FAILURE TO PROTECT CHILD SAFETY

HEARING

BEFORE THE

SUBCOMMITTEE ON HUMAN RESOURCES

OF THE

COMMITTEE ON WAYS AND MEANS
U.S. HOUSE OF REPRESENTATIVES

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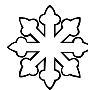

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CONTENTS

Page

Advisory of June 10, 2004, announcing the hearing 2

WITNESSES

Maryland Department of Human Resources, Hon. Christopher J. McCabe 7
Baltimore City Department of Social Services, Floyd R. Blair 10
Baltimore City Health Department, Peter Beilenson 17
University of Maryland, School of Social Work, Center for Families, Diane DePanfilis 22

SUBMISSIONS FOR THE RECORD

Cook, Theresa S., Santa Clara, CA, statement 42
Fight Crime: Invest in Kids, statement 47
Justice for Children, Eileen King, letter 50
Zero to Three: National Center for Infants, Toddlers and Families, Matthew E. Melmed, statement 51

FAILURE TO PROTECT CHILD SAFETY

THURSDAY, JUNE 17, 2004

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

The Subcommittee met, pursuant to notice, at 4:00 p.m., in room B–318, Rayburn House Office Building, Hon. Wally Herger (Chairman of the Subcommittee) presiding.

[The advisory announcing the hearing follows:]

ADVISORY

FROM THE COMMITTEE ON WAYS AND MEANS

SUBCOMMITTEE ON HUMAN RESOURCES

FOR IMMEDIATE RELEASE
June 10, 2004

CONTACT: (202) 225–1025

Herger Announces Hearing on Failure to Protect Child Safety

Congressman Wally Herger (R–CA), Chairman, Subcommittee on Human Resources of the Committee on Ways and Means, today announced that the Subcommittee will hold a hearing on a recent failure to protect child safety. **The hearing will take place on Thursday, June 17, 2004, in room B-318 Rayburn House Office Building, beginning at 4:00 p.m.**

In view of the limited time available to hear witnesses, oral testimony at this hearing will be from invited witnesses only. Witnesses will include State and local officials and outside experts familiar with the child welfare system in Baltimore, Maryland.

BACKGROUND:

News accounts have documented events leading to the recent death of twin infant girls in Baltimore, Maryland. These newborns were released to their mother, a foster care runaway previously involved with child welfare authorities. The circumstances of this tragedy have prompted numerous questions that highlight broader child welfare policy concerns: How well do government officials track children in their care and individuals previously in contact with child welfare authorities? Are child abuse cases reported and investigated promptly to ensure child safety? Are government agencies working together effectively to protect vulnerable children?

Federal taxpayers provided States with more than $7 billion in 2003 to promote safety, permanency, and well-being of children in or at risk of needing foster care. A significant share of these Federal funds support administrative costs, including systems and salaries dedicated to monitoring the well-being of children under the care of birth, foster, and adoptive parents. In recent months, the Subcommittee on Human Resources has held a series of hearings on another high-profile case involving a failure to protect children in New Jersey, as well as reporting and oversight issues that reflect on broader program trends and concerns in child welfare.

In announcing the hearing, Chairman Herger stated, "This incredibly sad situation highlights once again that the current child welfare system is ill-equipped to protect children. Such failures to ensure the safety of children are unacceptable. Federal taxpayers pay billions of dollars each year for systems and salaries designed to prevent such tragedies from happening. This hearing will examine the circumstances of this case to better inform policymakers about steps we should consider taking to better protect children."

FOCUS OF THE HEARING:

This hearing will focus on (1) the facts of a recent child welfare case in which twin infants died in Baltimore, Maryland; and (2) the implications of this case for efforts to improve the child welfare system.

DETAILS FOR SUBMISSION OF WRITTEN COMMENTS:

Please Note: Any person(s) and/or organization(s) wishing to submit for the hearing record must follow the appropriate link on the hearing page of the Committee website and complete the informational forms. From the Committee homepage, *http://waysandmeans.house.gov,* select *"108th Congress"* from the menu entitled, "*Hearing Archives*" (*http://waysandmeans.house.gov/Hearings.asp?congress=16*). Select the hearing for which you would like to submit, and click on the link entitled, *"Click here to provide a submission for the record."* Once you have followed the online instructions, completing all informational forms and clicking "submit" on the final page, an email will be sent to the address which you supply confirming your interest in providing a submission for the record. You ***MUST REPLY*** to the email and ***ATTACH*** your submission as a Word or WordPerfect document, in compliance with the formatting requirements listed below, by close of business Thursday, July 1, 2004. **Finally,** please note that due to the change in House mail policy, the U.S. Capitol Police will refuse sealed-package deliveries to all House Office Buildings. For questions, or if you encounter technical problems, please call (202) 225–1721.

FORMATTING REQUIREMENTS:

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

1. All submissions and supplementary materials must be provided in Word or WordPerfect format and MUST NOT exceed a total of 10 pages, including attachments. Witnesses and submitters are advised that the Committee relies on electronic submissions for printing the official hearing record.

2. Copies of whole documents submitted as exhibit material will not be accepted for printing. Instead, exhibit material should be referenced and quoted or paraphrased. All exhibit material not meeting these specifications will be maintained in the Committee files for review and use by the Committee.

3. All submissions must include a list of all clients, persons, and/or organizations on whose behalf the witness appears. A supplemental sheet must accompany each submission listing the name, company, address, telephone and fax numbers of each witness.

Note: All Committee advisories and news releases are available on the World Wide Web at *http://waysandmeans.house.gov*.

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

Chairman HERGER. Today's hearing focuses on a child welfare tragedy, the death of twin infant girls in Baltimore last month. I want to thank Mr. Cardin for suggesting this hearing as a continuation of our review of how child welfare systems are failing to protect children. Our purpose this afternoon is to understand what happened in this case so we do all we can to keep it from happening again in Baltimore and elsewhere. We welcome our guests from the State of Maryland and the city of Baltimore child welfare agencies. We also are pleased to be joined by the Baltimore City Commissioner of Health, who will discuss issues raised by the death of these 1-month-old girls. Finally, we welcome another ex-

pert and long-time observer of child welfare issues in Maryland who will place this case in context for us.

This Subcommittee has held several hearings recently to investigate the Nation's child welfare programs. We explored a disturbing case involving four adopted boys in New Jersey who were starved in their home, we reviewed Federal and State oversight measures designed to determine if local officials are doing all that is necessary to protect children, and we heard about Federal reviews of State child welfare programs. Unfortunately, what we learned was that not one State has passed their review.

Tragedies such as this case can happen in any neighborhood. Regretfully, the evidence we have seen shows that abuse cases, such as the one before us today, have occurred in every State. Since November, this Subcommittee has heard testimony from more than 30 individuals. We have received numerous e-mails, phone calls, and submissions for the record that highlight problems and concerns. What we have learned is that the current system is ill-equipped to protect vulnerable children.

The case we will examine today highlights where life-and-death decisions are made for these children, in homes, offices, courts, and hospitals across the country. With one more call, one more question, or one more background check, two little girls in Baltimore might be alive. We owe it to them and the other children who die each year to understand what went wrong so we can work with local officials to prevent such tragedies from happening again. No policy is or will be perfect, but we can all agree that what is occurring today in our country's child welfare programs is simply unacceptable and must change. Without objection, each Member will have the opportunity to submit a written statement and have it included in the record at this point. Mr. Cardin, would you like to make an opening statement?

[The opening statement of Chairman Herger follows:]

Opening Statement of The Honorable Wally Herger, Chairman, and a Representative from the State of California

Today's hearing focuses on a child welfare tragedy—the death of twin infant girls in Baltimore last month. I want to thank Mr. Cardin for suggesting this hearing as a continuation of our review of how child welfare systems are failing to protect children.

Our purpose this afternoon is to understand what happened in this case, so we do all we can to keep it from happening again in Baltimore and elsewhere.

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- We explored a disturbing case involving four adopted boys in New Jersey who were starved in their home.
- We reviewed federal and state oversight measures designed to determine if local officials are doing all that is necessary to protect children.
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The case we will examine today highlights where life and death decisions are made for these children—in homes, offices, courts, and hospitals across the country. With one more phone call, one more question, or one more background check, two little girls in Baltimore might still be alive.

We owe it to them and the other children who die each year to understand what went wrong, so we can work with local officials to prevent such tragedies from happening again.

No policy is or will be perfect. But we can all agree that what is occurring today in our country's child welfare programs is simply unacceptable, and must change.

Mr. CARDIN. Thank you, Mr. Chairman. First, let me thank you for calling this hearing so quickly in response to the shocking events that took place in Baltimore. I thank you for your continued commitment on this subject. As you pointed out, this is not the first hearing we have held in regards to the child welfare system. We have had several. The problems we see in Baltimore are not just in Baltimore, they are throughout the entire Nation. I thank you very much for your continued commitment and the commitment of this Subcommittee regarding the welfare of our children, our most vulnerable children that are in the child welfare system.

This hearing is being called because of the tragic loss of the death of twins in Baltimore, the Swann twins, that illustrate a system that is clearly failing the very children whom it is designed to protect. When we talk about the twins' case, I am not interested in accusations or political maneuvering. The safety of vulnerable children in our society is just too important, and we need to have answers as to what we can do to protect these children. I expect to hear today from our witnesses clear and concise suggestions on how to prevent such tragedies in the future. In short, we want results.

Mrs. Johnson, at one of our prior hearings, expressed, I think, the frustration of our Subcommittee; that we want to protect these children, and we want to find out how we can do it. We know we have to change our system, and we want specific recommendations. Only one thing is more tragic and more horrific than a child being beaten to death, and that is when the deadly abuse occurs after a variety of warnings signs that should have told us that there was a problem and we should have prevented this.

That is exactly what happened in Baltimore. On May 11, 1-month-old twin girls died after having their skulls and ribs fractured after being severely malnourished. The 17-year-old mother of these children, Sierra Swann, was a foster care runaway with a known drug problem who had another daughter recently removed from her custody because of a confirmed case of abuse and neglect, and yet she was still allowed to leave the hospital with twins after a hospital caseworker contacted the Department of Social Services (DSS) to inquire as to whether there was an open case or whether there was a concern for the mother.

There were all types of signs that this mother had problems, and the hospital worker did what she thought was right in contacting the DSS. Social Services indicated that there was no open case

with the agency. As a result, the mother left the hospital for a vacant basement with no electricity or running water. I don't know how many more signs could have been given that we had a problem here, and yet the children were lost because we did not respond.

Mr. Chairman, legally the parents of a child in foster care is the State. We are the parents. We are the ones who have responsibility, and we failed in that responsibility. As a result of failing a responsibility for our child, our grandchildren died. It is unacceptable. Unfortunately, this is not an isolated incident in Baltimore. For example, a year and a half ago a 2-month-old baby was beaten to death by a mother with a psychiatric problem who was still on probation for abusing her first son. This tragedy occurred after Child Protective Services (CPS) was informed that the baby was in danger because its mother was failing to take her medication.

Our past hearings, press reports from around the country, and Federal review of every State child welfare system suggests that Baltimore is not alone in failing to adequately protect their children. In fact, as you pointed out, Mr. Chairman, not one State in the Nation has passed all of the child well-being standards assessed by the Federal review process. Unfortunately, my own State of Maryland has failed in the seven measures that we use for child safety. That, obviously, is totally unacceptable. It is time, in fact it is past time, for action. We must take steps now to make sure that what happened in Baltimore never again happens anywhere in the Nation.

We need to do more at the Federal level, and, Mr. Chairman, I am encouraged by our discussions as we are looking at legislation in order to modernize the Federal child welfare issues, and I am hoping that we can pass some legislation at the Federal level in order to help our States, and if a few foundations come up with recommendations, we are going to look at that, but regardless what we do at the Federal level, immediate steps must be taken by our States to protect our children.

Therefore, I reiterate my request from the beginning. We want to know what can be done at the State level to protect our children today. I hope and expect the DSS will implement the necessary reforms quickly in order to protect our children. The lives of our children literally are on the line, and the cost of inaction is way too high. I look forward to hearing our witnesses in an effort that we make sure this never happens again.

Chairman HERGER. Thank you, Mr. Cardin. Before we move to our testimony, I want to remind our witnesses to limit their oral statements to 5 minutes. However, without objection, all of the written testimony will be made a part of the permanent record. This afternoon we will be hearing from Christopher McCabe, Secretary of the Maryland Department of Human Resources (DHR); Floyd Blair, Interim Director of the Baltimore City DSS; Dr. Peter Beilenson, Baltimore City Commissioner of Health, who is also the son of a former Member of Congress from my home State of California, Tony Beilenson; and Dr. Diane DePanfilis, Co-Director of the Center For Families at the University of Maryland School of Social Work. Mr. McCabe to testify.

STATEMENT OF HON. CHRISTOPHER J. MCCABE, SECRETARY, MARYLAND DEPARTMENT OF HUMAN RESOURCES, BALTIMORE, MARYLAND

Mr. MCCABE. Thank you, Mr. Chairman and Congressman Cardin, Congressman Camp, and Members and staff of the Subcommittee. Thank you for the opportunity to be with you again and to share perspectives on Maryland's child welfare challenges together with this very distinguished panel. We at the State level rely on partners to assist us in protecting children. Indeed, our work often begins after a child is referred to us from schools, hospitals, churches, or law enforcement in the community. We are then responsible to investigate these cases and take all appropriate actions.

Governor Ehrlich and I are grateful for your interest in support of human service issues and for the funding that is appropriated by Congress for these purposes. These issues are not glamorous, but are at times literally, as Congressman Cardin said, a matter of life or death. Just 1 month ago, I testified before you regarding the Child and Family Services Review (CFSR) process. Since then Maryland has received the final report from the Federal Government. The study found that Maryland was in substantial conformity with Federal standards in some areas, but did not meet Federal standards in others. The DHR has formed six Committees made up of agency employees and outside advocates to recommend a program improvement plan to meet Federal standards.

While the CFSR provides our State and every State a baseline from which to make systemic improvements in the practice of child welfare, on a daily basis our local agencies still face the stress of critical and difficult cases that test the capability of protecting children in at-risk situations. One of those such cases occurred in Baltimore City in May of 2004, which is also the subject of this afternoon's hearing. It has also been the subject of much angst within our local and central offices on what actions might have been done differently not just by our local agency, but a number of the partners in child protection. We do not do it alone. The Sierra Swann case is both sad and tragic. While limited under law regarding what can be said related to an ongoing criminal case, I can say that Sierra Swann was known by our local DSS in Baltimore City. Her case file alone measures 5 inches. News accounts revealed some but not all the pertinent history of the case.

Sierra Swann was a teenage runaway from a Baltimore City foster family. Her status as a runaway made the challenge of keeping a safety net for her only more difficult. In my observations, it is not uncommon that teenagers who have been in foster care for many years run away from the system that purportedly is there to help them. The majority of these individuals come back to their foster homes because they learn that the alternatives that they are facing are not acceptable. Sierra chose not to take this course.

When this case became known, we acted aggressively to determine what indeed had happened both internally, as far as the department's response, and externally with the hospital and within the community. Very specific changes are being made as a result of our investigation. I will let Director Blair speak about specifics, but I can tell you that one of the changes we are immediately mak-

ing is in the way critical communication is received and handled. Not only are we providing intensive training for our internal workers on how to field these child protective calls, and when to refer them to experts or up the chain, we will be working with sister agencies and community partners, again, schools, hospitals, churches, to explain our processes. In addition, the department has delivered a package of safety-related proposals, legislative proposals, that I will be sharing with Governor Ehrlich in the weeks ahead for possible legislative action in the 2005 legislative session in the Maryland General Assembly.

One systemic improvement that we are very aggressively trying to implement involves better and more timely information technology. A key component of improving information sharing is to bring our automated child welfare computer system, MD CHESSIE, to the desk of each child welfare worker in the city and across the State. You all help provide the funding for that system. Immediately after becoming Secretary of the department, I recognized our current child welfare computer system is minimally adequate and largely disjointed. Currently, among Maryland's 24 local jurisdictions, there are several partially automated child welfare tracking systems, none of which communicate across platforms. Though some of these systems are adequate for local needs, the major problem is they are not standardized statewide, and our largest jurisdictions, in particular Baltimore City, struggle most with this disparity.

Maryland's statewide automated child welfare information system (SACWIS) is still 2 years away, but we are committed to an early release of the child intake module. I'll repeat, are committed to the early release of the child intake module, and Baltimore City will be one of those jurisdictions. Other workers, their supervisors, and our executive staff deserve this 21st century tool to do their difficult jobs. The central offices and Baltimore City DSS are learning from the Sierra Swann case, as we do endeavor in each case. As we implement changes to fill gaps in our own system, we would expect our partners in child protection, hospitals, public health department, and others, to evaluate their own processes and to do the same. In turn, we all need to communicate with each other of our respective improvement plans.

In conclusion, will the improvements I have just mentioned and those that Mr. Blair will outline prevent the future deaths of children in cases similar to Sierra Swann's children? I cannot make that guarantee. Will it help reduce the likelihood that an incident like this will happen in the future? I believe so, and I am committed to doing what I can to do so. Thank you for your time and attention to this very serious matter, and I am prepared to answer your questions at the appropriate time. Thank you, Mr. Chairman.

[The prepared statement of Mr. McCabe follows:]

Statement of The Honorable Christopher J. McCabe, Secretary, Maryland Department of Human Resources, Baltimore, Maryland

Dear Mr. Chairman and Members of the Committee:

Just one month ago, I testified before you regarding the child and family services review process. Since then, Maryland has received the final report by the federal government.

The study found that Maryland was in substantial conformity with federal standards in training its workers, responding to the community, and licensing, recruiting and retaining foster and adoptive parents.

However, our State did not meet federal standards in several other categories, including an adequate statewide information technology system for child welfare and the number of children in foster care reunited with their parents.

The Department of Human Resources has formed six committees, made up of agency employees and outside advocates, to recommend a program improvement plan to meet federal standards.

While the child and family services review provides our state—and every state—a baseline from which to make systemic improvements in the practice of child welfare, on a daily basis, our local agencies still face the stress of critical and difficult cases that test the capability of protecting children in an at risk situation.

