

# **PROTECT OUR KIDS COMMISSION**

## **MEETING SUMMARY**

**March 27, 2015  
10:00 am – 2:00 pm**

**Texas Hospital Association  
1108 Lavaca Street, Suite 700  
Austin, Texas 78701**

The Protect Our Kids Commission held its third meeting on March 27, 2015 with further presentations on the work of the Department of Family and Protective Services (DFPS), and the Department of State Health Services (DSHS). Commissioners also heard reports from the chairs of the four workgroups: Child Fatality Review Teams, Data, Prevention and Sustainability.

### **Background**

The 83rd Legislature created the Protect Our Kids Commission, followed by the Commissioner appointments from the Governor, Lieutenant Governor, and Speaker of the House. The Legislature directed the POK Commission to:

- (1) identify promising practices and evidence-based strategies to address and reduce fatalities from child abuse and neglect;
- (2) develop recommendations and identify resources necessary to reduce fatalities from child abuse and neglect for implementation by state and local agencies and private sector and nonprofit organizations, including recommendations to implement a comprehensive statewide strategy for reducing those fatalities; and
- (3) develop guidelines for the types of information that should be tracked to improve interventions to prevent fatalities from child abuse and neglect.

### **Welcome from the POK Chairperson, Judge Robin Sage**

**Public Comment** from James Castro, CEO St. Peter St. Joseph's Children's Home (see notes at the end of this summary)

**Sasha Rasco, Director of Prevention and Early Intervention, DFPS, and Kathryn Sibley, Division Administrator for DFPS Office of Child Safety** presented and answered many detailed questions from the commissioners regarding two important reports that were released in March 2015:

- 1) DSHS/DFPS Strategic Plan to Reduce Child Abuse and Neglect Fatalities (DSHS/DFPS Strategic Plan)**
- 2) DFPS A Better Understanding of Child Abuse and Neglect Fatalities, FY2010 through FY2013 Analysis (DFPS Analysis)**

Top points from the DSHS/DFPS Strategic Plan:

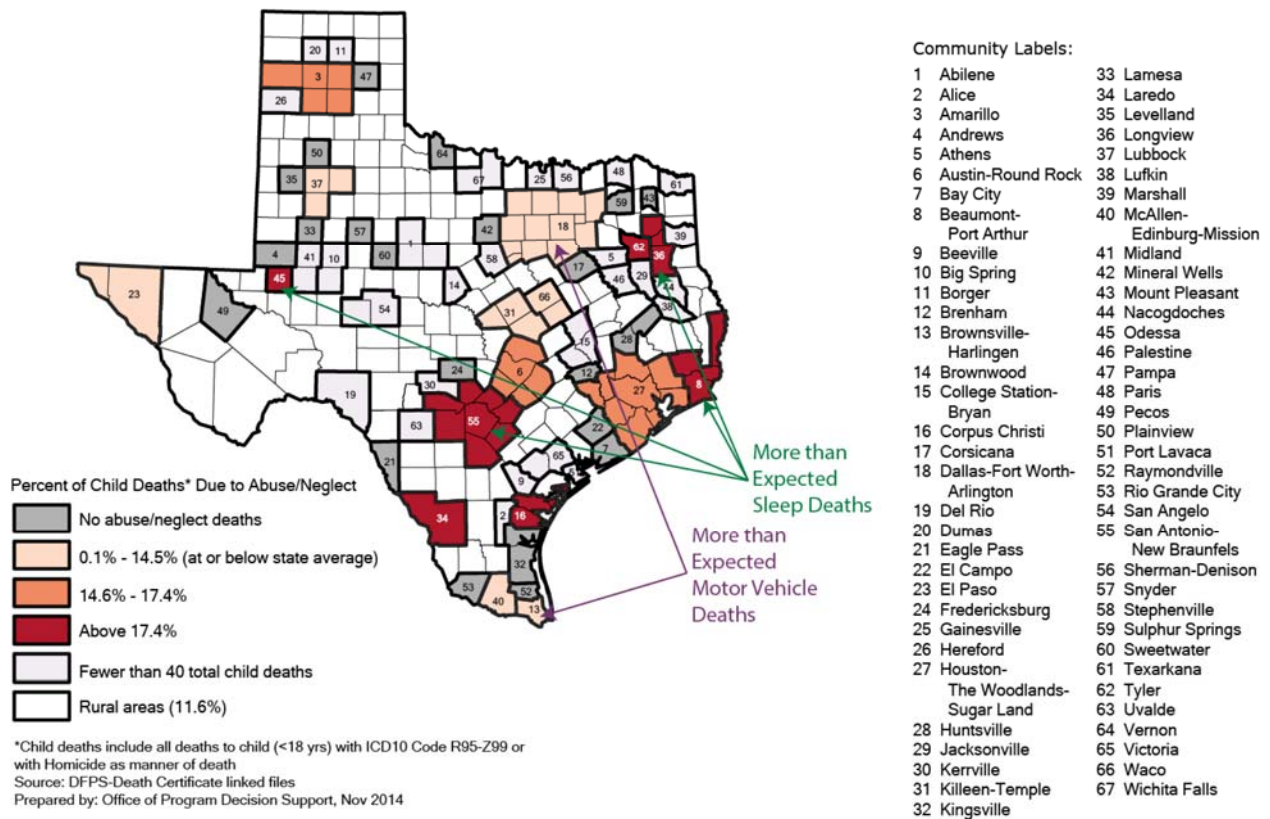
1) Understanding the Impact of Abuse/Neglect Deaths in the Population

- Of the 723 abuse and neglect deaths between 2010-2012, 342 (53%) had no CPS involvement prior to death, this is the reason why we have a population based strategy outlined in the plan
- 70% of A/N deaths are to children younger than 3 years old.
- 89.5 % are to children younger than 7 years old

2) Geomapping

- The slide below shows the relationship of abuse & neglect fatalities to all fatalities.
- Geomapping helps guide where DSHS/DFPS should start pilot projects.

