

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

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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

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**May 18, 2016**

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

U.S. House of Representatives,  
Committee on Ways and Means,  
Washington, D.C.

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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.

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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 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 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 legislation 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 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 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 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 working together to address these kind of concerns, back up and encourage the States, 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.

Chairman Buchanan. 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 committee, 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, quote, "cured," end quote, 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-slash-prison, if you want to call it.

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 removed 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. But, 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 or 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 Department for Community-Based Services with Kentucky Cabinet for Health and Family Services; Mr. Hector Glynn, vice president of programs, The Village for Families and Children; Ms. Katherine Barillas, director of child welfare policy for One Voice Texas; Mr. Bryan Lindert, senior director of quality management for Eckerd Youth Alternatives.

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

**STATEMENT OF MS. TINA WILLAUER, DIRECTOR, SOBRIETY  
TREATMENT AND RECOVERY TEAMS (START), DEPARTMENT FOR  
COMMUNITY BASED SERVICES, KENTUCKY CABINET FOR HEALTH AND  
FAMILY SERVICES**

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 outcomes. 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, 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? So 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, receive services. And what we know is preventing kids from entering foster care not only saves moneys, but it reduces trauma to children and families.

Thank you so much.

Chairman Buchanan. Thank you, Ms. Willauer.

Mr. Glynn, please proceed with your testimony, please.

**STATEMENT OF MR. HECTOR GLYNN, VICE PRESIDENT, PROGRAMS,  
THE VILLAGE FOR FAMILIES AND 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 and Children in Hartford, Connecticut. We are a large nonprofit 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 sort of 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 sort of 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 sort of ongoing relapses in which they needed a higher level of care or sort of newer levels of treatment.

We really do believe that this is 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.

Chairman Buchanan. Thank you, Mr. Glynn.

I would like to advise members that a series of votes have 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 need 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 in-patient 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, quote/unquote, "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 is extended, with strong supports 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.

Chairman Buchanan. Thank you, Ms. Barillas.

Mr. Lindert, please proceed with your testimony.

**STATEMENT OF BRYAN LINDERT, SENIOR DIRECTOR OF QUALITY MANAGEMENT, ECKERD YOUTH ALTERNATIVES**

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 member 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.

Chairman Buchanan. Thank you, Mr. Lindert.

I want to thank all of you for excellent testimony.

We now proceed to the portion for 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 was 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 out of 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 operate 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 is 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. -- 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 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, low pay, 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 our 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 I have 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 also and her husband 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, 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 the 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 families. 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 they are in 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. -- brain development, that that is why they want to keep mom and baby together. And so --

Mr. Reichert. Yep.

Ms. Barillas. -- 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. -- 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 information follows: [The Honorable Danny Davis Submission](#)]

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, 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. -- if we provide 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 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 in?

Anyone?

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, we have 24/7 on call. 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, so 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 maintain 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 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 resource and could be allocated more towards 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. -- 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 can 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 Ms. 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, and so 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 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. 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 them 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 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. -- 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, re-entry 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, and then 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, is 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 it 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 create 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 different than we approach cases on teenagers and 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, subcommittee stands adjourned.

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

**[Public Submissions For The Record](#)**