One of those such cases occurred in Baltimore City in May 2004, which is the subject of this afternoon's hearing. It has also been the subject of much angst within our local and central offices on what actions might have been done differently, not just by our local agency, but a number of "partners" in child protection.

The Sierra Swann case is sad and tragic. While I am limited under law regarding what can be said related to an ongoing criminal case, I can say that Sierra Swann was known by our local Department of Social Services in Baltimore City. Her case file alone measures five inches.

As news accounts revealed, Sierra was a teenage runaway from a foster family, licensed by the Department of Social Services, which made the challenge of keeping a safety net for her only more difficult.

When this case became known, we acted aggressively to determine what indeed had happened both internally as far as the Department's response and externally with the hospital and within the community. Very specific changes will be made as a result of our investigation, some of which were in process, but due to this tragedy, were suddenly propelled to a new level of intensity.

I will let Director Blair speak about specifics but I can tell you one of the changes we have made immediately is in the way incoming calls are handled. Not only are we training internal workers on how to take calls and when to refer them to the experts, but we will be working with sister agencies and community partners—schools, hospitals, churches—to explain our process.

We all have to be partners, working together as effectively as possible. The job is tough enough already and if we are not working together, tragic things like this can happen, as it does in other states.

One systemic improvement involves better and more timely communication. This is an ever present goal of the Administration. A key component of that improved communication is to bring our automated child welfare computer system, MD CHESSIE, to the desk of our child welfare workers.

Immediately after becoming Secretary of the Department, I recognized our current child welfare computer system as inadequate and disjointed. Currently, among the 24 local jurisdictions there are several partially automated child welfare tracking systems, none of which communicate across platforms. All DHR child welfare systems are predominantly paper based. Though some of these systems are adequate, the major problem is that they are not standardized statewide. Our larger jurisdictions struggle the most with this disparity.

Governor Ehrlich, Lieutenant Governor Steele, and I have made demonstrable and substantial commitments to providing Baltimore City Department of Social Services with the leadership, structure, and resources to effectively and efficiently serve the most vulnerable citizens of Baltimore City. We do this in the context of a statewide human services system in need of additional staffing resources and training needs, to mention a few.

In Baltimore City, we are committed that any reform we undertake will be data-driven and research-based, family—focused and strength-based, as well as based on interagency coordination.

Perhaps a little history is helpful in understanding the magnitude of these commitments.

- Soon after I was appointed Secretary, it became apparent that the Baltimore City Department was struggling under a great many management challenges.
- BCDSS had been operated under a federal consent decree, *lj vs. Massinga,* since 1989.
- Sixty to sixty-five percent of our total client needs for the entire state reside within the boarders of Baltimore City. The sheer size of the need in Baltimore has a disproportional impact on Maryland's success or failure.

For example, the overall span of control for its director was enormous:

- The local agency employs approximately 2,400 staff members.
- It manages 22 facilities spread across the city, touching nearly every community.
- The agency has high caseloads in its many programs, serving families literally from cradle to grave.
- Some facilities were found below par in terms of cleanliness and healthfulness.
- Equipment needs were manifest, with communication seriously impaired from an aging telephone system that frequently failed at various sites and did not even provide many staff members with voice mail. A significant number of staff members were without computers and thus without e-mail or internet access to do their work.

With Governor Ehrlich's support and that of the Maryland General Assembly, the Department of Human Resources undertook an extensive investment of time, funds, personnel and other resources to bring Baltimore City Department of Social Services into the twenty-first century.

- With four million dollars committed by the legislature, we are implementing a full upgrade of the outdated analog telephone system with a digital system, which on completion will provide voice mail throughout the 22 BCDSS work sites, as well as conferencing and transfer capability.
- We installed one thousand computers previously ordered but never delivered to staff.
- We invested significant resources in performing or negotiating with our landlords overdue repairs and renovations of facilities that were not providing a suitable work environment.
- We are investing in replacement of aging and nonfunctioning basic equipment staff members need to do their jobs, like copiers and printers.
- And most important, we have added fifty new state employees. Thirty-five of them are in child welfare to help make caseloads manageable at ninety percent of CWLA standards.

In addition to these immediate steps, however, we began a careful and critical examination in the child welfare system. We determined that, while no one model in its entirety seemed appropriate for BaltimoreCity, we needed to transform Baltimore City Department of Social Services to provide:

- Seamless service delivery (i.e., one-stop shops),
- An interdisciplinary team approach,
- Focus on Baltimore's communities,
- Strong interagency collaboration, and
- Data-driven and outcomes-based service delivery.

We are instituting a regional service delivery system co-locating services that serve the same clients so that they can find a variety of needed services across the hall rather than across town.

Thank you again for the opportunity to provide these updates. Mr. Blair will provide additional details.

Chairman HERGER. Thank you, Secretary McCabe. Now, Director Blair to testify.

STATEMENT OF FLOYD R. BLAIR, INTERIM DIRECTOR, BALTIMORE CITY DEPARTMENT OF SOCIAL SERVICES, BALTIMORE, MARYLAND

Mr. BLAIR. Good afternoon, Mr. Chairman and Members of the Committee. I am Floyd R. Blair, Interim Director of the Baltimore City DSS, the largest social services agency in Maryland. I am honored and pleased to speak before you today and provide an update about current progress on child welfare services in Baltimore City and improvements to its service delivery system. Baltimore is a wonderful city, yet at times it is a violent place. Unfortunately, this is not uncommon in large urban areas. Families in urban areas frequently face a multitude of issues: violence, substance abuse, men-

tal health issues, high unemployment, and a lack of family and community resources. Given this environment, children are often at risk, even in danger, while in the care of their own parents. It is a heart-wrenching for our workers to get a call to remove a child from a home where abuse and severe neglect compromise that child's safety and security. The home the child has known as his or hers, that safe place, in fact, is not, and out of necessity the child is uprooted, the family torn apart. On the average, our workers remove about 100 children per month from their families in Baltimore City.

When a child dies, it is a tragedy, and it is unacceptable. We have undertaken a serious, comprehensive review of the Sierra Swann case, reviewing not only the immediate circumstances of the case that eventually ended in the tragic deaths of the twins, but also a review of the case involving this teen mother since she first came to the attention of the department. Both processes are equally important to the continued improvement of our current system.

I will explain some of the facts we have found in our investigation. Prior to public reports, there was a previous report of child abuse against Ms. Swann. An older child had been removed from her care in October 2003. Once a child is removed from a parent's home and placed into foster care, that protective service case is considered closed, not active. It becomes an active foster care case and continues to be monitored by the foster care caseworker. It was also reported that Ms. Swann was a runaway from the State foster care system with an outstanding warrant for her to return to foster care.

Ms. Swann, already in labor, was taken to Johns Hopkins Hospital, where she delivered twins. A Johns Hopkins social worker attending to Ms. Swann called the number normally used by internal DSS staff and asked the clerk if Ms. Swann had an active child abuse case. After checking the appropriate data screen, the clerk answered no, which was an accurate answer. The social worker from the hospital did not ask any further questions about prior cases regarding Sierra Swann. This call was made to a clerk, not a screener. A screener is trained to go beyond the question that was initially asked by the person from Johns Hopkins.

When someone calls in to report suspected abuse or neglect, our screen unit takes the call. It is our standard operating procedure to do an intensive review of all such calls. Based on our review of the Swann case, we are implementing not only some immediate plans, but also systemic changes which have become part of our overall improvement plan, a copy of which you should have before you entitled, The Baltimore City DSS Systemic Improvements.

In the Swann case, we developed an action plan, and some of these are the key actions: all calls reporting maltreatment are now routed through a central number where trained screeners can access all available information on a case. We are implementing a written protocol for all staff who take outside calls, detailing how and when to refer appropriate calls to the appropriate staff who can give comprehensive information to qualified verified callers. We are implementing a runaway risk alert feature on all screens. We have a priority list of cases needing response within 1 hour. Today, staff have initiated contact with our outside partners through writ-

ten and verbal directives detailing our processes, educating our partners, hospitals, schools, et cetera, on the current and future protocol and procedures. We plan to convene face-to-face training with our community partners to reinforce our processes. We have added staff to our screening unit to ensure calls are answered timely and properly. On July 1st, we are enhancing our 24-hour, 7-day-per-week CPS hotline. Twenty positions have been added to work nights, weekends, and holidays. We need all of our advocates, community resources, public officials, neighbors, experts in the health care system, school systems, everyone to create a positive partnership to help us ensure that services are provided through a coordinated, unified system, so that a tragedy like this never happens again. I want to thank you for the time.

[The prepared statement of Mr. Blair follows:]

Statement of Floyd Blair, Interim Director, Baltimore City Department of Social Services, Baltimore, Maryland

- Good afternoon, Mr. Chairman and members of the committee. I am Floyd R. Blair, Interim Director of the Baltimore City Department of Social Services (BCDSS), the largest social services agency of the Maryland Department of Human Resources (DHR). I am honored and pleased to speak before you today to provide an update about our current progress on ensuring child safety and improving child welfare service delivery in Baltimore city.
- When speaking to parents about children, a famous children's television personality, Mr. Fred Rogers, said: "*the roots of a child's ability to cope and thrive, regardless of circumstance, lie in that child's having at least a small, safe place . . . (an apartment? A room? A lap?) Where, in the companionship of a loving person, that child could discover that he or she is lovable and capable of loving in return.*"
- This quote sums up for me, the fact that the most important aspect of a child's life is the security of a safe place. When children enter our care it is our priority to provide that safe place for those that have been abused or neglected.
- Specifically, I will be briefing you on a recent child welfare case you indicate is of special concern.
- Protecting children who are in the care of social services is one of the primary responsibilities of this administration.
- Governor Ehrlich, Secretary McCabe and I are committed to improving services in Baltimore city. Baltimore is a wonderful city, yet at times it is a violent place. Unfortunately, this is not uncommon in large urban areas.
- Families in urban areas frequently face a multitude of issues—violence, substance abuse, mental health issues, high unemployment and a lack of family and community resources. Given this environment, children are often at risk, even in danger while in the care of their own parents.
- Once the local department is involved with a family, we have an opportunity to begin to help that family address many of these difficult issues. Our staff work tirelessly under very strenuous conditions with limited resources, to try to make a difference in the lives of these citizens.
- I cannot say to you that all our workers are always giving 150%—I don't think anyone in management can say that with assurance. But what I can say is that these exceptionally dedicated men and women save lives every day. In fact, the final report of the recent federal child and family services review indicates that on its safety outcome 1, ensuring that children are first and foremost protected from abuse and neglect, the outcome was determined to be substantially achieved in 100% of Baltimore city cases reviewed.
- It is heart-wrenching for our workers to get a call to remove a child from a home where abuse and severe neglect compromise that child's safety and security—the home that child has known as his/her "safe place" in fact isn't—and out of necessity, the child is uprooted, the family torn apart.
- Our staff are trained to make those tough decisions—to remove a child from his/her parent's home when it is determined to be in the child's best interest.
- On average, our workers remove about 100 children per month from their families in Baltimore city.
- When a child dies **it is a tragedy**—and even more so when the department has previously intervened in an attempt to stabilize the family.

- Federal and state laws place certain restrictions on the department concerning case confidentiality. While this of course protects the families and children involved, it also limits what we might like to say to those who share our concern, particularly following a child fatality.
- Given the importance of recent events, I will share as much as I can in an effort to assure you that BCDSS and DHR have undertaken a serious, comprehensive review of the Sierra Swann case, reviewing not only the immediate circumstances of the events that eventually ended in the tragic deaths of the twins, but also the case involving this teen mother since she first came to the attention of the department. Both processes are equally important to the continued improvement of our current system.
- To better understand our role, the role of the hospital and others involved, we tracked the chronology of events in this case. It is important for us first to identify any gaps in service or procedure so that we may prescribe the proper remedies.
- I will explain some of the facts we found in our investigation.
- Prior to public reports, there was a previous report of child abuse against ms. Swann. An older child had been removed from her care in October 2003.
- Once a child is removed from a parent's home and placed into foster care, that protective service case is considered closed—not active.
- It was also reported that ms. Swann was a runaway from the state foster care system with an outstanding warrant for her to return to foster care.
- Ms. Swann, already in labor, was taken to Johns Hopkins hospital, where she delivered twins.
- The Johns Hopkins social worker attending to Ms. Swann, called a number normally used by internal DSS staff, and asked a clerk if ms. Swann had an "active" or "open" child abuse case. After checking the appropriate data screen, the clerk answered "no", which was an accurate answer. As I previously stated, once a child is removed from the parent's care and placed in foster care, the case is closed—and not active.
- The social worker from Hopkins did not ask any further questions about prior cases regarding Sierra Swann. This call was made to a clerk, not a screener. A screener is trained to go beyond the question asked.
- It was recently reported that sierra was charged, along with live-in boyfriend, Nathaniel Broadway, with the murder of their newborn twins.
- I would like to describe some of the standard operating procedures we follow after a fatality so you will know what DHR and BCDSS have done to address incidents surrounding the Swann case in particular.
- When someone calls in to report suspected abuse or neglect, our screening unit takes the call. It is our standard operating procedure to do an intensive review of all such calls.
- Based on our review of the Swann/Broadway case, we are implementing not only some immediate plans, but also systemic changes which have become part of our overall improvement plan—a copy of which is attached as "document a:BCDSS systemic improvements."
- BCDSS has begun to initiate process improvements. I wish I could say we always do everything right. It is frustrating that change is slow even when we put forth our best efforts. But we are making progress.
- In the Swann case, we completed a risk analysis and developed an action plan of systemic issues that we agree need to be addressed. They are:

    1. Implementation of a centralized number—all calls reporting maltreatment will go through a central number where trained screeners can access all available information on a case;
    2. Development of a written protocol—any general staff who take outside calls will be trained in how and when to refer calls to appropriate staff who can give comprehensive information to qualified/verified callers;
    3. Initiation of an alert feature—we will initiate runaway/high risk alerts on all screens;
    4. Revision of priority list of cases needing response within 1 hour to elevate the most urgent;
    5. Education of partners (hospitals/schools etc.) On protocol, procedures; and
    6. Addition of staff in screening units to ensure calls are answered timely and properly.

- We need all of our advocates, community resources, public officials, neighbors, experts in the health care system, school systems—everyone—to create positive partnerships—to help us ensure that services are provided through a coordinated, unified system.

- I met recently with charlie cooper, administrator for the citizens review board in Maryland. We discussed the combined recommendations that the child protection panels, the city child fatality review team, and citizens review board for Baltimore city have made for improvements to our agency.
- We have shared that information with internal BCDSS work groups which will be making recommendations for the redesign of our service delivery system.
- We are open to an ongoing dialogue with all stakeholders as we continue this process.
- We have incorporated some of the plans that a work group headed by Baltimore's health commissioner, Dr. Peter Beilenson, recommended—some I am pleased to say we had already identified in our internal workgroups. Others are under consideration.
- Our BCDSS mission is:

  To protect vulnerable children and adults,
  To preserve families, and
  To promote self sufficiency

- In support of our mission, here is what we are doing now:
  1. On July 1st we will enhance our 24 hours—7 days per week child protection service hotline.
  2. Twenty positions will be added to work nights, weekends, and holidays.
  3. A family preservation component will be initiated in the same unit to help children stay in their homes and keep families together when it is safe to do so.
  4. We have added sixty new positions to our family investment and family services programs through the support of Governor Ehrlich and Secretary McCabe.
  5. Caseload ratios will significantly decrease in our family services program (1:20) when all positions are filled.
  6. All family services staff have been issued personal digital assistant equipment to assist our workers in the field with proper reporting and follow up.
- We will continue to seek creative ways to work smarter and more efficiently with the resources that we have. It is our plan for the city's department of social services to be more user-friendly and full-service oriented.
- We can make a difference in the lives of Baltimore's most vulnerable families and children by working in a coordinated fashion with our community partners and sister agencies.
- Thank you for your commitment, involvement, and support as we move forward on this journey to excellence.