Percent of Child Deaths\* that Were Abuse/Neglect by Community, 2010-2012



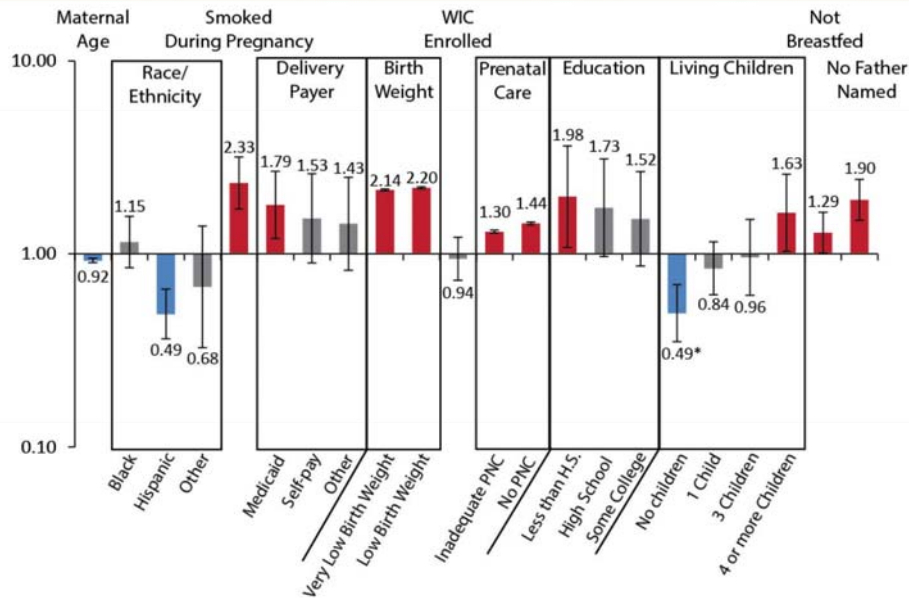
### 3) Data Matching for Risk Factors at Birth

When DSHS/DFPS looked at birth data about women who ended up being mothers of children who died of abuse and neglect they found:

- Having one child is risk factor for physical abuse fatalities
- Having more than one child reduces risk of physical abuse fatalities, but is an increased risk factor for neglect fatalities
- Breastfeeding became a protective measure (in combination with other risk factors.). This data led to a focus on breastfeeding strategies.
- Correlation with smoking and sleeping fatalities (be careful with causation and correlation) There is a higher rate of dying from abuse and neglect v. rate of dying from something else (not the rate of staying alive)
- Domestic violence – profiles look similar for women in domestic violence and in child abuse and neglect

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## Risk Factors at Birth



Gray bars are non-significant effects  
 Red bars are significant increases in risk  
 Blue bars are significant decrease in risk  
 \*No children is a decreased risk for some types of abuse, but it is an increased risk for physical abuse  
 Prepared by: Office of Program Decision Support, Nov. 2014



4) Questions from the commissioners and answers from Ms. Rasco and Ms. Sibley.

Q: Does bias affect this data? When we say someone died from abuse and neglect, we are naming culpability. For example, if there is no father named, there might be greater chance of abuse and neglect, but there is also a higher likelihood of it being labeled abuse and neglect more often than an upper class woman with husband by her side with exact same circumstance. Are we getting things labeled correctly?

A: Yes, there might be bias built in any time you use abuse and neglect data so the question becomes is the data still valuable? The abuse and neglect data is all we have and the best way to study abuse and neglect. (Some programs like NFP urge that we look at ER admissions/ injuries and DSHS/DFPS is open to considering this data.) It is important to remember that this Birth Matching data is not about predictive analytics for reporting from an emergency room. This is about trying to find an access point for conversations with mothers to get them enrolled in correct program.

Comment: Treat it like a public health issue, not a focus on culpability.

Q: What would the risk factors look like if you looked at the 804 child fatalities in Texas rather than the 156 fatalities labeled as abuse and neglect?

A: The 804 is included in the denominator. The DSHS data set denominator is all fatalities under 18 compared to numerator of abuse and neglect fatalities. So it looks at what are the common factors in the 804 (all fatalities) and the 156 (abuse/neglect fatalities). DFPS/DSHS identified one hundred other data matching points– could match on more specific parent behavior, or all fatalities reported, etc. to see where can introduce education earlier. For example, there is an intersection of 65% of families and WIC.

Q: So the numerator does not include the Unable to Determine cases? UTDs are in the denominator? We probably need study the risk factors for cases ruled RTB Not Fatal and UTD.

