON

CHILD DEATHS DUE TO MALTREATMENT

July 26, 2011

INTRODUCTION

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

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

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

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

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

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

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

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

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

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

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

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

THE NEED FOR STATE ENGAGEMENT IN IMPLEMENTATION OF GAO RECOMMENDATIONS

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

Improve the Completeness and Reliability of State-Reported Data

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

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

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

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

Expand Available Information on Child Fatalities

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

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

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

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

Improve Information Sharing

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

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

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

WHAT CONGRESS CAN DO TO REDUCE CHILD FATALITIES DUE TO MALTREATMENT

Preserve funding levels and align funding with program needs

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

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

intact by providing supportive services on the front end, and to keep children safe in their own homes, they need flexibility to use federal funds based on the unique needs and demographics of their respective jurisdictions. With a few modifications indicated in a May 25, 2011 letter⁵ APHSA supports passage of H.R. 1194 that renews the authority of the HHS secretary to approve new demonstration projects to test innovative strategies at the state level. Notwithstanding the need for this extension of authority, waivers are a stop-gap measure that highlight the need for comprehensive child welfare finance reform. Federal funding should be aligned in a way that promotes services to children and families in their own homes. Proven effective prevention and diversion pilot programs should be expanded to full-scale initiatives.

No Unfunded Mandates

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

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

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

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

Rebalance Systems to Allow Funding to Follow the Family

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

Funding for Training

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

Meaningful Accountability

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

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

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

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

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

CONCLUSION

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

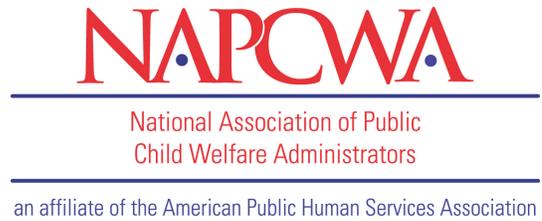
- **Seek states' input on reform efforts to improve the quality and comprehensiveness of national data on child fatalities.** States need to be a part of the national discussion and fully engaged in this process. Public child welfare administrators are well positioned to offer solutions on the topic. National forums and roundtable discussions sponsored by HHS could help guide this work. As a result, we hope to see a better federal and state partnership focused on preventing deaths due to child maltreatment.
- **Do not include unfunded mandates on states.** States should not have to divert funds from direct services that protect children and support families to gather national data on child fatalities. States have internal data sources that are used in combination with the national data to make data-driven decisions about programs. Currently, the process for national data collection and reporting has become administratively burdensome and costly for states. Posing unfunded mandates on states regarding data collection and reporting requirements would exacerbate, rather than improve, the issue. States agree that there needs to be more comprehensive and accurate data that paints a true picture of what is currently happening to at-risk children and families. Therefore, there needs to be a requirement for HHS to provide better assistance for states to establish a

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

- **Require HHS to create better guidelines to improve NCANDS data collection on child fatalities.** In addition to the technical assistance that HHS currently offers, training and technical assistance should focus on state-identified needs, targeted areas of improvement, and include a variety of methods such as peer-to-peer training, mentoring and site-visit observation of successful programs to replicate best practices.
- **Provide federal funding to support specialized training in professional schools** for social workers, day care providers, educators and medical providers, particularly for pediatricians, emergency room personnel and nurses. These professionals are mandated child protection reports. Therefore, a uniform approach for training professionals on child maltreatment is critical. Professionals need to be better educated on child abuse and neglect and know when and how to report it. This could contribute to reduced instances of child abuse and neglect and improve the way professionals properly address child maltreatment.

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

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



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