DOCUMENT A: Baltimore City Department of Social Services

Systemic Improvements

Problem/Barrier	Action Steps	Persons Responsible	Target Dates
1) Multiple Contact Numbers • CPS Intake • Central Intake (Family Support) • Adult Services • Information and Referral	*Immediate:* • All calls regarding child maltreatment go to 410–361–2235. Decisions of what constitutes abuse or neglect are the statutory responsibility of the Department. • Inform callers that their information is accepted for investigation (if screened in) and that they will receive acknowledgement letter with assigned worker's name	A.Towns, L. Williams	July 1, 2004

Systemic Improvements—Continued

Problem/Barrier	Action Steps	Persons Responsible	Target Dates
	• For 3–5 days, have clerical staff who answer 410–361–4033, keep a log of calls for information, data to assist in how to cease the inappropriate use of that number	L. Williams, M. Gordon	July 15, 2004 October 1, 2004
	Longer term: • Seek guidance from Legal to develop guidelines for appropriate use of the 4033 number • Incorporate in design of new phone system to be operational 10/01/04 • Determine feasibility of establishing a central "call center" for all calls	A. Towns, L. Williams	October 1, 2004
2) Two Data Systems (Client Information System and SADIE)	*Immediate:* • Continue current practice of clearing both systems on new referrals for investigation • Information to be given out from either system to be determined after protocol (in 1 above) developed	L. Williams and Staff	Current July 15, 2004
	Longer Term: • MD CHESSIE will provide complete data search (including CIS information)	DHR/OTHS	2006
3) No easily useable alert system for high risk situation (runaways, child abductions, etc)	*Immediate:* • Determine feasibility of using cross-bureau (that is, all programs including Family Investment) alert procedure developed by CPI Team	C. Henry, A. Towns, Holmes A.	July 1, 2004
	• Determine feasibility of using either CIS or SADIE for alerts	A. Holmes	July 1, 2004
	Longer Term: • MD CHESSIE has alert functionality	DHR/OTHS	2006

Systemic Improvements—Continued

Problem/Barrier	Action Steps	Persons Responsible	Target Dates
4) Priority Protocol needs refining to better identify cases needing immediate response	*Immediate:* • Review and revise the list and definitions to appropriately identify those cases needing 1 hour response	J. Smith, L. Williams	July 15, 2004
5) Limited services provided outside of the "normal" workday (that is, 8–5,M–F)	*Immediate:* • Continue plans for implementation of Extended Hours PLUS (full service Intake, including Family Preservation services) 24/7 • Insure case data availability for after-hours decision-making	F. Blair, C. Henry, A. Towns, L. Williams, A. Cobb A. Holmes	July 1, 2004 Aug. 2004
6) Partnerships need renewal for better collaboration	*Immediate:* • Develop schedule to meet with partners to re-iterate commitment to collaboration *Longer Term:* • Plan with them for regular follow-up to keep the communication open	J. Smith, L. Williams L. Williams	July 1, 2004 August 1, 2004
7) Training for staff and educational awareness for stakeholders needs to be updated	*Immediate:* • Develop training plan for all staff • Educate stakeholders in protocols that affect them *Longer Term:* • Build in regular updates	J. Smith, L. Williams, TSD L. Williams and Staff L. Williams and Staff	July 15, 2004 August 1–15, 2004 September 1, 2004
8) Staffing is not sufficient	*Immediate:* • 4 new PINS added to Screening • Additional needs to be identified • Replacement staffing plan needed for those positions where the incumbents are transferring to Extended Hours	E. Seale, C. Henry, A. Towns, L. Williams C. McCabe, F. Blair	July 1, 2004 June 15, 2004 July 1, 2004

Systemic Improvements—Continued

Problem/Barrier	Action Steps	Persons Responsible	Target Dates
	Longer Term: • Continue to evaluate needs as well as necessary staffing or workload shifts as program improvements are made		On-going
9) Case review process needs to continue	*Immediate:* • Continue to use the Quick Response Team staffings to evaluate case work and identify gaps	C. Henry, A. Towns Public Information	On-going
	Longer Term: • Evaluate the Quality Assurance process for changes to improve effectiveness	C. Henry, A. Cobb, A. Towns	Oct. 2004

Chairman HERGER. Thank you, Director Blair. Dr. Beilenson to testify.

STATEMENT OF PETER BEILENSON, COMMISSIONER, BALTIMORE CITY HEALTH DEPARTMENT

Dr. BEILENSON. Thank you, Mr. Chairman, and fellow Californian; and Mr. Cardin, fellow Marylander; and, Mr. McDermott, good to see you again, sir; Mr. Camp and staff. I am the City Health Commissioner, and so people have been asking why am I involved with this, the answer to that I will get to briefly, but I was Chair of a Committee that made recommendations, specific recommendations, on how to improve the child protective system both in Baltimore and in the State. We got to that point because I am Chair of the Child Fatality Review Committee in Baltimore. By statute, the health officer of each county is required to Chair the Child Fatality Review Committee. That Committee is charged with reviewing cases of unexpected childhood deaths and looking for themes and ways that can change those sort of things.

In Baltimore City, there are three major causes of unexpected childhood death: one, sudden unexplained death in infancy. A lot of that was due to co-sleeping cases with parents. We made public education and press conferences to let parents know about trying to avoid that. Second, were juvenile homicides. We set up a project, and Congressman Cardin has probably heard of it, called Operation Safe Kids, where we intensively case-manage the kids that are most at risk for shooting or being shot. The third major cause of unexpected childhood death are child abuse cases. There are two basic patterns of child abuse death cases in the city and, I would presume, around the country as well. Pattern number one: kid is neglected or abused. I will use mom, but it can be obviously mom or dad. Temporarily removed from the family, returned to mom, in-

appropriately we believe. Kid is killed by mom. I will talk about the recommendations we made for that pattern.

The second pattern, the one of the Swann case, is kid abused or neglected so severely that they are permanently removed from the family. As you heard from Mr. Blair, CPS closes the case; closes the case because there is no child to protect anymore, and those moms go on, almost inevitably, because they are all at reproductive age, to have another child within several months or a year or 2 years. As is the case here, it was actually a few months after the permanent removal. No one is following that mom from CPS. So, they are not offered contraceptive services, they are not offered mental health services, substance abuse services. That mom has another child who is at tremendous risk for neglect or abuse and is killed.

So we, in January, made recommendations that were forwarded to the State and to the city DSS on concrete things that we can do, we think, most of which are cost-neutral. Most of these do not cost money. I have attached them to my testimony. I am not going to go through all of them. I am only to go through a few that I thought might have some implication on a national level, or were so directly related to this case that I wanted to mention them.

First of all, improving the CPS Call Center. It has not changed. I am now, thanks to press coverage, getting a lot of calls from people who are reporting to me child abuse cases. I, in fact, called Baltimore County DSS, not us, a different DSS, and happened to know in a case that was reported to me that there had been five previous children removed, case closed, case closed, case closed, case closed; no services offered. A new kid has been born to this mom. There is now worry of abuse or neglect from the community. I call in and am only told by the person who answers the correct hotline, the correct hotline, because I did call the correct hotline, they did not tell me there had been previous cases. So, that had not changed.

We think, in terms of the temporarily removed kids, very specific team approaches need to be made. Team approach decisions need to be made as to when to return a kid. Far too many cases, and Congressman Cardin didn't mention the litany of cases that we have had of temporarily removed kids that are then returned to mom because they simply had parenting classes; because one social worker and, potentially, a supervisor made a decision to return the kid to mom, when there is all evidence to the contrary that that child should be returned to the mom. A team approach, multidisciplinary, should be instituted. I know it is talked about, but it is rarely done.

One of the biggest problems is there is a lack of caseworkers because, and, therefore, too high caseloads, because funding is a problem. You have to streamline the process by which caseworkers go to court. I don't know if the Congressman has been to juvenile court in Baltimore City, but it is chaotic, to say the very least. An immense amount of time is wasted by caseworkers just waiting around for cases that often just get postponed. Similarly, to keep judges involved and keep cases followed, just like you want to keep CPS involved with cases, it should be a one-judge, one-family setup. That has nothing to do with DSS or DHR, but it is something the court should be looking at.

Finally, as you can probably guess from my comments, it is, I would say, insane, it makes no sense, that when the child has been permanently removed from a family, that CPS case should not be closed. In fact, it should be stepped up, the kind of coverage for that family that needs to go forward. Last two points, confidentiality laws need to be revisited. I will be happy to take questions on that. Second, it has to be what is in the child's best interest, not reunification for any reason. As Congressman Cardin knows, I am a dad. I have four kids. Being a father is one of the very most important things in my life, and preserving family is crucial. However, there are some cases where you should not reunite a family because it is simply not in the child's best interest. Thank you.

[The prepared statement of Dr. Beilenson follows:]

Statement of Peter Beilenson, M.D., Baltimore City Commissioner of Health, Baltimore, Maryland

Good afternoon, Chairman Herger and members of the Subcommittee. I am Baltimore City's Commissioner of Health, have held this position for 12 years, and have been appointed by two mayors. Since our Health Department is most often associated with health service delivery, many have asked why I am involving myself in the reform of social service systems. It is my experience as chair of Baltimore City's Child Fatality Review Team that brings me here today, and it is the pattern of child abuse deaths that leads me to advocate for swift systemic changes to our Child and Protective Services. Unfortunately, the terrible deaths of two infants at the hands of their parents have brought this advocacy to the forefront.

The Child Fatality Review Team (CFR) is a multi-agency, multi-disciplinary team that reviews unexpected deaths (those not occurring in a hospital) of infants and children through age 17. The purpose of the team is to review all pertinent information on a specific case and come up with recommendations on how future deaths could be prevented. The team meets once per month and reviews over 100 cases per year.

During recent years, as chair of the local CFR, three major causes of unexpected death in children have emerged. First, SIDS and SUDI (Sudden Infant Death Syndrome and Sudden Unexpected Death in Infants) occur repeatedly. In response to this, we held several press events to address adults co-sleeping with their babies, which can lead to suffocation. A second main cause is juvenile shootings, especially as related to the drug trade. Our Health Department has pioneered Operation Safe Kids, a program designed to protect our city's youth that are most at-risk for shooting or being shot. Finally, we have reviewed countless child abuse deaths. The majority of these deaths fall in two categories. One—the Child and Protective Services had removed a child temporarily from a parent's care due to abuse and neglect and then the child was returned to that parent and killed. Or two—after a parent had a child permanently removed previously from their home due abuse or neglect, the parent had *another* child, which s/he then abused and killed.

To respond to these common patterns of child abuse deaths, with the Mayor's encouragement, we formed an interdisciplinary task force, the Child Welfare Reform Committee, to examine this flawed system and to draft recommendations for improvement. Composed of eight local leaders from medical, therapeutic, advocacy, law enforcement, and judicial sectors, this committee represents decades of experience with the local child welfare system.

Rather than the protracted processes that frequently plague longstanding commissions and committees, the Child Welfare Reform Committee held two targeted meetings. In meetings in November and December of 2003, we pointedly asked and answered, "Where are the gaps in our city's Child and Protective Services and what measures will close those gaps?"

In January of this year, I submitted to the Mayor the Committee's recommendations for system reform. The briefing memomorandum included recommendations that impact upon a part of the process as well as recommendations that affect the system globally. The recommendations were then forwarded to the State Department of Human Resources, which oversees Child and Protective Services, and were widely covered by the press.

Four months subsequent to the Committee's recommendations, the horrific death of two infant twins at the hands of their parents shocked the entire region. Factors of poverty, mental health, and substance abuse played a role in the atrocity, but

what is worse—and unfortunately not at all new to the citizens of Baltimore—is the fact that Maryland's safety net for victims of abuse and neglect failed these babies miserably. A case review shows many warning signals—namely, a runaway teenage mother whose previous child was permanently removed from her care because of abuse. Sadly, it took the Broadway twins' case to prove the pertinence of our recommendations.

Speaking to you today about the system's recurring failure to protect children, I would like to share with you a selection of the Child Welfare Reform Committee's recommendations—those that particularly relate to this case. Implementation of these ideas would likely have impacted the outcomes in this most recent tragedy.

"Improve effectiveness of CPS call center by increasing training and staffing." When called, had the worker not simply commented that there was no open case but actually looked at the record, when Johns Hopkins Hospital called they would have been notified that, in fact, there was a closed case for severe abuse and neglect, but there was also an open foster care runaway case, which would have unquestionably resulted in immediate appropriate referral of the case to Child and Protective Services.

"Staff Johns Hopkins Hospital 24 hours per day, 7 days per week." Had there been a worker on-site, the Hopkins social worker would have had a direct contact to the Department of Social Services. We recommend this service for this facility because it is the primary medical center for children suspected to be victims of child abuse.

"Equip CPS offices with adequate information technology." It may not be fair to completely blame the telephone operator. If adequate information technology had been available, the intricacies of the case may have been available on his/her computer screen.

Most salient of all, in January, we recommended that the system **"Design measures to protect future children of a parent who has been convicted of [or otherwise implicated in] abusing previous children."** This idea is so completely logical; it almost defies explanation. We often speak of preventive care for high-risk populations. A new child in the care of those who have a history of abuse is undoubtedly at the *highest* risk of all, yet, incredibly, it is exactly those cases that are permanently closed and the abusive parent is basically free to have additional children without any services or follow-up to help prevent abuse of these new children—exactly as occurred in the Broadway twins' case.

It is unrealistic to believe that the Baltimore City Department of Social Services and Child Protective Services can change overnight. Undoubtedly, they have an uphill battle where fiscal and human resources limitations are consistent obstacles. However, a review of these recommendations shows that the vast majority of the suggestions are cost neutral, simply requiring a redistribution of resources or a revised mindset.

Recently, we have begun to hear from the State's Secretary for Human Resources and the Director of Baltimore City's Department of Social Services. Frankly, I have been disappointed by the vague responses to our recommendations and the middling willingness to redress the gaps in operations, policy, and strategy of this CPS system. There is also a terrible lack of urgency in addressing these gaps.

I fear that the State is in danger of talking about this issue *ad nauseum* without institutions actually changing. The case of Emunnea and Emonney Broadway is one that will never fail to stir emotion. It is my hope that as legislators and leaders our emotions will be stirred to **mandate State involvement in any family where children have been previously removed**.

Thank you for your time and devotion to these issues.

Child Welfare Reform Committee Recommendations

Dr. Peter Beilenson, Chair

Recommendations: The recommendations listed are concrete steps to begin reform for this agency in crisis. The Committee's recommendations include "Process Recommendations" which include reforms for reporting, responding, decision-making, placement, and ongoing services. "Global Recommendations" include overall systemic and philosophical changes.

Process Recommendations

Reporting

- Improve effectiveness of CPS call center by increasing training and staffing. Committee members found wait-times for calls to report abuse or neglect to be over 30 minutes at times and conducted by unprofessional operators.

Responding

- Staff Johns Hopkins Hospital 24 hours per day, 7 days per week. These facilities are the primary medical centers for children suspected to be victims of child abuse. A large proportion of incidents occur on nights and weekends, and while the hospitals' pediatric emergency departments are open 24 hours a day, 7 days a week, there is not a DSS worker to seek care for the child at these hours. Currently, an abused or neglected child may sit in the emergency room alone hours waiting for DSS attention.
- Implement on-call system to respond to child abuse crises at other hospitals. Should another hospital identify an injury or condition outside of business hours, DSS should be able to send a worker on-call.

Decision-Making

- Stat-like roundtable prior to court hearing should allow more thoughtful, informed decision-making. An interdisciplinary review of case files, reminiscent of our KidStat process, would prepare involved parties for court day and hold DSS caseworkers accountable. We hope that this collaborative approach will decrease the likelihood of a child being returned to a dangerous home at the discretion of just one caseworker.
- Triage process needed to identify cases that should be presented for roundtable discussion. With over 7,500 BaltimoreCity children in out-of-home placements it would be neither feasible nor necessary to bring every case to a roundtable review. Triage must assure that only cases that require discussion be considered in this formal way.
- Streamline process of scheduling workers to be in court. Caseworkers' time in court, though essential, detracts from case management and time with children. DSS, similar to other court-appearing agencies (i.e. Police), should thoughtfully schedule appearances.
- Institute "one judge, one family" approach in scheduling CINA proceedings. Since CINA cases involve a sequence of hearings and court involvement, which can extend over the length of a child's life as a minor, assigning one judge to all of a child's or all of a family's court affairs is a logical measure. More informed, consistent judicial decision-making should result if the same judge or master were to hear all proceedings related to a particular child or family. Furthermore, the courts would save time because the judge should already know the background of the case. "One judge, one family" should also prevent court decisions that may place a DSS child in harm's way. Jurisdictions all over the country have instituted this measure.

Placement

- Increasing foster care parent recruitment. The low number of foster parents in comparison to the number of children needing out-of-home care, contributes to overcrowded and suboptimal placements.
- Check criminal background and child abuse registry. While potential foster care/adoptive parents and guardians not related to the child receive extensive criminal background checks. However, family members who are providing kinship care do not receive background checks. All out-of-home placements should experience the same level investigation as foster applicants, including an application for guardianship.I
- nclude mental health history in application for foster care and guardianship. In an effort to better place children, it should be required that all foster care and guardianship applicants include their mental health history in the application. The current uneven screening of guardians was a factor in recent high-profile deaths.

Ongoing Services

- Utilize a high standards approach in order to achieve 100% of required services for children in out-of-home care. As a response to the October 2003 legislative audit, which showed that DSS was not meeting bench marks for ongoing serv-

ices, the Department should be guided to assure that 100% of children in out-of-home care:

- receive recommended therapy
- have monthly face-to-face meetings with DSS worker receive annual well-child exam
- receive required annual dental exams
- are enrolled in school
- have their caregivers contacted monthly by DSS have their homes/facilities subjected to annual health and safety inspections

- Institute a case file checklist procedure to assure children's receipt of these services.L Placing a checklist in caseworker's files should allow caseworkers and supervisors to best keep track of these services. As the Department increasingly employs information technology, this type of checklist recordkeeping may be computerized as well.

Global Recommendations

- **Recruit more trained social workers as opposed to current human service workers.** A small proportion of caseworkers are actually trained social workers presumably due to the high stress and workload of the position.
- **Equip CPS offices with adequate information technology.** Technological capacity at Baltimore City DSS can hinder productivity.
- **Change emphasis from "family preservation" to "child protection."** Though "child protective" in name, CPS has historically taken a turn toward keeping family intact—often in instances that do children more harm than good.
- **Revisit confidentiality laws; consider allowing the release of case files following child fatality.** Revealing the information like the caseworker's name upon a child's fatality could be a tremendous source of accountability in DSS.
- **Design measures to protect future children of a parent who has been convicted of abusing of previous children.** Currently, there are no measures in place to supervise a convicted child-abusing parent who has goes on to have more children. The Child Fatality Review Team has seen multiple deaths as a result of this abusive pattern.
- **Redefining child's best interest.** Over time, the court's definition of a "child's best interest" has strayed from true consideration of the health and safety of the child. Future legislation may be necessary to guide this philosophical change.

Chairman HERGER. Thank you, Dr. Beilenson. Dr. DePanfilis to testify.

STATEMENT OF DIANE DEPANFILIS, CO-DIRECTOR, CENTER FOR FAMILIES, SCHOOL OF SOCIAL WORK, UNIVERSITY OF MARYLAND, BALTIMORE, MARYLAND

Dr. DEPANFILIS. Okay. Thank you, Mr. Chairman and other Members of the Subcommittee. I speak to you today as a social worker with over 30 years of experience in child abuse and neglect issues, currently as a researcher and educator at the University of Maryland's School of Social Work. What can we learn from this tragic situation which we have already heard the details about from our other witnesses? I offer three suggestions: first, I believe it is time for a paradigm shift in the way our child protection service systems are designed. Second, I emphasize the importance of working across disciplines and community systems, which reinforces what Dr. Beilenson just emphasized also. Third, I emphasize the importance of using evidence-based practices, using what we know has a greater chance of working to deal with this complex problem of child abuse and neglect.