A: This is public health prospective, so we are trying to compare what we know about all children as well as children in abuse and neglect community.

Comment: When assessing risk factors it might be helpful to look at all kids who were born who died from sleep related deaths compared to those kids who didn't die to eliminate the abuse label/possible bias problem. In other words, look at all children born who had an outcome we didn't want.

Q: This report is based on combination of info from DFPS, DSHS, birth and death and community level factors. The fatalities are from non-natural deaths under 18,

including accidents, homicide, suicide all unknown or undetermined. Are cases included where abuse and neglect contributed to fatality?

A: Contributed to/ caused by are used interchangeably and are in the numerator. The RTB Non-Fatal cases are not in the numerator.

Q: How can this data set include all child deaths if not all child deaths are reviewed?

A: The data set was not dependent on being reviewed by CFRT. It is based on complete death set from DSHS (have a death certificate, go back find birth certificate, and go back and pull CANDY data set based on where it happened).

Comment: It is an important question to ask what data might be missing.

A: This data match and report was a beginning point to see what could be done. POK might be able to recommend what else DFPS should be matching, suggestions for a public health strategic plan, studying the data at different stages, gaining better surveillance data, better death certificate data, what should be in the numerator, whether to use hospital injury data, and whether to include RTB non-fatal. These are all good ideas for the future. A second data matching project will begin in the spring where more abuse and neglect information will be used for a new match with a larger, more encompassing view of child abuse and neglect.

This data helps DSHS/DFPS to decide what to work on right now. Improvements to the data collection can help in the future, but this initial look gives us insight into areas with specific needs. Matching the data helps DSHS/DFPS prioritize and understand the needs. For example hyperthermia occurs in very small numbers, but these deaths are 100% preventable, so they are very important. Sleep related deaths have higher numbers. All of this data informs program recommendations.

## 5) Summary of Program Recommendations

1. Motor Vehicle-related Hyperthermia - Heat Exposure (Dallas, Fort Worth)
2. Motor Vehicle-Pedestrian Fatalities (Border Counties)
3. Sleep-related Fatalities
  - Highest number of fatalities (San Antonio-New Braunfels area)
  - Higher than expected (Beaumont/Port Arthur and Midland/Odessa)
4. Physical Abuse

Kathryn Sibley next presented on the DFPS Analysis, A Better Understanding of Child Abuse and Neglect Fatalities with continued questions from the commissioners. The DFPS Analysis includes data from FY2010 through FY2013:

- descriptive analysis of victims, perpetrators, cause of fatality
- current initiatives to address child fatalities & strengthen child safety

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## Child Population and Reports of Child Abuse and Neglect

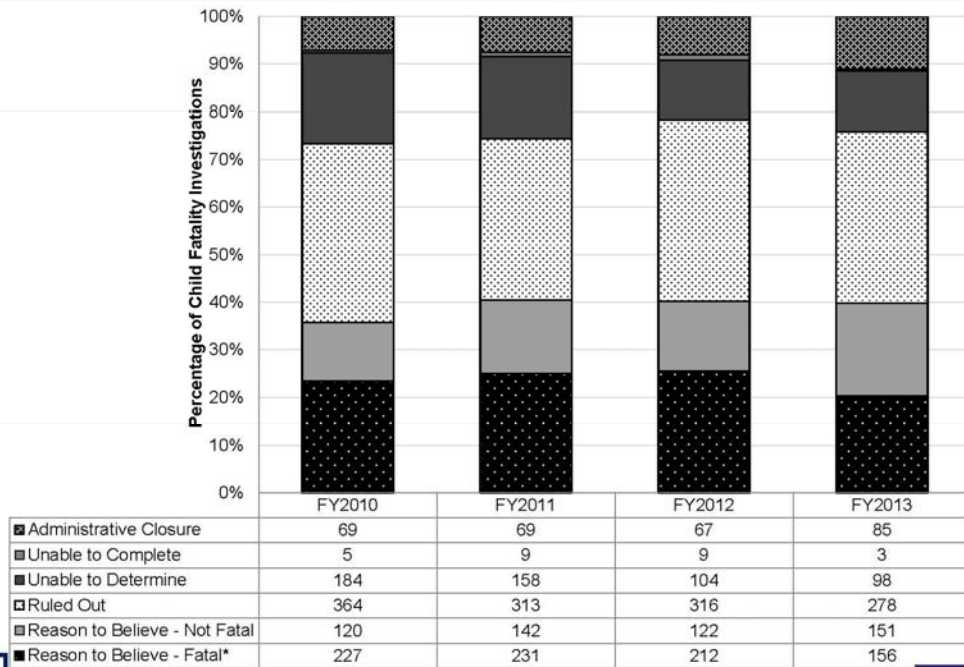
	FY2010	FY2011	FY2012	FY2013
<b>Child Population of Texas</b>	6,865,824	6,952,177	6,996,352	7,121,499
<b>Number of Intakes Assigned for Investigation by CPS</b>	231,532	222,541	206,200	194,801
<b>Number of Investigated Child Fatalities</b>	1024	973	882	804
<b>Number of fatalities where abuse/neglect was confirmed</b>	227	231	212	156
<b>Child Fatality Rate per 100,000 Children</b>	3.31	3.32	3.03	2.19
<b>National Rate for Equivalent Federal Fiscal Year</b>	2.10	2.10	2.20	2.04



Q: Are there child fatality reports that are closed administratively?

A: For all child fatalities that come into statewide intake, if there is no allegation of abuse/neglect, the case is given a “priority none” assignment, and is then sent to a screener in the field who will review and make follow-up contacts to make sure there are no issues of abuse or neglect. The case can be elevated for investigation if concerns are found in follow up. DFPS is working on getting those numbers into report, working on sorting that out.

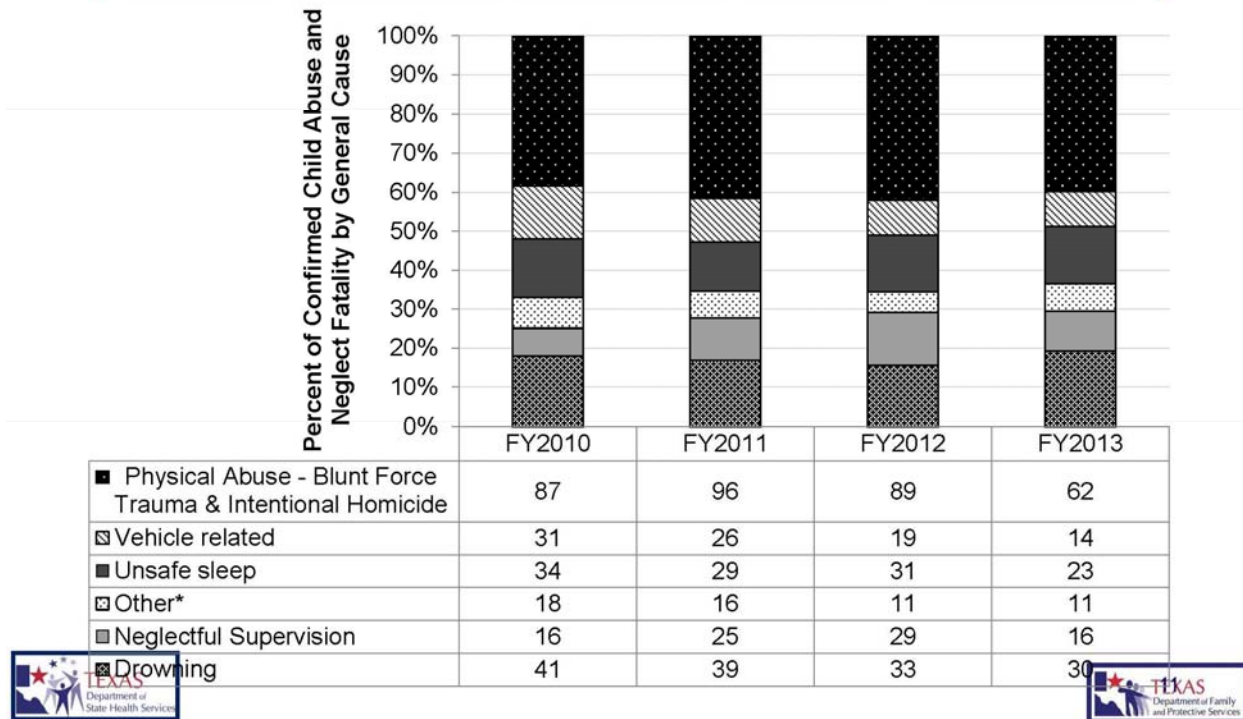
## Percentage of Completed Child Fatality Investigations by Disposition per Fiscal Year



An important part of the report was on the number of certain dispositions per year. In FY 2012 DFPS focused with staff on making consistent dispositions across neglectful supervision fatalities (co sleeping, drowning, firearms, suicide, or hot cars). Enhanced Disposition Guidelines were rolled out in 2012 to provide more guidance on what constitutes a child abuse fatality and what doesn't. The goal was to have outcomes consistent from city to city across the state, not different standards depending on where you are. For example, one area that needed more guidance and clarification was in neglectful supervision cases. Neglectful supervision fatalities are more difficult because there are not as many community partners (law enforcement, medical community) involved in thorough investigations. In physical abuse case, there is much more community involvement.

The outcomes from the Enhanced Disposition Guidelines were good with more involvement and investigation, enhanced training, and streamlined policy. The decision making process improved as well. The data is more accurate now. One suggestion for better consistency in reading the data was to draw a line or make some sort of delineation between pre and post Enhanced Dispositions Guidelines data.