I need to emphasize that none of these points are new ideas, and I think that we have known much more than we have applied over the years, if we sort of trace the chronology from the first enactment of the Child Abuse Prevention and Treatment Act (CAPTA) (P.L. 93–247). My written testimony elaborates on all these points in much more detail, but I am just going to highlight a couple of those in the oral testimony. It is my opinion that one of the principal failures to respond to protect these two infants, or any other children that might be classified as at risk of child abuse and neglect, is because our system is designed to respond only to the most serious cases. Our definition of child abuse and neglect requires there to be an act or omission that results in harm or serious threat of harm. In this case, the facts are unclear how much of that was actually reported, actual harm at that point in time. So, without pointing fingers, and without dwelling on that, I think we really need to take a look at whether or not that type of revolving door makes the most sense given where we are today.

My research, as well as other research, have suggested that families may be reported for child maltreatment as many as 25 times over 5 years. That was research where I followed families over 5 years in Baltimore City. The system continues to screen out, investigate, and serve the same families over and over again, and we often fail to stop this pattern that continues sometimes for generations. It is no wonder that this particular case record is 5 inches thick, and I think we see many, many, many other situations similarly.

Despite the fact that research indicates that when you have a chance to help a family the first time they are known to some system, we tend to fail to respond to families until situations are seriously complex, perhaps fatal, and, therefore, the chance of success is not great. I have an analogy in my written testimony to try to highlight the importance here, suggesting that if you detected a cyst that you would worry might be cancer, it would be the same thing as being told you have to wait to get medical treatment until the possibility of cure is almost nonexistent. I think that is the picture that we have in today's child protection system.

In my opinion, protecting children seems to occur more by chance than through a system that is structured to respond differentially based on the safety needs of families and of children. I do think there has been some movement in some States to change this picture, and it is called the System of Differential Response. In the States that are trying a new reform of the child welfare system, systems are redesigned to deliver quality supportive services the first time there is a red flag, and instead of waiting for children to experience serious and sometimes fatal injuries from neglect and abuse, there is a triage system where community agencies can work together to respond differentially to those needs. The second point that I emphasize is the importance of interdisciplinary efforts, which you have already heard about, so I will not go forward on that. The third thing that I was asked to discuss is the importance of using evidence-based practices in our response to child abuse and neglect. Child abuse and neglect does not happen in the same way in all situations. It is a complex problem that really requires complex solutions, and I think we need to use the evidence

and the research that helps us understand what works best in certain situations.

The Office on Child Abuse and Neglect presented the results of the Emerging Practices in the Prevention of Child Abuse and Neglect Project, which was initiated to try to identify some of these effective programs, and in the context of that work, our Family Connections Program in West Baltimore was highlighted as one of the programs that was deemed demonstrated effective. The results that we are pleased to report about in this project, which was quite small, reaching out to families before they were known to child abuse and neglect, suggested that over a short period of time, families could be helped to increase protective factors related to parenting attitudes, parent competence, social support; decrease known risk factors for child abuse and neglect, like depression and parenting stress, and life stress; and improve safety, both physical care, psychological care; and the prevention of child abuse and neglect known to CPS agencies.

In summary, I think if we want to prevent future fatalities due to child abuse and neglect, we really need to drastically reform the way our community systems are structured. We need to look at this promising effort called differential response, or other ways to get responses to families before serious or fatal injuries occur. We need to work more effectively together using evidence-based practice strategies. Thank you. I would be happy to answer any questions.

[The prepared statement of Dr. DePanfilis follows:]

Statement of Diane DePanfilis, Ph.D., Co-Director, Center for Families, University of Maryland, School of Social Work, Baltimore, Maryland

Mr. Chairman and members of the subcommittee, my name is Diane DePanfilis. I am an Associate Professor, Director of the Institute for Human Services Policy, and Co-Director of the Center for Families at the University Of Maryland School Of Social Work. I have more than thirty years of experience in the child protection field as a social worker, supervisor, administrator, national consultant, and researcher. I am the co-author of *Child Protective Services: A guide for caseworkers* [1] published by the Department of Health & Human Services (HHS), Children's Bureau, co-editor of the *Handbook for Child Protection Practice,*[2] and a former President of the Board of Directors of the American Professional Society on the Abuse of Children. Last year, I conducted an important study on the investigatory practices of reported child abuse and neglect in out-of-home care in the state of New Jersey in collaboration with Children's Rights, Inc. I have been a consultant with the state of California and other states as they undertake efforts to reform their child protection systems and I am on an advisory committee for the University of Chicago's Chapin Hall Center for Children related to a study of the impact of some of these reforms. I am also currently collaborating with the Institute for the Advancement of Social Work Research with support from the Annie E. Casey Foundation on a study of the effectiveness of practices to retain professionally prepared social workers in public child welfare.

Thank you for inviting me to present my views on the safety of children following the tragic death of two infants in Baltimore. I commend you and the committee for undertaking a series of hearings on the safety of maltreated children in this country. Today, I speak to you based on my research and experience with child protection systems in Baltimore. I have studied: (1) the recurrences of child maltreatment in Baltimore in collaboration with the Baltimore City Department of Social Services; (2) screening practices regarding child abuse and neglect reporting in Baltimore and

[1] DePanfilis, D., & Salus, M. (2003). *Child Protective Services: A guide for caseworkers.* Washington, D.C.: U.S. Department of Health and Human Services, Administration on Children and Families, Administration for Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect.

[2] Dubowitz, H., & DePanfilis, D. (Eds.). (2000). *Handbook for child protection practice*. Thousand Oaks, CA: Sage.

other jurisdictions in collaboration with the Maryland Department of Human Resources and the State Council on Child Abuse and Neglect; and (3) the efficacy of a promising preventive intervention in West Baltimore called Family Connections. My views are based on my experiences as a social worker and researcher and I do not formally represent any group.

What can we learn from this tragic situation in which two young lives were lost? I offer three related suggestions. First I believe that it is time for a paradigm shift in the way our child protection systems are designed. Second, I emphasize the importance of working across disciplines and community systems. Third, I emphasize the importance of using evidence-based practices to respond to the complex problem of child abuse and neglect. These are not new ideas.

Too Little Too Late: Time For a Paradigm Shift

Our current laws our designed for the public child protection system to respond when there is a reason to believe that a child has already been harmed or is at serious risk of harm. Only a very small percentage of the children and families with maltreatment or risks of maltreatment actually receive help. Over ten years ago, the Federal Advisory Board on Child Abuse and Neglect declared that the child protection system was in a State of Emergency.[3] The state of emergency continues.

Let's begin with the call to CPS. CPS workers are charged with screening reports of child abuse and neglect according to definitions in state laws.[4] If the alleged concerns do not meet the state definition of child maltreatment, workers make appropriate decisions by not accepting reports for investigation. The Child Abuse Prevention and Treatment Act (CAPTA) sets the standards for a state definition of child abuse and neglect. *The term "child abuse and neglect" means, at a minimum, any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse or exploitation, or an act or failure to act which presents an imminent risk of serious harm.*[5]

While I am not familiar with the "facts" of the Baltimore City case other than what I have read in the *Baltimore Sun,* I'm not sure that a report that alleged that a mother who was *known to social services as a foster care runaway from whom a previous child had been taken away because of abuse and neglect*[6] would constitute an imminent risk of serious harm.

It is my opinion that the failure to respond to protect these children is not the failure of the CPS agency, but a failure of our state laws that dictate that children need to be harmed or at imminent risk of harm before someone in the community responds.

What do we know about screening practices in Maryland? In 2001, a collaborative research team reviewed all screened out reports of child abuse and neglect in Maryland for one month. Reviewers, including University researchers and state policy analysts, determined that most (83%) of the screening decisions made that month were consistent with state policies.[7] Of the 5,023 referrals received by 24 local CPS jurisdictions in the study month, an average of 36% of referrals was screened out. The proportion of referrals screened out significantly differed between jurisdictions ranging from 62.5% to 5.6%. Larger jurisdictions tended to screen out fewer referrals (29.8% in BaltimoreCity; 25.7% in Prince George's County) than the state average (36%). These variations are consistent with screening practices nationally. Screening rates vary substantially between states from a low of 1.7% in Alabama to a high of 72.3% in Maine.[8]

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[3] U.S. Advisory Board on Child Abuse and Neglect. (1993). *Neighbors helping neighbors: A new national strategy for the protection of children.* Washington, DC: Department of Health and Human Services, Administration for Children and Families.

[4] Wells (2000). How do I decide whether ot accept a report for a child protective services investigation? In H. Dubowitz & D. DePanfilis (Eds.), *Handbook for child protection practice* (pp. 3–6), Thousand Oaks, CA: Sage.

[5] U.S. DHHS, Administration for Children and Families, Administration on Children, Youth, and Families, Children's Bureau, Office on Child Abuse and Neglect (2003). *The Child Abuse Prevention and Treatment Act including Adoption Opportunities and the Abandoned Infants Assistance Act, as amended by the Keeping Children and Families Safe Act of 2003.* Washington, DC: Author. Retrieved June 6, 2004 at *http://nccanch.acf.hhs.gov/general/legal/federal/index.cfm.*

[6] Klein, A. (2004, May 24) Officials seeking better safeguards to protect children from abuse. *Baltimore Sun*, 2b.

[7] DePanfilis, D. (2003). Report of the Research Committee to the State Council on Child Abuse and Neglect. Baltimore: Author.

[8] US DHHS, Administration for Children and Families, Administration on Children, Youth, and Families (2004). *Child maltreatment 2002: Reports from the states to the national Child*

Continued

It is my opinion that assessing the safety of children occurs inconsistently between local and state jurisdictions. Society should not wait until a child has experienced a serious or fatal injury before responding to referrals of concern about children at risk of maltreatment. Our community systems must be available to respond to all families at risk for child maltreatment.

For some families, the child protection system is like a revolving door. My research, as well as research, by others has found that families may be reported for child maltreatment as many as 25 times in five years.[9] The system continues to screen out, investigate, and/or serve the same families over and over again as we often fail to stop a pattern that sometimes continues for generations. Despite the fact that research also indicates that we have a chance to alter this picture if families can be helped the first time someone recognizes a problem, our systems too often get involved too late. We are serving only the tip of the iceberg and waiting too long to offer help that has any chance of success. *Imagine detecting a cyst that has a chance of being diagnosed as cancer but being told you can't access medical care until the chances of recovery are almost nonexistent.*

It is my opinion that as a society we must develop new strategies for early detection and response to families at risk for child maltreatment.

In 2002, state CPS agencies received 2.6 million referrals alleging maltreatment related to 4.5 million children.[10] Of the referrals accepted as a report and investigated, more than half of the reports (60.4%) led to a finding of unsubstantiated suggesting that sufficient evidence of child abuse or neglect was not found by the CPS worker. In contrast, an estimated 896,000 children were determined to be victims of child abuse or neglect in 2002 based on determining that a report was substantiated or indicated. There is growing consensus that the legalistic process of reporting, investigating, and substantiating or unsubstantiating does not lead to the protection of children.[11] While some reports that are unsubstantiated may not require a community response, it is likely that at least some of these reports represent children and families who could benefit from family support or other community services that may prevent child abuse or neglect in the future.

In the current system, most reports of child abuse and neglect do not result in services to prevent the occurrence or recurrence of child maltreatment (DHHS, 2004). Think of a funnel. Extrapolating from national reporting data, consider the following scenario. Out of every 100 reports of child abuse and neglect, 67.1 are screened in for an investigation. Of those 67 reports, 20 (30.3%) are substantiated or indicated. Of those, 11.8 children may receive a service response beyond an investigation of the report. The deaths of these infants in Baltimore is an example of a tragic situation that may have been screened out from receiving the benefit of a safety assessment.

It is my opinion that protecting children seems to occur more by chance than through a system that is structured to respond differentially based on the safety needs of children and families.

The beginnings of a paradigm shift. As others[12] have asserted, the system designed to protect children is not working. In 1990, the U.S. Advisory Committee made a most compelling argument that we ignored. *The most serious shortcoming of the nation's system of intervention on behalf of children is that it depends upon a reporting and response process that has punitive connotations and requires massive resources dedicated to the investigation of allegations. State and County child welfare programs have not been designed to get immediate help to families based on voluntary requests for assistance. As a result, it has become far easier to pick up the*

Abuse and Neglect Data System. Washington, DC: U.S. Government Printing Office. Retrieved June 3, 2004 at *www.acf.hhs.gov/programs/cb/publications/cmreports.htm.*

[9] DePanfilis, D., & Zuravin, S. J. (2002). The effect of services on the recurrence of child maltreatment. *Child Abuse and Neglect, 26*, 187–205; DePanfilis, D., & Zuravin, S. J. (2001). Assessing risk to determine the need for services. *Children and Youth Services Review, 23*, 3–20; DePanfilis, D., & Zuravin, S. J. (1999). Predicting child maltreatment recurrences during treatment. *Child Abuse and Neglect, 23* (8), 729–743; DePanfilis, D., & Zuravin, S. J. (1999). Epidemiology of child maltreatment recurrences. *Social Services Review, 73,* 218–239; DePanfilis, D., & Zuravin, S. J. (1998). Rates, patterns, and frequency of child maltreatment recurrences among public CPS families. *Child Maltreatment, 3*, 27–42.

[10] US DHHS (2004).

[11] Drake, B. (1996). Unraveling unsubstantiated. *Child Maltreatment, 1* (3), 261–271; Melton, G. B. (2003, October). Mandated reporting: A policy without a reason. *Commentary prepared for a virtual discussion sponsored by the International Society for Prevention of Child Abuse and Neglect.*

[12] See for example, Waldfogel, J. (1998). Rethinking the paradigm for child protection. *The Future of Children Protecting Children from Abuse and Neglect, 8* (1) 104–119.

telephone to report one's neighbor for child abuse than it is for that neighbor to pick up the telephone and receive help before the abuse happens.[13]

It is time to consider that *there must be a better way*. During the past 10 years, there has been a growing consensus that states and communities need to change the way they protect children, and many states have taken the charge to make the protection of children a community responsibility. One type of reform to child protection systems has been implemented: *differential response*. These newly designed differential response systems provide non-adversarial, flexible responses to individual family circumstances. Systems are redesigned to deliver quality supportive services the first time red flags are identified instead of waiting for children to experience serious and sometimes fatal injuries from neglect or abuse. Community agencies, in partnership with child protective services, work to triage services so that together the community can help families meet the basic needs of their children and keep them safe. A national study of child welfare reforms[14] identified twenty states that offer one or more alternatives to the traditional CPS investigative response. While it is not yet clear whether these efforts will yield better outcomes for children, some early evaluation results are promising.[15] States have reported improvements in child safety and child and family well-being compared to families served through traditional services. Previous testimony before this subcommittee by Tom Birch on behalf of the National Child Abuse Coalition (2004) has already outlined information about the costs of *not* investing in prevention and early intervention.

Working Together Across Systems

Protecting children is a community responsibility. This statement has been emphasized since the enactment of CAPTA in the 70s. For example, the current edition of one of the federal government's user manuals suggests that all *relevant professionals must be aware of their role in child protection and the unique knowledge and skills they bring to their community's prevention and intervention efforts. They must also understand the roles, responsibilities, and expertise of other professionals.*[16] All practitioners must also have sufficient competence and time to perform the roles they are assigned. Federal and state governments have invested considerable resources to require multidisciplinary teams and state coordinating bodies to collaborate in broad efforts to protect children. Unfortunately, these requirements do not always ensure that all professionals and organizations will work together on a daily basis. And there are some disagreements about how these multidisciplinary teams really should work.[17] Child abuse and neglect is a complex problem that requires interdisciplinary efforts. That means we must work together, not side by side. The tragic case of the twins in Baltimore is an example of serious failures in multiple systems. Pointing fingers and blaming each other will not prevent future failures. Coming together and developing ways to work together on a daily basis will keep children safe. This is not a situation of not knowing how. It means we must have the will to make it happen. In Baltimore, Secretary McCabe and Director Blair, other witnesses here today, have already taken steps to bring groups together. We must tackle the serious barriers to keeping children safe as new protocols and procedures are established to prevent future avoidable tragedies.

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[13] U.S. Advisory Board on Child Abuse and Neglect (1990). *Child abuse and neglect: Critical first steps in response to a national emergency*. Washington, DC: Author.

[14] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation *and* Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2003). National Study of Child Protective Services Systems and Reform Efforts Review of State CPS Policy. Washington, DC: Author. Retrieved June 6, 2004 at *http://aspe.hhs.gov/hsp/cps-status03/state-policy03/*.

[15] Institute of Applied Research. (1998, January). *Missouri child protection services family assessment and response demonstration impact evaluation: Digest of findings and conclusions.* St. Louis, MO: Author.

[16] Goldman, J. & Salus, M. (2003). *A coordinated response to child abuse and neglect the foundation for practice.* Washington, DC: US DHHS, ACF, ACYF, Children's Bureau, Office on Child Abuse

Institute of Applied Research. (2003, February). Minnesota alternative response evaluation second annual report: Executive summary. St. Louis, MO: Author; Texas Department of Protective and Regulatory Services. (1999). *Flexible response evaluation*. Austin, TX: Author; VirginiaDepartment of Social Services. (1999). *Final report on the multiple response system for Child Protective Services in Virginia*. Richmond, VA: Author.

[17] Wilson, C. & McGrath, P. (2004, Spring). In search of a new model for coordinated urban child abuse investigations. *APSAC Advisor, 16* (2), 5–10.

Evidence-Based Practices

Since child neglect and abuse are rooted in multiple and interacting intrapersonal, interpersonal, and environmental factors, no one intervention or treatment is expected to be effective in all situations.[18] Even though research on *what works* to prevent and respond to child maltreatment is limited, recent reviews of intervention and treatment effectiveness have identified some core elements.[19] As we reassess the field's response to child abuse and neglect, it is incumbent that we employ methods to prevent and respond to child abuse and neglect which have some evidence that they are effective in reducing the risk of child maltreatment.