## General Cause of Confirmed Child Abuse or Neglect Fatality by Fiscal Year





## Profile of Victims and Perpetrators

### Victim Profile

- Male – 55%+
- 3 and younger – 80%
- Hispanic

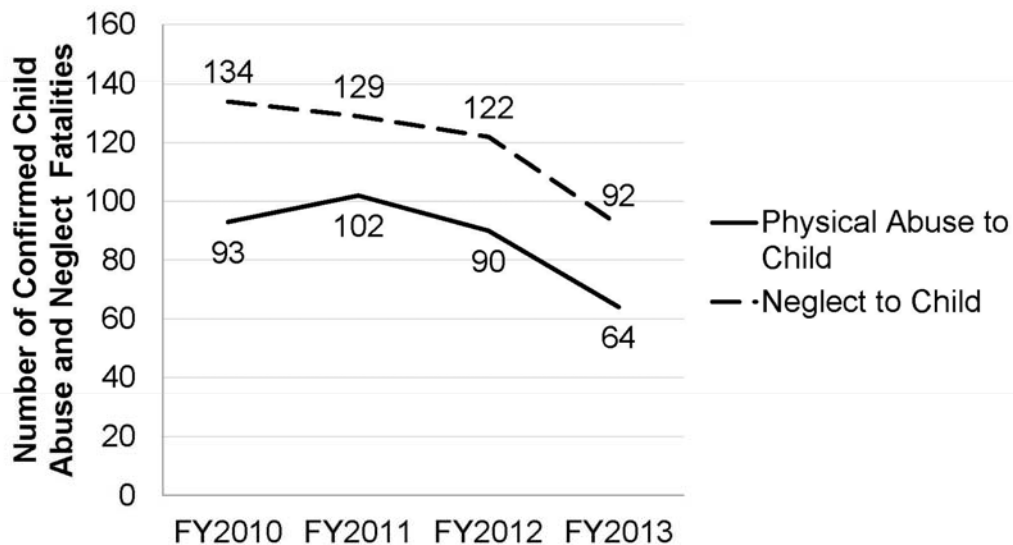
### Perpetrator Profile

- Parents are the most common perpetrators
- Blunt force trauma inflicted by a father or boyfriend.
- More that 50% had no history with CPS.
  - Open CPS case: most fatalities were unintentional acts involving inadequate supervision.
  - Prior CPS history: most fatalities were the result of intentional acts such as physical abuse.



Hispanic and African American children are more often victims. DFPS is researching this disproportionality.

## Comparison of Intentional Physical Abuse and Neglect Fatalities by Fiscal Year



### Addressing Child Fatalities

- 1) DFPS Transformation
  - Streamlining Policy Risk and Safety Assessments
  - Utilizing Predictive Analytics
  - Improving Case Transfer
- 2) Prevention and Early Intervention
  - Office of Child Safety – Public Website Information
  - Public Awareness Campaigns
  - Project HOPES
  - Project HIP
- 3) Collaboration
  - DSHS Strategic Plan
  - Casey Family Programs - Child Safety Forums
  - CECANF / Protect Our Kids Commission

# Workgroup Reports

## CFRT Workgroup

Carmen Dusek, Chair

Lisa Black

Julie Evans

Leticia Martinez

Judge F. Scott McCown

Dr. Marian Sokol

Luanne Southern

Dr. Reade Quinton

Amy Bailey

Tammy Sajak

Judge Robin Sage

The CFRT Workgroup has met three times and has identified the following areas to focus on and to continue researching and evaluating:

- A. Ways to alleviate strain, frustration and workload from CFRT members,
- B. The need for greater consistency in the review process, including obtaining autopsies,
- C. The need for increased training for Justices of the Peace and CFRT members,
- D. Shortening the time frame for cases to be reviewed, and
- E. Coverage of 100% of Texas counties.

### **Coordination, training and better consistency for CFRTs**

Amy Bailey, DSHS State Coordinator for CFRTs, recently conducted a survey of CFRTs. Amy Bailey is still obtaining information from additional CFRTs but has shared the information she has obtained thus far with the workgroup on matters such as: how often teams meet, which deaths are reviewed, and whether the teams use the national case report.

Tammy Sajak of DSHS has noted that CFRTs have never had any funding at the local level, and it is truly remarkable what has been achieved with volunteer commitment only. Tammy Sajak and Amy Bailey have shared with the workgroup their concept of adding one full-time employee (“FTE”) to each of eight the Regional DSHS offices to serve as a staff member to support the local CFRTs. There are 11 Public Health Regions that are housed in 8 offices, with 3 regions sharing office locations. A map is attached hereto showing the 11 regions and 8 offices.

Tammy Sajak and Amy Bailey believe the investment of only a few employees statewide to support the CFRTs could dramatically impact the effectiveness and consistency of the CFRTs’ work by providing meeting coordination, training, and data entry assistance to local CFRTs and would ultimately help lead to better child fatality information and thereby better prevention efforts. It has been noted by Tammy

Sajak and members of the workgroup that the needs of CFRTs vary between urban and rural teams, but two critical goals should be met: (1) regions with rural teams need more technical assistance and coordination of multiple teams; and (2) regions with urban teams need assistance to work the high volume of cases. The workgroup has also discussed whether DSHS or DFPS would be the best agency to hire the FTEs and whether each should be hired by the State Coordinator, Amy Bailey.

It is possible that regional support could also help to ensure that counties without current CFRT coverage can join an existing CFRT or become part of a new CFRT.

With the Legislature currently in session, the workgroup reached out to DSHS and DFPS to determine if either agency was in a position to make a budget request for these new FTEs. Both agencies had already submitted their budgets; accordingly, no opportunity existed to take action on this concept during the current Legislative session. The workgroup as a whole believes this concept is one to continue to evaluate and consider; however, the workgroup felt we did not have sufficient information about how it could be implemented in order for the POK Commission to take action during this current Session. It is a concept that we anticipate continuing to research and consider as a solution to several of the critical needs for CFRTs.

### **Autopsies**

Currently, the death of any child under the age of 6 is required to be immediately reported to the medical examiner or, in counties without a medical examiner, a justice of the peace. An exception to this requirement is when the death is a result of a motor vehicle accident. A reported death requires the justice of the peace or medical examiner to conduct an inquest. One requirement of the inquest is an autopsy. Exceptions to the autopsy requirement are expected deaths due to a congenital or neoplastic disease. Under certain circumstances, a death caused by an infectious disease may also be exempted. Consent for an autopsy is not required, and the statutes allowing objections to an autopsy do not apply to required autopsies.

Judge McCown has raised the idea in a Commission meeting of requiring autopsies of all child deaths in

Texas. The workgroup is working to determine the approximate number of additional autopsies which would be required each year if the age requirement were raised and the approximate cost which would be associated with requiring autopsies for all unexpected, non MVA child deaths.

### **Shortening the time frame for cases to be reviewed**

The workgroup has discussed obstacles which cause delays in the review and reporting process. These delays include matters such as: the amount of time required to obtain toxicology results, and thereby final autopsy results, and hesitancy by law enforcement and/or prosecutors to provide information on fatalities until a criminal case is fully resolved. Some CFRTs obtain faster notification of child deaths by receiving notice from County Registrars instead of waiting to receive a death certificate from DSHS. Faster notification may help expedite the review process in many cases. More information needs to be obtained and considered regarding the expense of this faster notification process as well as whether it would ultimately expedite the review process.

### **Coverage of 100% of Texas counties**

The workgroup has recently begun looking at the counties which are not part of a CFRT to evaluate whether 100% participation would significantly impact the information obtained by the State CFRT and thereby used to identify trends and prevention efforts.

Currently, a county with a population of less than 50,000 may join an adjacent county or counties to establish a CFRT. Attached to this summary is a map showing the Texas counties currently without CFRT participation. Also attached is a list of the counties without CFRT participation with the risk levels identified by Madeline McClure in her presentation to the Commission on January 16, 2015. The factors used to determine risk were: (1) domestic abuse, (2) substance abuse, (3) teen pregnancy, (4) child abuse fatalities, and (5) child poverty.

### **Data Workgroup**

Dr. Nancy Kellogg, Chair

Judge Peter Sakai

Dr. Eric Higginbotham

Madeline McClure

Judge Robin Sage

On 3/17/15, TDFPS released a new report written jointly with TDSHS, “Strategic Plan to Reduce Child Abuse and Neglect Fatalities.” In this report, data was combined from DFPS, DSHS, birth records, death records and community-level risk indicators, which was one recommendation of this subcommittee. This combination of data has produced a broader view of child fatalities, is child-centric and focused on preventable deaths, consistent with a public health approach; this was another recommendation of the subcommittee. In addition, specific focus areas for intervention are identified and action plans are elaborated based on identified areas of need. This report represents a commendable step forward in understanding why children die in Texas.

The separate data bases maintained by TDSHS and TDFPS are still useful for tracking trends and should continue to be reported every year. It is important to acknowledge the hard work, time commitment, and dedication of the individuals that gather, review, and enter this data, many of whom are volunteers committed to saving children’s lives. Individuals that serve on child fatality review teams are to be commended for their work and particularly for the prevention strategies that have emerged from fatality reviews. Additional support for local CFRTs is needed to continue to identify and gather information that will improve intervention and prevention strategies to reduce child maltreatment deaths.

Current CFRT data collection should be evaluated for consistency and reliability to identify opportunities for improvement. This is also consistent with conclusions stated in the Strategic Plan to Reduce Child Abuse and Neglect Fatalities: “Improve identification, classification and data collection.” In addition, a parallel data base should be developed that includes child maltreatment deaths (Reason-to-believe fatal designation in TDFPS 3/17/15 report “A Better Understanding of Child Abuse and Neglect Fatalities”; abuse or neglect caused *or* contributed to

the death), near fatalities (where abuse or neglect caused or contributed to the injury/condition) and preventable deaths (suicides, accidents, homicides, unknown, and undetermined causes of death; currently tracked with new combined data base). Most children dying of child maltreatment are under 3 years of age. There are 3 primary safety nets these children may encounter prior to their death: CPS, health care providers, and day cares. Current and future databases should incorporate information about medical care and daycare use by these children and their caretakers to evaluate opportunities for enhanced detection, intervention, and reporting to CPS prior to death. The Strategic Plan document indicates that most mothers involved in a confirmed child abuse or neglect fatality were enrolled in the Nutrition Program for Women, Infants and Children (WIC) during their pregnancies; in addition, risk factors for abuse and neglect may be identified during well- or sick-child visits and pre- and post-natal maternal health care visits. While re-referrals and child deaths are being tracked by CPS for families receiving in-home services, there are other in-home intervention and prevention services (NFP, HIPPY, SafeCare, Healthy Families/Precious Minds, Parents as Teachers, etc.) and parent education programs (Period of Purple Crying, Triple P, etc.) not directly affiliated with CPS that may impact child maltreatment rates; data on CPS referrals and child deaths during and following these interventions should also be gathered and tracked.