In 2003, the Office on Child Abuse and Neglect (OCAN) presented the results of the *Emerging Practices in the Prevention of Child Abuse and Neglect* project, which was initiated to identify effective and innovative programs in child abuse and neglect prevention around the nation. In partnership with the prevention community, OCAN implemented this review to elevate understanding of prevention programs and initiatives, and to share information on emerging and promising practices with the field.[20]

In coming here today, I was asked to speak briefly about a program called Family Connections in West Baltimore, which was deemed "demonstrated effective" by the OCAN initiative. Family Connections received this designation because the Advisory Group determined that the program had undergone rigorous evaluation using an experimental design with random assignment, and the results demonstrated positive outcomes for participants.

Family Connections is a multi-faceted, community-based service program that works with families in the context of their neighborhoods to help them meet the basic needs of their children and reduce the risk of child neglect. The program was developed by the University Of Maryland School Of Social Work in collaboration with the School of Medicine and the Department of Pediatrics. It was launched through a federal demonstration project funded in 1996 and has since been supported by a combination of federal, state, private foundation, and other sources. The mission of Family Connections is to enhance the safety and well-being of children and families by combining education of graduate social work interns, services to families in the West Baltimore Empowerment Zone, and research about the process and outcomes of the intervention. *Our goal is to reach families and to prevent the need for a formal child protective services intervention.*

The program was designed to specifically target factors known to increase the risk of child neglect. The choice to focus on the prevention of neglect came out of research on the recurrence of child abuse and neglect in Baltimore. The program operates from an ecological developmental framework using Bronfenbrenner's[21] theory of social ecology as the primary theoretical foundation. Child neglect is thought to evolve when risk factors related to the child, caregivers, family system, and environment challenge the capacity of caregivers and broader systems to meet the basic needs of children. Family Connections uses a home-based, family-centered model of practice consistent with other home-based, tailored intervention approaches.[22] Nine

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[18] National Research Council (1993). *Understanding child abuse and neglect*. Washington, DC: National Academy Press.

[19] Becker, J.V., Alpert, J. L, BigFoot, D. S., Bonner, B. L., Geddie, L. F., Henggeler, S. W., Kaufman, K. L., & Walker, C. E. (1995). Empirical research on child abuse treatment: Report by the child abuse and neglect treatment working group, American Psychological Association. *Journal of Clinical Child Psychology*, *24*, 23–46; Corcoran, J. (2000). Family interventions with child physical abuse and neglect: A critical review. *Children and Youth Services Review, 22*, 563–591; DePanfilis, D. (1999). Intervening with families when children are neglected. In: H. Dubowitz (Ed.). *Neglected children* (pp. 211–236). Newbury Park, C: Sage; Kluger, M. P. Alexander, G., Curtis, P. A. (2000). *What works in child* welfare. Washington, DC: Child Welfare League of America; Oates, R. K., & Bross, D. C. (1995). What have we learned about treating child physical abuse? A literature review of the last decade. *Child Abuse & Neglect, 19*, 463–473; Thomlison, B. (2003). Characteristics of evidence-based child maltreatment interventions. *Child Welfare, 82,* 541–569; Wolfe, D. A. (1994). The role of intervention and treatment services in the prevention of child abuse and neglect. In G. B. Melton & F. D. Barry (Eds.), *Protecting children from abuse and neglect foundations for a new national strategy* (pp. 224–303). New York: Guilford; Wolfe, D.A., & Wekerle, C. (1993). Treatment strategies for child physical abuse and neglect: A critical progress report. *Clinical Psychology Review, 13,* 473–500.

[20] U.S. Department of Health and Human Services [U.S.DHHS]. (2003). *Emerging practices in the prevention of child abuse and neglect.* Washington, D.C.: Author.

[21] Bronfenbrenner, U. (1979). The ecology of human development: Experiments by design and nature. Cambridge, MA: Harvard University Press.

[22] Dunst, C.J., Trivette, C.M. and Deal, A.G. (1988). *Enabling and empowering families: Principles and guidelines for practice.* Cambridge, MA; Brookline Books; Kinney, J., Strand K., Hagerup M., & Bruner C. (1994). *Beyond the buzzwords: Key principles in effective frontline practice.* Falls Church, VA: NCSI Information Clearinghouse.

practice principles guide FC interventions: community outreach; individualized family assessment; tailored interventions; helping alliance; empowerment approaches; strengths perspective; cultural competence; developmental appropriateness; and outcome-driven service plans.[23] Individualized intervention is geared to increase protective factors and decrease risk factors.

The core components of Family Connections include: (1) emergency assistance; (2) home-based family intervention (family assessment, outcome driven service plans, individual and family counseling); (3) service coordination with referrals targeted toward risk (e.g., substance abuse treatment) and protective factors (e.g., mentoring program); and (4) multi-family supportive recreational activities.

Research supported through the demonstration project illustrates positive improvements for children, caregivers, and families.[24] The sample included 154 families (473 children) in a poor, urban neighborhood, who met risk criteria for child neglect, and who were randomly assigned to receive either a 3—or 9-month intervention. Self-report and CPS data were collected prior to, at the end of, and six-months post intervention. Observational assessments were made at the beginning and the end of the intervention. Data were analyzed using analyses of variance (ANOVA) with repeated measures. Results for the entire sample indicated:

- enhanced protective factors (parenting attitudes, parenting competence, social support);
- diminished risk factors (parental depressive symptoms, parenting stress, life stress);
- improved child safety (physical and psychological care of children); and
- strengthened child well-being (decreased externalizing and internalizing behavior).

The nine-month intervention was more effective in certain areas compared to the three-month intervention (e.g., fewer caregiver depressive symptoms, fewer child behavior problems). Prior to Family Connections' intervention, CPS had received 274 reports of child abuse or neglect related to 87 of the 154 families (56.5%) in this sample. Fifty-nine (38.3%) of these reports were indicated. While Family Connections was providing intervention, twenty-four CPS reports were made related to seventeen families (11% of 154 families), and 12 of these were indicated. Six months following the closure of intervention, searches on 139 families found that there had been eleven reports made to CPS. (Fifteen families had less than six months follow-up time and were not included in the search). Five of the fifteen reports were for three-month families and six were for nine-month families. Of these 11 reports, five of them were indicated (four for three-month families and one for nine-month families). The low number of reports overall precluded tests of significance between groups. Family Connections appears to be a promising model for preventing neglect and enhancing children's safety and well-being. Limitations of this original project are now being addressed through the replication of this program in 8 sites. The Office on Child Abuse and Neglect has funded one replication in Baltimore which is targeting grandparents raising grandchildren. Other projects are funded in California (2 programs); Michigan; Texas (2 programs); West Virginia; and Tennessee. Further information about this program may be found at the Family Connections' web site at *http://www.family.umaryland.edu*

A workshop on the program will also be presented at the U.S. Department of Health and Human Services, Administration for Children and Families, Children's Bureau sponsored **Biennial Child Welfare Conference: Focus on Evidence Based Practice** being held on June 29th, 2004 at the Marriott Wardman Park Hotel in Washington, D.C. This national conference will provide training experiences and best practice models in child welfare as well as many opportunities for collaboration and partnership building. It is expected to bring together 500 participants across the spectrum of child welfare. The participants will include state child welfare directors, policy makers, judicial representatives, federal, state and local agencies, community-based organizations, faith-based organizations, advocacy groups, direct service providers, related associations, and other partners in the field.

[23] DePanfilis, D., Glazer-Semmel, E., Farr, M., & Ferretto, G. (1999). *Family Connections intervention manual*. Baltimore: University of Maryland, Baltimore. Retrieved June 15, 2004 from *http://www.family.umaryland.edu.*

[24] DePanfilis, D. (2002). *Helping families prevent neglect final report.* Study funded by the U.S. Department of Health and Human Services, Children's Bureau 1996–2002 (Grant Number 90CA1580). Baltimore, MD: University of MarylandSchool of Social Work. Retrieved June 15, 2004 at *http://www.family.umaryland.edu; DePanfilis, D., & Dubowitz, H. (Submitted for peer review, January 2004). Family Connections: Preventing child neglect—promoting well-being and safety.*

Lessons Learned

In summary, I firmly believe that if we want to prevent future fatalities due to child abuse and neglect, we need to drastically reform the way our communities are structured to respond to families who may be at risk for child abuse and neglect. *Governments ought to facilitate the development of community environments that by their nature provide family support and that ensure watchfulness for children. Help—and, if necessary, monitoring and control—ought to be built into primary community settings in a manner that minimizes intrusions on privacy and that improves the everyday quality of life for children and families, whatever their vulnerability and needs.*[25] One such promising method for accomplishing this goal may be to reform child protection systems to differentially respond to children and families. We must also practice working *together* systematically on a daily basis.

Finally, more attention needs to be paid to testing strategies to prevent and intervene so that we more efficiently use the limited resources available to dedicate to this major social problem. Despite gains in evaluating the effectiveness of interventions in the past ten years, we do not yet completely understand what interventions work with whom and under what conditions. Federal and state support for research on the effectiveness of child maltreatment related prevention and intervention efforts are limited. If we want to invest in programs that work to help children and families achieve safety and well-being, we must undertake rigorous studies on the efficacy and effectiveness of different program models.

Thank you for an opportunity to express my opinions about what we may learn from this tragic situation in Baltimore.

Chairman HERGER. Thank you very much. The gentleman from Michigan, Mr. Camp to inquire.

Mr. CAMP. Thank you, Mr. Chairman. Dr. Beilenson, it seems to me that the hospital had an obligation to do more than simply place a phone call to a clerk. You had a single parent coming in with twins and low birth weight. All the red flags went off that this person should not have been just simply sent home. Can you just tell me a little bit about why the hospital did not do more?

Dr. BEILENSON. Yes. I actually know about the case. I am just the City Health Commissioner, I don't work at Johns Hopkins, but I actually do know the case, and I have also said in the press that I think the Secretary and Mr. Blair have kind of taken too much of the heat; that not only did Johns Hopkins make that call, they actually knew, and the referral form that was eventually sent did have on it that they knew a permanent removal had occurred. So, I do think it was incumbent on Johns Hopkins staff to have gone ahead and called CPS, even though they were told by the clerk that there was no open case.

Mr. CAMP. So, they had other knowledge?

Dr. BEILENSON. They did have other knowledge. So, that is why it shouldn't have happened. That is why one of the recommendations I didn't mention, because it was very specific to the case, is Johns Hopkins, and you wouldn't know this, but Johns Hopkins happens to see the vast majority of physical child abuse cases in the city. So, we recommended not a hotline extended hours, but 24-hour, 7-day-a-week coverage at Johns Hopkins. So, a CPS person could have been there and just been called upstairs.

Mr. CAMP. From what I have seen in press reports, the circumstances of the mother coming in indicated no prenatal care.

Dr. BEILENSON. Delivered in a sweat pant.

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[25] Melton, 2003, p. 9.

Mr. CAMP. I think there were other issues. I appreciate your comments on reunification. This clearly was not a reunification case. I think the Adoption and Safe Families Act (P.L. 105–89) really does give the authority to the judges to make the decisions that need to be made, but it is interesting to hear that your experience is they are not doing that. So, we may have to take a look at that in another issue.

Secretary McCabe, it seems to me that this whole legislative or legal point that the State cannot act on a presumption that the same parent will abuse a child later, I know other States have different laws. For example, in Michigan, a subject can incorporate by reference what has happened to one child to other children later. It seems to me there should be a legislative change there to correct that. I know other States do that, and I am surprised, frankly, that Maryland does not have the ability to do that.

Mr. MCCABE. We will certainly look at that. We want to learn from this. I think differential response that the doctor talked about points to that, and we will do that, Congressman. If I can also, I talked a little about partners in this, and I think it is important to also make a point that judges ultimately have the discretion and the authority to determine what custody is for a particular child. We spend a lot of time, our social workers, working with judges. Hence, they, in our State, very much believe in reunification, as we do as a department. Whenever possible we want to reunify. In fact, we are mandated by law to try to reunify to the extent we can. So, we will certainly look at that.

Mr. CAMP. I understand, but I am really looking at the point at where files are closed, particularly after one child may be removed. If one child has been removed, and then a later child is born, there is a fairly high indication there may be problems again. I know other States account for that, and the evidence in the previous file can come in in a judge's determination. The other point I wanted to ask you about is when you testified before us in May, you said that the Baltimore City DSS had been operating under a Federal consent decree since 1989, and the local agency is obligated to make systemic improvements in their programs. Obviously, there have been problems in the Baltimore welfare system for some time. I wondered if you could tell us more about why the consent decree was put in place, and what it means today; what improvements does it require; and how are these paid for? A little background on that, please.

Mr. MCCABE. Sure. In 1989, the Federal courts established, in LJ v. Massinga, which was a class suit by plaintiffs' attorneys, that the Baltimore City DSS would be operating under this Federal consent decree. Others could probably comment even more knowledgeably than I can, but I think it was because there were children in foster care that had been lingering there, and there did not seem to be any significant improvement in trying to find permanency for kids in foster care.

As a result of that Federal consent decree, we are now required to measure our progress in a report every 6 months to plaintiffs' attorneys, these are pro bono attorneys who are doing this, about progress against several measurable standards. I have to admit to you all that I think for many years it was a kind of a pro forma

exercise, where we internally recognized we had to do this report, but we had not been committed, as much as I think we should be, to making improvements so that someday we could qualify to get out from under this Federal consent decree. I have made a commitment with the plaintiffs' attorneys to do everything I could to make changes so that we could qualify for coming out from underneath that. The systemic issues that they reference in that are still very much in play, and we are trying to do something about it.

Mr. CAMP. There have been some comments about the technology here, and if there had been better technology. Under the Maryland system, even if the technology was perfect, they would not have told the hospital that there was a case, because it was closed. So, all the technology in the world wouldn't fix that. I think you have a legal problem there. I noticed in your written testimony you mentioned 1,000 computers had been ordered but never delivered. Can you tell me about that and the reason for that delay?

Mr. MCCABE. Sure, Congressman. Well, when I came on board, and I think Mr. Blair can confirm this in his shorter time at the helm, we recognized that the conditions in which our workers operated, particularly our frontline workers, was just unacceptable. So, we committed, I committed and the Governor committed, to doing everything we could to make sure that those tools were available to them. So, now every caseworker, believe it or not, has a computer on their desk. We are finally getting a phone system that you and I have enjoyed for years. We are finally getting our workers those tools, and that is a good thing.

Specifically, I talked about MD CHESSIE, which is our SACWIS system. I don't want to oversell the technology. Any technology is only as good as it can be if people who are using it either understand it or understand the value of it. Otherwise, it is just that, it is technology. So, we are very much committed to training our workers to use it. The more information the better. The MD CHESSIE system, when fully implemented, will have all the relevant case information, including placement opportunities open, where we can actually place a child, at the fingerpoint of the person operating the computer. That simply does not exist, and it just compounds the difficulty our caseworkers have.

Mr. CAMP. Thank you, Mr. Chairman.

Chairman HERGER. The gentleman's time has expired. The gentleman from Maryland, Mr. Cardin to inquire.

Mr. CARDIN. Thank you very much, Mr. Chairman. I want to ask a few questions about the Swann case to find out what happened, but also to see whether we have made changes in our system so that what happened in the Swann case will not happen again.

The first point is you have a young teenager who is a runaway from foster care, becomes pregnant. She has a child. The child is taken away from this young teenager because of abuse and put in foster care. You have a big folder, You said, 4 or 5 inches thick. Why wasn't she put into foster care or the juvenile system, or why wasn't there any services provided to her after she had abused her child? You had to take the child away, and she is still a foster child herself. We have a responsibility. So, why wasn't there any services provided, either through foster care or the juvenile justice system,

if need be, so she is not on her own on the streets? Question number one. Have we taken steps to make sure that doesn't happen again in another case that might be looming?

Mr. BLAIR. Congressman Cardin, yes, she was in foster care. She was on runaway status, meaning that she had left her foster care parent which is provided by the State and the services we would be providing for her. She had run away from us, and we were making strenuous attempts to find out where she was. We did not know she was living in an abandoned building, and we did not know she was pregnant.

Once a case is closed, in a sense, the child is transferred to an active foster care case, where he or she will receive the supportive services from our agency; so she was receiving services. For whatever reason, which I don't know and can't comment on now, she ran away from us. She ran away from the foster home, and we were trying to find where she was. We had no idea she was living in an abandoned building and no idea she was pregnant. It was brought to our attention only after this case was brought to our attention, sir.

Mr. CARDIN. My real question said, when she had her first child and the first child was taken away, why didn't then more intense services, if she had a child while she was in foster care, and she abused that child, it seems to me that is a signal that intense intervention is necessary, and it is our responsibility for intense intervention, and just putting her back into a foster care situation that couldn't supervise doesn't seem like it is a safe alternative for either Ms. Swann or society, and it proved to be that way.

Mr. MCCABE. Can I comment, just to clarify a little about our internal processes? The question the Johns Hopkins worker asked our clerical staff, which was, was there an open child abuse case or child abuse case, and the answer was no. When an investigation occurs, and then an action is taken, we may remove a child, within our own system we close the investigation. That, however, doesn't mean that there is not an active foster care case. So, we are not only providing for the child, the well-being in a new foster home, our caseworker, the foster worker, also has a dual responsibility to help the foster worker.

Mr. CARDIN. I think I understand that point, but I think Dr. Beilenson's point is that this is a real big flag going up, and we need to provide intense services. The case should not be closed from the point of view of service after you take a child away from an abusive parent, particularly if that parent is your responsibility under the foster care system.

Mr. MCCABE. We were continuing to provide services. Now, I agree with Dr. Beilenson, the level of service that we can provide a caseworker, to both a child who is in care as well as the teenage mom, probably they do the best they can with the tools they have got.

Mr. CARDIN. I want to give Dr. Beilenson a chance at that, but the second point, and I want to make sure time doesn't run out, is that Johns Hopkins evidently had a telephone number to call. It is an internal number. I don't know who gave them the number to call, and I am not trying to say Johns Hopkins shouldn't have done a better job in the case, but it seems to me if Johns Hopkins has

an internal number to call in the DSS, and you are calling from a hospital as far as children being sent home with a parent, that number should have connected to a person that could have given them the right information. Again, I am not trying to place blame here, but have we made the corrections now so that if a hospital contacts the DSS they can know for sure whether there is an open case with a mother before letting that child go home with that mother?

Mr. BLAIR. The answer is yes, sir. For several years prior to me coming on board, this back-door number had existed basically based on workers who worked for the department who moved on to other employment, such as Johns Hopkins and other hospitals, and they utilized this number just to get simple information, not to actually report an issue of abuse. So, the worker was calling a number that she knew she would get cursory information. She did not suspect abuse. That is why she didn't call the correct number, which is the CPS hotline. Presently that number has been shut down.

Mr. CARDIN. Mr. Chairman, with your patience, a question to Dr. Beilenson. Do you have a comfort level today that we have in place in Baltimore information in the delivery rooms of our hospitals, particularly Johns Hopkins, which is the largest, you said, for potential child abuse cases, so that if the hospital in good faith is trying to get information, they can get information? Number two, are you confident that if you have a foster parent who delivered a child after they had another one taken away from them, that there is something in place that ensures that the foster child is going to get adequate services?

Dr. BEILENSON. No.

Mr. CARDIN. Thank you, Mr. Chairman.

Chairman HERGER. I thank the gentleman. The gentleman from Louisiana, Mr. McCrery to inquire.

Mr. MCCRERY. I have no questions at this time, Mr. Chairman.

Chairman HERGER. The gentleman from Washington, Mr. McDermott to inquire. Does the gentleman from Washington have a question?

Mr. MCDERMOTT. Yes, Mr. Chairman. I am interested in hearing from the witnesses whether they think the Federal Government has any role in this? Do you need Federal standards? Do you want Federal standards? Do you want us to stay out and just ship the money, or what is your view? We have been having hearings on this stuff for the last couple of years. We heard about New Jersey, and we have a big report here from the GAO, and we get all this stuff, but we never write any legislation. So, I am kind of wondering what the point is. Are you here asking or think we ought to do something?

Mr. MCCABE. If I may, Congressman, I served 11 years in the Maryland Senate, and when an incident occurs, it, rightfully so, creates a lot of visibility and usually action. It should. We need to take urgent steps to make a fix, and we are planning to do that in Maryland. However, the CFSR demonstrate that we just can't make a quick fix in all cases. We have got a real long-term systemic weakness in our system in Maryland, as usually most other States do. The Federal Government absolutely has a role, not just

by shipping money to us, and we are very grateful for that; we rely on it significantly. Two out of every $3 which funds Maryland's DHR comes from the Federal Government. So, we absolutely need that partnership.

A hearing like this, frankly, brings all of us to this table and really requires us to listen to each other. That is something that doesn't always happen. As Dr. DePanfilis mentioned, we all work in our own little tunnels sometimes. I spoke with Dr. Beilenson about the three of us meeting next week to talk about what the health department does with our department and how we can better work together. So, in terms of Federal standards and legislation, I think the CFSR is that Federal role that you indicated is so important. We have to provide a program improvement plan which will incorporate this, or we risk a significant penalty.

Mr. MCDERMOTT. Has any State ever been penalized? Have you ever been penalized?

Mr. MCCABE. We just received ours, and to the best of my knowledge that hasn't occurred. Our expectation, and I think the expectation of the Federal Government, is we will get a plan in 90 days to them that is workable and doable.

Mr. MCDERMOTT. So, you don't think there is any real positive thing that the Congress could do in this? It is already in place, and it is really up to you guys at the local level? Or you folks, because it is men and women.

Mr. MCCABE. Congressman McDermott, Congressman Cardin, I know the Committee is aware of the Pew Foundation on Foster Care, and one of the things we all talked about is the need for intensive services before abuse happens. Right now there is an incentive really because we get money only after we take a child out of care. The recommendations that will be before you indicate that States need more flexibility for the moneys they receive so they can provide some of those up front services that Dr. Beilenson and others have talked about. That is a big, long process, and that is in your hands; that flexibility for the use of Federal funds would be helpful.

Mr. MCDERMOTT. Any of the others of you?

Mr. BLAIR. As a local director, the Secretary is correct. We are receiving children who have multiple problems. Their lives are shattered long before they encounter a local DSS office, across the country, not just in Baltimore. Times have changed. Times are more difficult. So, clearly being able to utilize funding to create more preventive services to help children before they enter the stream.

We are looking at a local DSS where we basically have a safety net out trying to catch as many as we can, but they have been abused or neglected long before they encounter our agency. So, any assistance from the Federal Government that would allow the State, which means local DSS, to create sort of these out-of-the-box type of collaboratives with the health department and others, and education and housing and all these other things that are important to the children before they come in contact with DSS, would be most appreciative, sir.

Dr. BEILENSON. I will just be blunt. I think that by far the most important thing you are doing is holding these oversight hear-

ings, because, with all due respect to the Secretary, who is a very decent, caring guy, who really does care about these issues, what has happened in the past when a bad case occurs, at least in Baltimore, is press, all these guys from Baltimore, cover it for 2 or 3 days; DSS hunkers down, waits for the wave to crash over their heads, public outcry to die down, and nothing ever really changes.

We made these recommendations to the Secretary and the head of DSS back in January. As Congressman Cardin knows, being the former Speaker of the House of Delegates, it was done to get there before the legislative session in case legislation had to change. I don't think Federal legislation is necessary, with one exception: confidentiality. I can't ever get from our own people whether it is State law or Federal law that affects releasing information, but I really believe in transparent government. This is part of transparent government. Too many times people fall back on, we can't release the details of this case. Even fatal cases. I don't understand the confidentiality of fatal cases actually. I have never understood that. We cannot discuss them.

There is no way you are going to solve problems or change the system unless confidentiality, and I am all for confidentiality. I don't want my medical records divulged, but that is not what we are really talking about here. This is to protect kids, and you keep falling back on confidentiality. So, if there is any one issue that the Federal Government, and I don't know specifically where the confidentiality issue lays, Federal or State. That might be something you can be involved in. This oversight is making a difference because these recommendations are getting a lot of coverage now.

Dr. DEPANFILIS. I would like to offer a possible alternate, but somewhat complementary, view, and that has to do with the way that our Federal and State systems are designed to respond after the fact. So, the guidance that the CAPTA sets up, which sets the standards for child abuse and neglect reporting laws at the State level, has a very narrow definition of child abuse and neglect. It is only when those omissions or acts create harm for children, or a serious risk of imminent harm for children, are our current systems able to respond. That, in combination with the funding issues, where much more support is provided after the fact, when there is a need to remove children, which comes out of Title IV–E funding, we end up with this pattern of spending all our resources to serve the same families at the high end, at the deep end, this revolving door.

So, I think we really need to look in this country at a total new system and quit taking the easy road, with these small solutions, and really look much more deeply. Maybe the whole thinking was faulty to begin with, to think you could take a legalistic response to such a complex problem. We know that prevention works in many other fields of practice, if you look at medicine and others. We need to look at prevention with respect to child abuse and neglect.

Mr. MCDERMOTT. It seems to me, Mr. Chairman, and I realize my time is up, but I think we spend $700 million on prevention and about $7 billion on treating the results of the problem. That seems like that is somewhat of an imbalance, and maybe it is something we really ought to look at in terms of what we do with

our money. I think it is a suggestion that this Subcommittee could have an impact on.

Chairman HERGER. The time has expired, and I have been very generous with the time, because certainly this issue is critically important to the young people, to the children of this Nation. I again mention that the purpose for this hearing is to bring to light the challenges, the problems that we have out there. This Subcommittee is looking at coming forward with legislation. We have just had recently the Pew Foundation study that has come out. I am working with Ranking Member Cardin, along with Mrs. Johnson, Mr. Camp and others, to come up with legislation where, hopefully, we will be going out of our way to address these problems that we are seeing coming forth that are, again, not just unique to Baltimore or Maryland, but we see tragically all too often taking place in our other 49 States as well. Mr. McCabe, if I could ask you, who, if anyone, is responsible for determining whether a new mother, especially a teenaged mother, is fit to take a child home from the hospital?

Mr. MCCABE. Ultimately, the way our process works. Oh, excuse me, in terms of who makes that determination whether a child should be released after birth in a hospital?

Chairman HERGER. Yes, and do the hospitals release newborns, for example, to mothers who live on the streets; to mothers who live in homeless shelters? Maybe Director Blair, or anyone else.

Mr. MCCABE. This is where Dr. Beilenson is saying everybody has to work together to determine what makes a rightful plan. Ultimately, judges in Maryland, in our juvenile system, have a role where we make recommendations to them on the disposition of children. So, if there were someone clearly at risk and there was history of it, I think that we do have a role to advise and recommend what the proper disposition is. As this case illustrates, in real time, two children were born in a hospital setting and calls were made. My view is that the right additional questions were not asked and that all parties had some role in failure here.

Chairman HERGER. Anyone else have a comment?

Dr. DEPANFILIS. Basically, I think what you are talking about is, a child is born, there is an assessment of the capacity of that parent to provide adequately for that child when the child leaves the hospital with the parent. If that person, that team in the hospital, has reason to believe that the child will be maltreated, according to the definition in State law, they may make a report of child abuse and neglect. In this case, it would be a risk of child abuse and neglect.

So, it depends how convincing of an argument that person making the call can make to suggest that the conditions that they are aware of would create a significant risk of serious imminent harm when that child leaves the hospital. So, if the parent has been noncommunicative about the information, about their plan, if there is a history of substance abuse, if there is enough, if there is a good enough assessment done at the hospital, then you should be able to make a convincing case, such as in this case. It doesn't sound like that happened. So, it doesn't sound like the call was actually made to report the suspicion of child abuse and neglect, and that is why it fell, in this case, through the cracks.

Mr. CARDIN. Would you yield, just so I can clarify that? If the assessment is made that there is a risk here, the call is made to the DSS; the child, the baby, would normally be released within a very short period of time, 2 days. So, you are saying that the DSS would be contacted by the hospital, and then DSS would then come out and make an on-the-spot investigation? That would be the normal process that would be used?

Mr. BLAIR. Yes, sir. As a Director, I have done that with my workers. I have gone to CPS and taken a call, and we followed through on an investigation, myself as Director, just to see what the process is myself, so you make decisions. You are making it in real time, and that is exactly what happens.

Mr. CARDIN. So, it is your agency's judgment, and you said there were 100 cases that you act on, on abuse, a month in Baltimore City?

Mr. BLAIR. Correct.

Mr. CARDIN. How many of these are made in this type of circumstance at the hospital?

Mr. BLAIR. That number I can't say. I can only say that, over the year of 2003, we had over 13,000 phone calls of people making allegations of abuse in 2003. I don't know how many came exactly from the hospital, but I can get that information to you, sir.

Mr. CARDIN. Thank you.

Chairman HERGER. Thank you. The gentleman from California, Mr. Stark, to inquire.

Mr. STARK. Thank you, Mr. Chairman. I am just trying to see if I can focus here, Mr. Blair, on how the system works in Baltimore City. You have a ratio of 17.5, I see here, of caseloads per worker. Now, is that just for this chart I am looking at, is child protective foster care, adoptions and whatever SFC is? Is that the 17.5, or is this caseload for all families who would come to the attention of your department?

Mr. BLAIR. I believe that is our foster care ratio.

Mr. STARK. That is just foster care.

Mr. BLAIR. I believe that is what that is.

Mr. STARK. You have a Family Preservation Program?

Mr. BLAIR. Yes, sir, we do.

Mr. STARK. Give me an idea, if I were to suggest to you that if all Temporary Assistance for Needy Families (TANF) beneficiaries that had children, what would be, what would you guess the caseload to social workers would be? If you lumped all of these, all of your clients together, what are you operating on in your department in terms of caseload? Make a guess.

Mr. MCCABE. We have approximately a little over 70,000 temporary cash-assistance customers in Baltimore City, excuse me, Statewide, and of that, a number of them single only, the child is a temporary cash assistance client. I don't have that, those numbers.

Mr. STARK. Hundreds?

Mr. MCCABE. I am not sure if I understand the question.

Mr. STARK. Well, how many? All of these people have to be supervised somewhere or another, minimally, if they are not in any immediate danger, but they have to be assigned to a professional, I would presume, a caseworker. I am trying to get your caseload

here, as you say, for foster care and other services is about 17.5 cases to the social worker. I am trying to get, if you take all of your TANF clients and others in your DSS program, what is the overall caseload?

Mr. BLAIR. The persons on TANF are receiving temporary assistance, temporary aid. So, most of them, more than likely some of them have active foster care cases. So, what happens?

Mr. STARK. They do not come under Family Preservation?

Mr. MCCABE. No. What they do, we have within our system in Baltimore City, as across the State, we have separate eligibility workers who work with those clients. They are different and distinct from the people who provide these social services to child welfare.

Mr. STARK. Is there, do they interface a lot?

Mr. MCCABE. They should interface a lot better. We have information.

Mr. STARK. The idea of Family Preservation is that there is housing and food and poverty and transportation and child abuse, and foster care gets to be a very small number, but my suspicion is that not, it happens in Alameda County, California, is that you are closer to individuals supervising a hundred cases. That means you get to look at somebody in their surroundings to see whether there is a house or whether there is assistance and parenting needed once every 3 months as opposed to more often. I am just trying to get, in terms of the resources that we might offer, I am just trying to see how pressed you are for additional resources.

Mr. BLAIR. As a local DSS director, we always welcome any type of resources.

Mr. STARK. What do you pay a starting caseworker in the child protective? What does a child protective caseworker get as a starting salary? After they graduate from Dr. DePanfili's program, what do you pay them?

Dr. DEPANFILIS. First of all, I need to say that most workers in Maryland are not social workers. They have other training.

Mr. STARK. Good training?

Dr. DEPANFILIS. They have other education.

Mr. STARK. Is there a training standard?

Dr. DEPANFILIS. I really don't know. I know that there is a training certification that occurs for all. If they have graduated with their masters in social work, they start at around $33,000.

Mr. STARK. If they teach in the public school and teach in third grade, what do they start with?

Mr. MCCABE. I would suspect higher than that in Baltimore City, without a masters degree.

Mr. STARK. I guess what I am concerned about is that, this is a concern that I have across the country, that we have awfully minimal standards for people who are charged with observing families who probably don't rise to the level of incipient abuse, but if they are not trained, they are not going to spot it. They are trained to add up the numbers and say, "You don't qualify for food stamps any more." It is not that that isn't a job that needs to be done, but if we cannot somehow raise the professional level of your undergraduates and if Mr. Blair can't demand a bachelors degree or some intern training of a couple of months rather than a 10-hour

indoctrination course, I think we just miss a lot of cases. That, I am just concerned that we are not doing that. I don't know how, I know you are limited in the resources you have. I think that is something, Mr. Chairman, that we could do more as we do these programs and not only just by the money we provide, for instance, in TANF for the training, but we are impacting these communities who have to put into operation the plans that we create. I don't know how we get more generous, but I think we have to be. Thank you.

Chairman HERGER. I thank the gentleman from California. Dr. DePanfilis, could you identify for us some of the factors known to increase the risk of child neglect? Are child welfare systems in the United States currently designed to identify those factors and respond with assistance?

Dr. DEPANFILIS. Yes. First of all, let me say that each case, each family situation is different. The things that have been shown in research to increase the likelihood that the basic needs of children are not met, which is one broad definition of neglect, substance abuse, domestic violence, mental health problems of the parents, I would say would be the primary ones. Then you have social isolation, having no one to turn to, lots of stress, high relationship between poverty and meeting the basic needs of your children, but it doesn't mean, most poor people don't support their families. In spite of that, they can still adequately care for their children. So, poverty alone usually does not result in neglect. Poverty puts you in neighborhoods where you have poor housing, where you have poor educational opportunities, lots of high rates of crime and other violence, which then makes the neighborhoods unsafe.

So, I would say those are the core factors that relate to neglect specifically, and neglect is the primary reason that most families are referred to the child welfare system, and those in my own research on the recurrence of child abuse and neglect. Neglect circumstances are the most likely to come back over and over and over again because we failed to respond effectively the first time we become aware of a family who is under stress and is having challenges to meet the basic needs of their children.

Chairman HERGER. Are there any Federal policies that you feel that we might come up with that might more actively encourage States to target these families with these factors to prevent abuse from happening?

Dr. DEPANFILIS. Well, I think the whole emphasis, both within the CAPTA and also the way we allocate our resources under Title IV–E all put an emphasis on after the fact. I think, especially in cases around neglect, this isn't like a one-time thing usually. It is not like an event occurs today and that is it. It is this chronology of omissions in care that sort of mount up and, in the life of a child, mean a great deal to their opportunities or lack of opportunities to succeed in any part of their life. So, I think we really need to go backward, I think, and look at, where are we going to put the minimal resources we have? I think we should change that ratio.

Chairman HERGER. Well, I would like to thank you. I would like to thank each member of our panel.

Mr. CARDIN. Could I make one quick comment? Appreciate that. Just one quick comment. First, I want to first point out, I think the

suggestion that you are now talking more among yourselves is very helpful. If these hearings help facilitate that then that, in and of itself, is important. I am glad to see that you are all trying to get as much expertise as possible to deal with this issue. I just would be bold enough to make just two suggestions that I think have come out of this hearing. One, it seems to me that, I understand Baltimore City has approximately 500 confirmed cases of abuse or neglect a month, of which, 100 results in the child actually being taken out of the family, from the information that I got from Secretary McCabe.

That is a tough assignment. I understand that. I would just suggest that, number one, in the hospital itself we could be doing a better job with children who are born there. I think, I know Dr. Beilenson has made some recommendations here, but it seems to me that we should be able to assist the hospital in carrying out its very tough responsibility, to get DSS involved before a child is allowed to come home. It seems to me we should have better guidelines to help the hospital get the information from DSS or report the information to DSS in order to make the appropriate evaluation.

The second point I would suggest is that, when we have a child in foster care who is a very tough assignment, such as Ms. Swann, we should have some type of way of putting a high priority to provide services to that individual. Again, it may not be appropriate within foster care. We might have to go beyond foster care. We should be able to put a high priority on that type of a case. We should be able to identify that. Once again, Mr. Chairman, I want to thank you very much for permitting this hearing so that we could try to understand what happened in Baltimore and use that not only to help people in our jurisdiction but to use it as a way to try to get national involvement to try to help our children.