### Recommendations

1. Evaluate **currently** available child fatality data resources (CPS and CFRT data) and develop strategies to improve **completeness, consistency, validity and utility** by:
  - a. Evaluating mechanisms to ensure that all counties in Texas have CFRTs, and all unexpected infant/child deaths have autopsies and are reviewed. To improve consistency of data collected by CFRTs, definitions and indications for autopsies should be reviewed and training should be provided to ensure that CFRTs work from the same base level of knowledge and expectations. Mechanisms for providing infrastructure and financial support for data collection by CFRTs are recommended and should be explored.
  - b. Reviewing current data collection methods and tools used for child maltreatment deaths to ensure that collection methods are standardized and terms are clearly understood and defined. For example, developing a more specific definition for a “near fatality” would facilitate a more consistent appraisal by physicians.
  - c. Add clearly defined criteria for “near fatalities” and “serious injuries” to be tracked by CPS, and address HIPAA regulations to allow this new, de-identified aggregated data, to be shared with the public.
2. Support efforts to prolong the length of time records are maintained by CPS, such that Reason-to-Believe with removal, Reason to Believe with Disposition of RTB for Sustained Perpetrator, Reason-to-Believe without a removal, Unable to Determine, Unable to Complete, and Ruled Out with risk factors indicated, and Ruled Out with risk factors controlled case records are retained by CPS for 50 years, 20 years, 20 years, 5 years, and 5 years, respectively, following case closure.
3. Evaluate enhancements to the new combined data base to include:
  - (a) near-fatalities and serious injuries due to child maltreatment;

(b) an expanded analysis of opportunities for preventing child maltreatment fatalities by improving earlier detection of risk, ensuring appropriate multidisciplinary case reviews when maltreatment is suspected, and assessing the impact of current community prevention programs on risk of child maltreatment fatalities.

4. Develop mechanisms to gather, analyze and track **new** information or data that may improve earlier detection of child maltreatment or risks related to child maltreatment and therefore impact (or prevent) child maltreatment fatality or near-fatality rates, such as:

(a) Utilization of pediatric health care, including

(1) Number of well child examinations

(2) Number and location (PCP office, ER, facility specializing in pediatric care) of sick visits

(3) Prior injuries, growth percentiles (weight and height), development milestones documented in medical records

(b) Utilization of day care facilities, including documented injuries or conditions concerning for physical neglect

(c) Prior contact with CPS including number of referrals and disposition of each prior referral, including:

(a) Priority None or Administrative Closure,

(b) Differential Response (call screened out),

(c) Alternative Response provided,

(d) Investigated and ruled

i. Unable to Complete,

ii. Unable to Determine,

iii. Ruled Out or

iv. Reason to Believe

ii. Disposition of "Reason-To-Believe (RTB) cases resulting in:

(a) Referral to family-based services;

(b) Inclusion of a safety plan;

(c) Services were offered to family, types of services and compliance/completion;

(d) Removal of the child

5. Develop mechanisms to gather, analyze and track **new** information or data that may improve interventions once child maltreatment is suspected and reported, including whether:

(a) Intra-agency (CPS or law enforcement) or multidisciplinary (CAC) case reviews of serious or near-fatal injuries in children 3 and under impacts re-referrals to CPS and child death rates.

(b) Services provided by CPS, such as Project HOPES and Project HIP impact (or prevent) child maltreatment fatality or near-fatality rates.

(c) Child maltreatment fatalities or near-fatalities are found to be associated with *multiple* previous CPS referrals involving any of the children in the home (as in 1ci, above).

3. Develop mechanisms to gather, analyze and track **new** information or data on whether various types of preventive services (such as parent education programs, in-home services, hospital-based programs) impact (or prevent) child maltreatment fatality and near-fatality

rates. In addition to the predictive analytic data discussed in 1c, above, data from currently existing programs for families with young children may also guide prevention strategies. There are several in-home prevention programs and parent education programs throughout Texas, some well-known and with a strong evidence base that are not services contracted by CPS. Prevention services providers typically do not know if families receiving services are referred to CPS. Developing mechanisms for tracking whether such families participating in preventive services are referred to CPS or experience a child maltreatment death would be useful in evaluating whether these programs effectively prevent child abuse and death, particularly among at-risk families.

## **Prevention Workgroup**

Madeline McClure, Chair

Dr. Jamye Coffman

Dr. Angelo Giardino

Luanne Southern

Sasha Rasco

Dr. Chris Greeley

Judge Robin Sage

### **Child Abuse Fatalities in Texas: Prevention Solutions (see Power Point presentation Tab 8 of March 27 POK Meeting Materials)**

Highlights from the presentation:

Why Texas Needs to Invest in Prevention, Texas Ranks:

32 <sup>nd</sup>	Economic Well-Being
34 <sup>th</sup>	Education
35 <sup>th</sup>	Child Abuse Fatalities
40 <sup>th</sup>	Overall Child Health
43 <sup>rd</sup>	Overall Well-Being
48 <sup>th</sup>	Teen Pregnancy
50 <sup>th</sup>	Repeat Teen Pregnancy