Mr. MCDERMOTT. Can I ask another question of them?

Chairman HERGER. Very briefly.

Mr. MCDERMOTT. My question is this: if neglect of children is the major reason that you pick kids up, to what extent are, or are you yet seeing any impact? Or do you anticipate impact from the lessening of the availability of Section 8 vouchers and, therefore, the loss of housing, so that people start living in their cars and that kind of thing?

Dr. DEPANFILIS. I think, in Baltimore in particular, I think we are all sort of nodding our head. The housing, both the quality of housing and the quality of housing at an affordable price, high content of lead in the poor housing, high density of people within four walls, all of those things are major issues and have a big impact on how adequately parents can care for their children.

Mr. MCDERMOTT. Thank you.

Chairman HERGER. Again, I want to thank each of our panel members for appearing before us on this very difficult issue to discuss this tragic case. I look forward to continuing to work with all of you to ensure that States are doing all that is necessary to protect children from abuse and neglect. With that, the hearing stands adjourned.

[Whereupon, at 5:15 p.m., the hearing was adjourned.]

[Submissions for the record follow:]

Statement of Theresa S. Cook, Santa Clara, California

I am a Mother who has lost a son to the Department of Children and Family Services not only because of a "system that is broken" but because "the system is corrupt". There are NO changes possible for Children in the System until you remove the problems from which they are rooted. The root to all and mainly to this evil is the people who currently run the programs. The Best Interest has somehow gotten lost and greed has taken over. These people are given bonuses for every adoption, tax deductions, awards, not to mention what is paid under the table and much more. One who denies any of this to be truth is not only lying to themselves but disgustingly; they also lie to the children. I know first hand because my son was lied to and I was lied about. The record is set up against me and it's all-fraudulent. Time and time again, I continue to present my case to committees just like this one and time and time again I am ignored. I have the evidence to prove the lies yet; no one wants to take the time to see them. I am just one voice in a crowd of many who keep screaming out for help and are not being heard. Change is on the horizon, we have heard this for many years now and nothing has changed. Only the order of the words seems different. Before you make change, you must fix the problem. Get the criminals out of their positions, appoint "watchdog" citizen panels to review the cases, RETURN the children and as you witness the reunions, the looks of the parents who will never get their child home because of death, the scars so many have suffered from and the sigh of relief at a mother who holds her child after thinking she would never ever see him again, take those moments into consideration when deciding what changes you have to make. The answers are there as they have been all along. Any one of you who can't look at the number of children being removed, the number of children not being returned should have some concern why those numbers are so high. KEEPING FAMILIES TOGETHER IS SUPPOSED TO BE THE GOAL HERE. Why then are so many children not going home? How many more children will it take to slip through the cracks before you realize the truth? This is Tragedy that could be so easily prevented if that were the true intensions at stake.

Comments on Testimony

Having had experience with the System and becoming an Advocate for other parents who are suffering as I am without my child, I would like to comment on the testimonies taken on June 17, 2004.

A. To The Honorable Wally Herger;

1. You stated that the purpose of this hearing was to understand what happened in the Baltimore case so it could prevent it from happening again.

Your Honor, when will it be a reality to all of you that sitting down to talk about it will not solve the problem? You "explored" the case of the starving children in NJ; you have reviewed federal and state oversight measures, and even heard about each and every state FAILING the Federal Reviews. This is not the first year they have failed; this is one of many years it failed. And every year new changes are going to be made and every year, more children are taken and every year more children die and every year, this committee sits down to talk about it. The tragedy of a family being torn apart for ever, the death of a child who's left in a strangers home to die alone, the bruises and the scars other children have and are suffering from tonight and the silent cries of children for their mothers and the mothers for their children whisper in the wind each night as the world lays down to sleep. Children are being physically dragged from their families, beaten, molested, killed all the while they are lied to and drugged and moved from place to place. They lose their identities, their rights and the very core of who they really are.

Stopping the tragedies takes more then sitting down, it takes action and it takes immediate action in order to attempt to prevent the next from happening. True, no policy is perfect but it's the people who have the power to implement them that are to blame here. They take the polices and manipulate them to their own benefit and that's where change must occur.

B. Floyd Blair;

2. Ask any family who has been involved with the system if the Department addressed the families' difficult issues in any other way but to use them against them in court? Limited resources are not the issue. The resources exist and many of them good ones. The problem is with the Social Worker who is under pressure of a Director who looking to make brownie points with members of the Board of Supervisors or someone else in position. Most social workers don't care what the families issues

are, they are just out to get the child put somewhere and the last place they consider is to return them home. You will see in my own personal story how well the Social Worker helped my family. Social Workers do give 150% and that's in making sure the child never returns home.

Heart wrenching is when a parent busts their rear end to get their child back and a social worker recommends termination of rights because of lies. Heart wrenching is having a 6-year-old boy tell his mom that he will promise to come home when he gets big and to not move so he can find her. Heart wrenching is when the birthdays, Xmas, Mother's Day, Father's Day etc. roll on by each year and there's an empty void because someone very special is missing.

The statistics will show, if taken honestly and they aren't, that most of the children who die in the homes of their parents are children who have been abused for years or most of their lives. They are "damaged" in the eyes of the Department and would be harder to place if they were to be removed. So, they are left behind. During a termination of rights hearing, features, "adorable-adoptable", always describe the child. Children are described at the Reunification trials as to having severe mental health issues that will only be aggravated more if returned home but shortly after while in the.26 hearing, this mental health issue will diminish and the child is deemed adoptable.

We have proof in the county where I live in that paperwork is changed and altered by Officials. They even get to keep tier job when the paperwork is exposed. Money embezzled from someone amounts to jail time for a "citizen" yet, if a county or state employs you, you are not even held accountable. That is what happens in Santa Clara County and I'm sure it happens elsewhere too.

C. To Peter Beilenson;

3. Your recommendations are logical and unfortunately have "suppose ably" already been implemented but still they hold too many gaps. What about foster parents who adopt or take in several children, like the NJ case? What about the unlicensed social worker? Many of them are. What about the social workers having to produce evidence to prove their statements not just allow hearsay to be admitted. What about a Judge who gives the perpetrator of domestic violence custody even though classes was never completed? What about the social workers accountability for NOT following the mandates as they are written.

You spoke about the three major causes of childhood deaths; SIDS (adults cosleeping with infants mentioned), Juvenile shootings and a) CPS having removed a child and returned it only to be killed by the parents b) one child removed and another killed later. Be realistic with your studies. California has the largest amount of children taken into custody by CPS. Experts here say that out of the 75,000 children taken up to 50% could have been left home. DCFS comes into contact with nearly 180,000 children each year. That's five-fold and its doubled in the nation. More then 660 children have died since 1991 and more then 160 were homicide victims. Go onto the website "Forgotten Children" you'll see the horror these children are suffering in the hands of CPS. There are many, too many other websites filled with these inexcusable and preventive deaths.

There have been numerous lawsuits settled that involve CPS. Hundreds of parents are stepping forward and begging for help from our Government to get their children back because of the injustices CPS is inflicting upon us all. Yet, you refuse to hear the truths and continue to point fingers at the parents. That is just the easy way out of a very bad situation in which it appears that each and everyone of you A) Just don't care B) profit from it in one way or another or C) are just too naive to understand about it.

It is frustrating to try and understand why you would state that you are disappointed in the vague responses to your recommendations to the State's Secretary for Human Resources and the Director of Baltimore's DCFS. Doesn't that non-willingness of participation ring a bell for you? What will it take to get you to see why you are not getting prompt responses? And what do you intend on doing about the lack of concern on their part?

Before making any future recommendations, I would suggest looking at the reality of what is happening here and while you face it deal with it accordingly. For instance, December 2, 3003, President Bush signed the so-called "Adoption Promotion Act". This signature expanded an existing adoption bounty program. The bounty encourages states to tear children from their families-especially easy-to-adopt infants. Even if the adoptive parents decide to give children back, states keep their bounties and toss them into slipshod placements which are even more likely to fail. Fewer foster parents are willing to adopt then promised yet, termination of rights has increased. Between 1997–2001, 92,000 parental rights were terminated. A generation of "legal orphans". In 2002, 3000,000 were taken from their parents with termi-

nation of rights taken. I know, my child was one of those children. Children are trapped in foster care each and everyday and the end results are needless.

D. To The Honorable Christopher J. McCabe,

The only comment needed here is that it is very strange how your explanation of the Departments situation and plans just so happens to be the same as every other Social Services Department in the country's explanation. I am beginning to believe that is something one would learn in a Social Services 101 Class.

E. To Diane DePanfilis,

"Family Connection" is also a program that was implemented here in Santa Clara County. Problem is the program hasn't benefited any parent or child that I know of. The County Officials have once again formed another committee to "aid families" and no results have taken place. I can say that it is more likely then not that the Federal Funding was received and probably spent elsewhere as Federal money is easily obtainable resulting in very little progression for the safety of the children. Has anyone thought to recommend that any Federal money given should be only spent on those that produce positive results? Positive results meaning families stay together and family issues resolved. Positive results meaning fewer children removed and fewer children abused and killed. Positive results are having a truly abused child's life saved. One who's importance would normally slip through the cracks because the focus is on taking a child whose parent is willing to make changes and whose willing to do whatever it takes to get their child home to them.

We already have the "Working together across systems" going on here in Santa Clara County. It consists of a team of *A Superior Court Judge and/or Commissioner, *CountyCounsel, *A Social Worker, *A District Attorney, * Juvenile Dependency Attorney, *A therapist and *a psychologist. As a team, they all work together to promote the negative issues of the family over a limited period of time thus resulting in the termination of parental rights for adoption of the child.

These "known professionals" need only the "evidence of hearsay" to establish their case against the parents. The parents are greatly involved in each and every case as this team demands completion of the case plan. Parents are told after complete ion that it wasn't good enough or that they didn't learn enough or that time had run out. Might I add that a greater number of these "so-called professionals" are not even licensed. The ones that are were only required to take training courses which ran 4 to 6 hours each.

IN RE: JOHN C.

March 13, 2000, my son John, three years old at the time was taken into custody after a 911 call. I had argued with my two older boys about a relapse I had. Having been in treatment and diagnosis with Bi-Polar Disorder, I was suddenly caught in the middle of a nasty divorce, insurance cut off and no medication. The only thing I knew was to self-medicate. I was not happy with that decision and to prove to the kids I didn't want to continue using, I dialed 911. Thinking I would end up at the county hospital, I soon realized I was headed to jail and John to the Shelter. Previously, four other children had been removed and I had never been offered any kind of treatment plan. Two other children went to live with their Dad but the Courts recommended I do drug treatment at my own expense and I had no income at the time. My two children were taken by their Dad out of state where he has held them away from me for over 11 years now.

I was told by the first Social Worker that if I completed my case plan, my son would be returned home. I was put into intensive programming dealing with "dual Diagnosis" and I successfully completed each and every class I went to. I obtained employment and worked with other addicts, built a strong support group and continue to maintain my sobriety and contacts with my sponsor who is my best friend. I complied with everything. I struggled with dealing with my ex-husband and his family who did everything to keep me from regaining custody. There were phone calls made to the social worker several times, which were made out of complete vindictiveness. The social worker (SW # 4) admitted to never investigating these allegations. She merely wrote reports to the Judge and submitted the allegations as facts. She lied and manipulated my son away from me over a period of 2½ years. I was accused of telling my son to lie—accused of having "diluted" tests", burning my son with a cigarette intentionally amongst other things. A social worker from the DA's office put the icing on the cake with the cigarette burn. One burn which he had no doctors report on, no visits were stopped and my son was not removed at the time he says he saw the burn. Amazingly, on the witness stand this "so-called expert" admitted to seeing a burn and then he stated he never saw it. Out of five Judges

who sat on my case, one described me as being a MBPS Mom. Despite numerous letters from my doctor, the Court and the social worker made their own diagnosis and said that the people that were with me on a daily basis (who never witnessed any of the allegations I have described) were incredible. My rights were terminated on September 20, 2002. It had been 6 months that I had seen my son as they had terminated my visitation in May 2002.

My son and I were very closely bonded. He was the sparkle of my eye and I was a very good mother to him. I never let him down until the Department stepped into our lives. Once involved, they made sure I failed my son in every way and told him I was the cause of the failure. He would beg for me to let him stay at my house. He cried when I had to take him back to his Aunt's house and told me I didn't' love him. This result after a perfect weekend we had spent doing things together and with other family members. The system literally tore my son and I apart with their lies. I have proof to each and every lie they told and I have shown several entities, including this committee the documents, yet I am unheard and my son is to this day, somewhere out there. I have no idea if he is even alive. If he is being abused, if he is happy, sad, has a home, a bed . . . I have no idea and the unknowing is pure torture.

Your system and the people who run it should be abolished. You people have got to do the right thing and bring our children home. I don't mean to round table discuss this matter but to put it into action immediately. "Let our children go." Where have you heard those words before? Each and every day, each and every hour, each and every minute that goes by with no immediate action taken on your part is a crime and a lack of concern to humanity on your part. Too many children are being taken, why can't you understand that there is a serious violation being committed against the families of America and even other nations if that were to be sized properly. What is happening is not just a matter of a case or two. It's a matter of millions of cases and it's a greater chance that if this keeps going many, many more children will go unprotected as the billion-dollar industry of stealing and selling children is kept alive.

There are many parents like myself who realized their mistakes and sought help. This has to amount for something other then the loss of our children. In today's society, drug addicts are frowned upon and treated as if they can never make changes. Investigations are done and the results are "Looking into the family history and the social workers notes". We obliviously all know that cycles of family history can be broken and that the programs work for those who want to work them. If it is true that drug addicts can not change then why are so many federal tax dollars being "wasted" on the programs? The truth is that the programs are working and the results are showing. So, the question now shifts to the Juvenile Dependency system. Unlicensed social workers are being allowed to opionate to a judge without even following state mandates. There is no room to err on the part of a parent but the social workers are not obligated to accountability on anything they do. The sickest part of the whole situation is that they know it and they will take advantage of it.

The social worker in my case told me exactly what the Judge was going to rule on 6 months before the trial and she had already informed my son that he was never going to see his mom again. Another social worker told my son that he was going to be getting "proper parents". This is a child who was never abused, who was close to both parents even though my ex and I did not get along, we both were bonded to our son. This child was the focus and center of attention at all times and no matter what, his needs always came first. Yet, the social worker told me I was an "unfit mother." When I got upset over that remark, she informed the Judge that I was "maniaced and spinning out of control".

When the opinion of the Sixth District Court Appeals came out, I was appalled. The facts of the case were incorrect. They didn't even mention testimony and documented proof that those facts were proven wrong during the termination of rights trial, instead they focused on a previous trial. Termination of Reunification was a complete sham. Represented by a "public defender", my rights were certainly not protected in the course of the trial. They brought in statements that were not true and my attorney did nothing to protect my interest. She even told me after the trial that there was no reason to appeal because I had nothing to appeal about. I found out months later that the entire contents of the trial was appeal able and had I appealed I probably would have had my son returned to me today. The Justices sure made comment to the fact that I did not appeal the trial, but never mentioned as to why that occurred.

I want my son back and I want him back now. I have patiently waited for two years now for people like this committee to take action and do what needs to be done. In LA County, they are returning children as they have admitted the wrong of the department. Here in my county, the Board of Supervisors continues to shuffle

the blame. Over the past two years or so, the County has been exposed in the following:

1. Juvenile Hall Officials were busted for physically abusing the kids in custody. “Counselors”, better known as Police Officers were using excessive force on these kids resulting in bruises and broken bones. In CYA, they had cages they put the kids into. This abuse has been reported for years and has been ignored until recently. Many cases of abuse could have bee prevented had the voices been heard. To date, nothing has been mentioned about the reprimand of the officers. Child abuse is a crime and a felony at that. I wonder why it’s not being imposed in these cases?
2. The Children’s Shelter investigation results were horrifying. Especially since my son spent a considerable amount of time there during the reporting period. He was 3 and 5, having been placed back into the system by my ex-sister in law after my visits were terminated. She didn’t raise her own son due to mental illness and had no intensions of raising mine. Her goal was to show me that she had the power as she put it, to stop me from getting my son back. She proved it all right at my son’s expense. She and the ex brother in law are now divorced and she has moved out of the state. The investigation of the shelter produced many abuses. Children were restrained and locked into a closet like room until they calmed down. We have discovered that the children are rugged. Thorizione and Adavent are given to little children to keep them calm and zombie like. Drugs and prostitution were exposed. Molestations. The Feds told the County that no child under the age of 6 is to be left at the shelter overnight. Only for the amount of processing time. It was discovered that this was not honored and that several children remained there for several days under the age of five. One six-year-old girl was molested by a thirteen yr old boy. This was exposed with the next that occurred in this county.
3. Following the Shelter report, a Civil Grand Jury began investigating our complaints against the Department of Social Services. They spoke to the Ombudsman’s office. What they discovered soon made local news as the Director of that office was making 200, 0000.00 from the county for services and she spent the majority of her time in Costa Rica. She fired the two whistleblowers that exposed more of the evidence and documents against the Department’s Director and the Children’s Shelter. The Director-altered documents which detailed the molestation of the little girl. Altered documents were also submitted to the Board and there were other documents submitted altered. Thus, the final reports were not true. Turns out the Chairman of the Children and Family Service Committee knew about the Ombudsman’s Office and so did the Director. A going quay party was thrown for her when she first left. Those that attended were people in position in the County. End results of that scene were that the County fired the Director of the Ombudsman’s Office and denied knowing anything more about it. The Director who altered documents still continues in her position and the Board members are acting as if it never happened and that what happened was innocent and done for good cause and our DA is turning his head the other way. The local NAACP Office who opened the can of worms by allowing the parents to hold an open forum with County Welfare Officials present has announced that no civil rights were violated, (The Civil Grand Jury is supposed to file a report stating that there has been violations) and he has reneged on each and every promise made to the parents who spoke at that forum. Inside scoop is that the Chairman of the Committee has told the NAACP to “get the parents off his back”.