- Lifetime Costs of Maltreatment in TX - \$14 Billion
- Child Abuse Prevention Services:
  - Texas vs. US average (for Prevention, Texas spends a small fraction of the US state average)
  - Texas Child Abuse Costs vs. Prevention Investments
  - Prevention Funding, Adjusted for Texas Child Population Increase and Inflation (State/Local Govt. Implicit Price Deflator)

Child Fatality Prevent Framework:

*Investing in EBP “Touchstones” - Developmental Trajectory*

#### **Universal Prevention Programs: Evidence Based Practices**

- Triple P Level 1: Universal Messaging
- Period of Purple Crying / Other hospital-based post pregnancy education



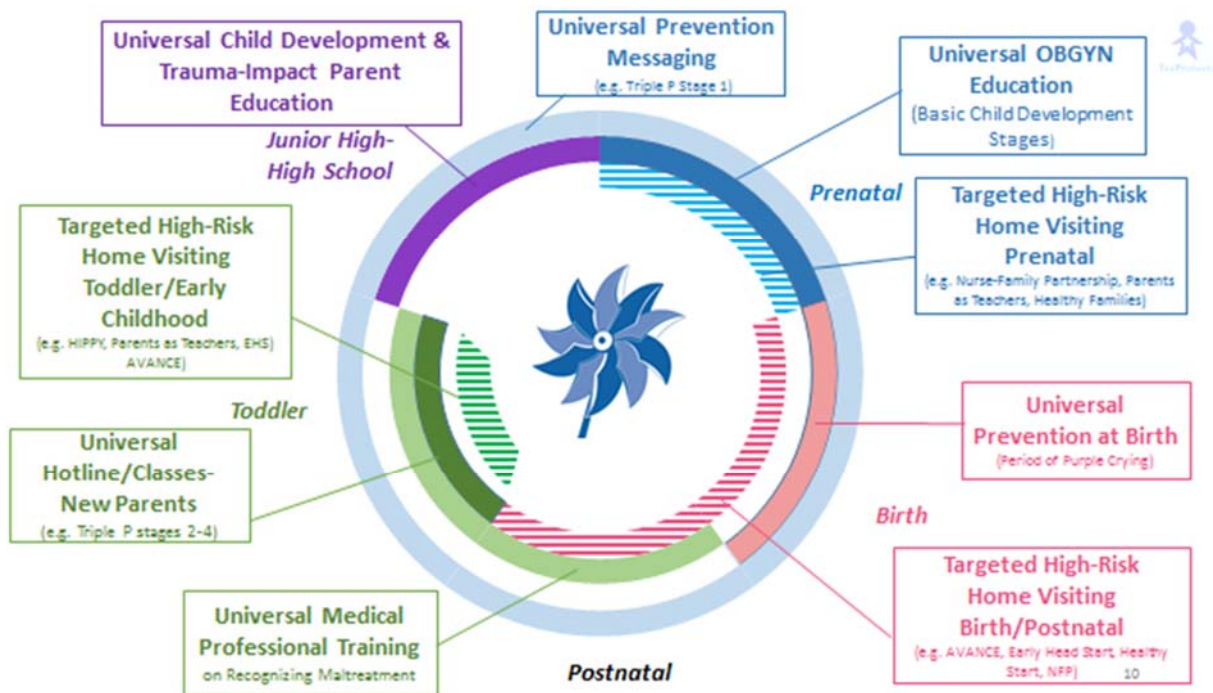
- Triple P Level 2-4: Parenting Hot-line; Seminars; Parent Education

**Universal: Promising Practices**

- Child Development Education-Ob-Gyn CME / Distribution of EBP child development materials
- Recognizing and Reporting: Pediatricians/ ER professionals (school, university and child care professionals in statute)

Child Development /Trauma-Impact Education-Junior High (permissive statute)

**TexProtects Risk Assessment & Families Served with Home Visiting**



## **Sustainability Workgroup**

Judge Robin Sage

Judge Peter Sakai

Judge F. Scott McCown

*We may not know what recommendation we want to make in terms of sustainability until we know:*

- 1) what our other recommendations are; and*
- 2) the effects of any new legislation from this session.*

*Our Commission dissolves December 31, 2015.*

Questions to consider:

- Does the specific work we are doing need to be carried on beyond that point?
- If the Commission does not continue, are there parts of the work that need to be carried on? For example, recommendations about prevention policy? How to spend funds?
- Specific things to elevate State CFRTs and give them a bigger voice?
- Sustained funding?

### **Public Comment** from James Castro, CEO St. Peter St. Joseph's Children's Home

- There is a need to respond to child mental health traumas with the same urgency as physical safety traumas.
- Child placing agencies need access to the bio family to provide the best care
  - CPAs need developmental history of child to put into context how abuse has impacted who they are today/now. This would help providers give more accurate care (example of stranger taking an unknown child to a doctor; can't answer doctor's questions b/c they don't know the child's history)
- St Peter St Joseph's expedites mental health assessments:
  - Within 3 days they gather basic knowledge of medical background
  - Within 10 days they have a clinical online assessment (child has seen necessary medical professionals – psychiatrist, psychologist, speech therapist, etc.)
  - Within 14 days they have a brain map made and use it to plan interactions and activities with child
  - Train their staff with individual care of child or provide training to foster home parent