Having spoken to an FBI agent in our County about the corruption, she stated that they knew that there was a lot of money here being passed but that they didn’t know how it was “going from hand to pocket”. She asked me if I knew anything and although I have been privy to some things, I told her no. That was because she told me that even if I had all the facts about the money, it would not change the status of my case as what they are doing is “legalized kidnapping”. I would have to prove fraud.

In Black Law’s Dictionary, F–R-A–U-D is defined over several pages starting with this; “An intentional perversion of truth for the purpose of inducing another in reliance upon to part with something valuable thing belonging to him or to surrender legal right. A false representation of a matter of fact, whether by words or by conduct by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives and is intended to deceive another so that he shall act upon it to his legal injury/ Anything calculated to deceive, whether by a single act or combination, or by suppression of truth. Or suggestion of what is false,

whether it be by direct falsehood, by innuendo, by speech or silence, word of mouth, or look or gesture."

Fraud is what has happened in my case and in several millions of cases all across the USA. California is the worst. I do believe that this problem can be fixed if it's truly the intent of your discussions. If you are truly concerned about the safety of these children then you MUST take immediate action. Return my son and other children who have the right to be where they belong. Stop the overflow of the foster care and you will then have enough fostering places for those children who clearly do need the help like the twins that brought you all together.

For too many years, the system has been on the "hot seat" and vowing to make changes for the "Best Interest" of the children. The results prove that the System is failing our children. Time has come to look into other solutions. Such as doing the right ways by returning children, removing those who are being paid to do nothing but make more excuses every time another child dies, let the people work for the system and the system for them. You can figure the rest out. After all, that's your job.

My space is limited and trying to submit my evidence in 10 pages is impossible. I truly believe that the System knows that you people will not look into lengthy exhibits and that's why they drag the situation out. Think about it. We are dealing with a highly intelligent group of people who like living in the high life and will do it at the expense of a child. The proof is there. The question is "How many more children is your Committee willing to let die before you decide to take action?" Tell the children yourself, how many of them will NOT be with their parents. Face the end result of the child who has been raised by the system and yet cannot get a grip on life and how to deal with it. There are too many wrongs here and no rights. Make the way clear.

I am available for further information if you need it. Thanks for your time and patience. Have a good day.

Statement of Fight Crime: Invest in Kids

Mr. Chairman and Members of the Subcommittee:

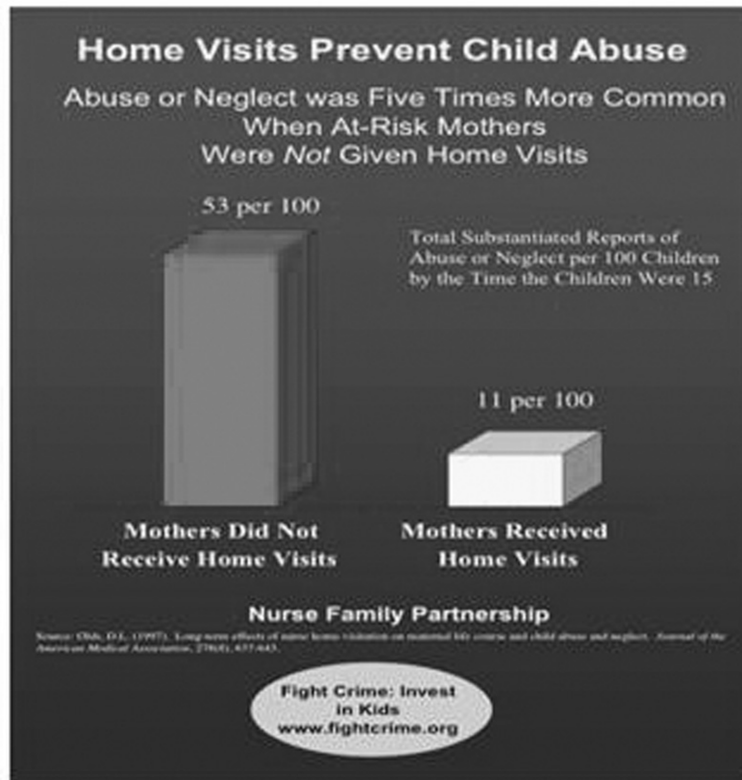
Thank you for the opportunity to submit this written testimony. My name is Sanford Newman, and I am the President of Fight Crime: Invest in Kids, an anti-crime group of more than 2,000 police chiefs, sheriffs, prosecutors and victims of violence from across the country who have come together to take a hard-nosed look at what the research says works to keep kids from becoming criminals. In considering how to reduce child abuse and neglect tragedies, such as that of Sierra Swann's children, the Subcommittee faces a formidable and very important task. I hope my testimony will help this Subcommittee make choices that will prevent child abuse and neglect, and reduce crime now and in the future.

The members of Fight Crime: Invest in Kids, on the front lines of fighting crime, know that that there is no substitute for tough law enforcement. However, once a child has become a victim of child abuse and neglect, a jail term for the offender cannot replace the innocence or the life that is lost.

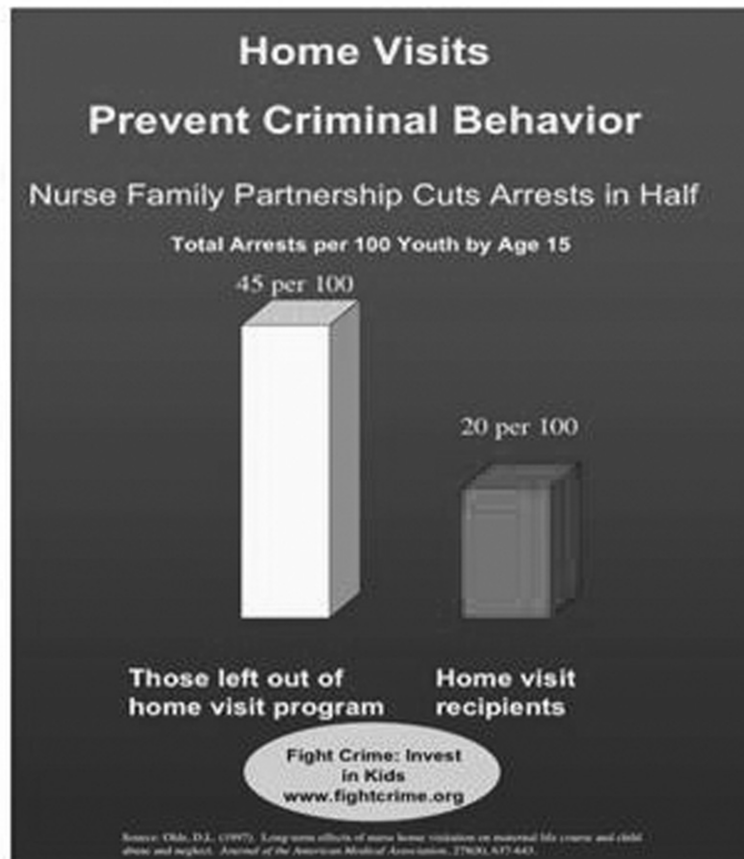
On May 11, 2004, Emonney and Emunnea Broadway became yet another national tragedy. Both girls, only a month old, were found dead—victims of child abuse and neglect. The situation that led to Emonney and Emunnea's deaths is unfortunately not a rare occurrence in our nation. In 2002, the latest year for which data is available, the Department of Health and Human Services reported that 896,000 children were victims of abuse and neglect, and 1,400 children died. Of these 1,400 children, 41% died before reaching their first birthday. And over half of the children who die from abuse or neglect were previously unknown to child protective services.

Child abuse and neglect is itself often a crime, and it also produces a cycle of violence whereby victims of child abuse and neglect grow up to become perpetrators of violence. Sierra Swann, a foster child, was a victim of child abuse and/or neglect herself. While most victimized children will not commit violent crimes later in life, being abused or neglected sharply increases the risk that children will emerge as violent criminals in their adulthood. When that happens, many thousands of additional innocent people become victims. The best available research indicates that each year 35,000 additional violent criminals and more than 250 murderers will emerge as adults who would never have become violent criminals if not for the abuse and neglect they suffered as children. But this fact need not become a reality if we invest in programs—such as in-home parent coaching—that are proven to reduce child abuse and neglect.

Research has shown that providing in-home parent coaching to at-risk moms like Sierra Swann can dramatically reduce child abuse and neglect. For example, rigorous research published in the *Journal of the American Medical Association*, shows that children of mothers left out of the Nurse Family Partnership program (NFP)—an in-home parent coaching program through which trained nurses visit single, poor, first-time young mothers during and after pregnancy—had five times as many substantiated reports of child abuse and neglect as the mothers who participated.



A fifteen year follow up study of NFP participants showed that mothers in the program had only one-third as many arrests, and their children had half as many arrests compared to those who received no services.



In another study, the Healthy Start program in Hawaii (which is the basis for the nationwide Healthy Families in-home parent coaching program) succeeded in reducing severe abuse and neglect through in-home parent coaching. In at-risk families that received parent-coaching, only 2 in 1,000 children were hospitalized for child abuse and neglect compared to 13 in 1,000 children from similar at-risk families not receiving parent coaching. In other words, failing to provide high-risk families with in-home parent coaching makes the children six times more likely to be hospitalized for abuse and neglect.

Currently, only 12,000 eligible mothers are being served by NFP. The Healthy Families program serves only 50,000 families. Other in-home coaching programs combined still leave at least 500,000 at-risk mothers in need of in-home parent coaching. Providing in-home parent coaching to all at-risk mothers, like Sierra Swann, means tragedies—such as the death of Emonney and Emunnea Broadway—are far less likely to happen.

The Sierra Swann case highlights a nationwide problem that, if not properly addressed, can lead to more crime and even death. However, the tragedy does not end there. Child abuse and neglect costs America upwards of $80 billion a year. Two-thirds of that is in crime costs alone. A study by RAND concluded that the Nurse Family Partnership program saved taxpayers four dollars for every dollar spent on the program and paid for itself by the time the kids were three years old. In an era of soaring budget deficits, we can no longer afford NOT to make the needed in-

vestment to support a nationwide in-home parent coaching effort that would serve nearly a million at-risk mothers across the country.

One word of caution: the President, in his Fiscal Year 2005 budget, suggested changing the Title IV–E foster care entitlement into a state option capped grant, in order to free up more funds for prevention services, such as in-home parent coaching. While well-intentioned, we are concerned that implementation of such a proposal would likely be counter-productive, and endanger children, because: (1) there are no guarantees that under the state option grant "flexible funding" plan proposed by the Administration, states will actually use the money on child abuse prevention services (and, historically, only small percentages of mixed-use funding pools tend to go to prevention—the vast majority tends to go to addressing the needs of children already in the system, also currently underfunded); and (2) there is inadequate protection for children who have been abused or neglected and need foster care—especially if there is a sudden upsurge in cases, as there was during the crack/cocaine epidemic in the late '80s and early '90s.

In his Fiscal Year 2005 budget, the President also proposed increasing the Promoting Safe and Stable Families Program and the Child Abuse Prevention and Treatment Act—the two primary federal investments specifically addressing child abuse and neglect prevention. Congressional passage of the President's proposed increases would be an excellent first step. However, even the President's proposed increases would leave hundreds of thousands of America's most vulnerable children without the services they need.

Law enforcement leaders know that one of the best ways to reduce future crime is to invest in programs that prevent child abuse and neglect. Furthermore, studies have shown that in-home parent coaching is effective at preventing child abuse and neglect. It is time for Congress to get tough on crime by providing the resources needed to support in-home parent coaching for all at-risk mothers.

Justice for Children
Washington, DC 20005
July 1, 2004

Chairman Wally Herger
Subcommittee on Human Resources
Committee on Ways and Means
1102 LHOB
Washington, DC 20515

Dear Representative Herger and Members of the Subcommittee:

We commend your initiative in calling this hearing on behalf of Maryland's children, spurred by the tragic death of two children in Baltimore City.

Justice For Children, a national child advocacy organization, is composed of concerned citizens who share the belief that our community must act together to protect abused and neglected children from further abuse and to defend every child's right to grow up in a safe and loving environment. Justice For Children works together with Children's Protective Services and other such agencies for the welfare of these children, and, when appropriate, intervenes on behalf of children in court or agency actions that have the potential to compound the harmful effects of the abuse they have already suffered.

Since our founding in Houston, Texas in May 1987, Justice For Children's accomplishments have been nationally recognized. Our achievements have been featured on ABC's Prime Time Live, on the ABC Prime-Time documentary "Crimes Against Children," a PBS documentary entitled "Boy Crying, Baby Crying," and on Good Morning America, Donahue, and HBO. In our effort to expand our commitment to serve as an advocate for all abused children, Justice For Children now has chapters in Arizona and the District of Columbia.

Our mission is to raise the consciousness of our society about the failure of our governmental agencies to protect victims of child abuse, to provide legal advocacy for abused children and to develop and implement, on a collaborative basis where possible, a full range of solutions that enhance the quality of life for these children. We accomplish this mission through intensive case advocacy, providing pro bono counsel for children or the protecting parent, court watch, filing friend of the court briefs in selected appellate cases, a community resource hotline, referrals and community presentations. Our public policy recommendations are based on hands-on expertise with abused children whose cases that have fallen through the cracks.

Since the founding of our Washington, D.C. Chapter in 2000, many cases of "system failure" involving abused children in Maryland have been referred to our office for advocacy.

One of the first cases that came to our attention was that of little Collin Horridge. In 2000, when he was nearly one-and-a-half years old, Collin's mother brought him and his older sister from Texas to live in St. Mary's County, Maryland. She shared a house with a male friend with children of his own.

Collin's father, Eric Horridge, worried about Erica and especially Collin: their mother had been abusive to him in the past. When Mr. Horridge remembers that when called to speak with the children, he sometimes heard her hitting Collin on his head—once using the phone receiver. Another time he recalls hearing a crash and then the baby's screams after Collin's high chair was tipped over.

Mr. Horridge has phone records documenting his futile attempts to get St. Mary's Co. Department of Social Services ("DSS") to intervene and protect Collin. After many calls, DSS sent a caseworker out to the house as a "courtesy" to what they obviously thought was a "disgruntled" ex-boyfriend.

The caseworker gave Collin a cursory check and noted bruising around his eye and on his forehead. She reported that this 19-month-old baby stated: "I fell on my toy." She never bothered to lift his shirt or remove clothing to look at his tummy, buttocks, back or legs. Shortly thereafter, Mr. Horridge was informed by DSS that they had closed Collin's case and that he should just stop calling them.

Two weeks later, Mr. Horridge received a telephone call: his son was dead. Collin had massive internal injuries as well as over forty-four old or new wounds and bruises on his small body, according to the medical examiner's report. His nose was broken and hanging over to the side of his face. A large footprint on his abdomen resulted when the mother's friend stepped on him with his full weight of 185 lbs. for five seconds—an attempt to "resuscitate" the baby as he testified at trial (he was tried and acquitted twice).

St. Mary's County released Collin's body to his mother even though she was at that time charged with contributing to his death. She immediately cremated his body—effectively doing away with state's evidence—and to this day she has possession of his ashes. To this date, no one has been held accountable for Collin's brutal death.

Jervis Finney, Chief Counsel for Maryland Governor Robert Erlich, confirmed in writing that Collin's death has never been investigated by Maryland Fatality Review Board or by any other state agency.

At hand of our extensive experience with cases of system failure in Maryland as well as in many other states, we have come to recognize the patterns and weaknesses that allow children to fall through the cracks.

I am attaching a document created by the Arizona Chapter of Justice For Children called "Eleven Components of an Effective Child Protection System." I hope you find them of interest as you continue to hold hearings on the failings of the child welfare system in America.

Once again, we thank you for your understanding of the urgent need for systemic changes to protect Maryland's children and all children in America!

Respectfully submitted,

Eileen King
Regional Director

Statement of Matthew E. Melmed, Zero to Three: National Center for Infants, Toddlers and Families

Mr. Chairman and Members of the Subcommittee:

I am pleased to submit the following testimony on the safety of very young children in foster care on behalf of ZERO TO THREE. My name is Matthew Melmed. For the last 9 years I have been the Executive Director of ZERO TO THREE. ZERO TO THREE is a national non-profit organization that has worked to advance the healthy development of America's babies and toddlers for over twenty-five years. I would like to start by thanking the Subcommittee for all of their work to ensure that our nation's infants are safe. I commend you and the Committee for holding hearings on the safety of maltreated children in this country.

The tragic Baltimore case on which your hearing focuses today raises concerns not only about the problems of adolescents growing up in the child welfare system, but also about the particular vulnerability of very young children and the intergenerational nature of abuse and neglect. I know that you have received very

able testimony on the subject of older children in the system. I would like to address the effects of abuse and neglect on infants and toddlers and offer recommendations for your consideration as you look at systemic changes to the way in which states address child welfare. I also would like to describe a promising approach, Court Teams for Change, that helps improve the well-being of maltreated infants and toddlers and their families and seeks to break the intergenerational transmission of abuse and neglect.

We know from the science of early childhood development that infancy and toddlerhood are times of intense intellectual engagement.[1] A child's first years set the stage for all that follows. During this time—a remarkable 36 months—the brain undergoes its most dramatic development, and children acquire the ability to think, speak, learn, and reason. In fact, by age three, roughly 85 percent of the brain's core structure is formed.[2] Future development in key domains—social, emotional, and cognitive—is based on the experiences and relationships formed during these critical years.

Portrait of Very Young Children in Foster Care

Infants are the fastest growing category of children entering foster care in the United States.[3] They comprise the largest cohort of young children in care—accounting for 1 in 5 admissions.[4] Twenty-one percent of all children in foster care were admitted prior to their first birthday and 45 percent of all infant placements occurred within 30 days of the child's birth.[5]

Once they have been removed from their homes and placed in foster care, infants and toddlers are more likely than older children to be abused and neglected and to stay in foster care longer.[6] Half of all babies who enter foster care before they are three months old spend 31 months or longer in placement[i] and they are less likely to be reunified with their parents. Thirty-six percent of infants who enter care between birth and three months of age are reunified with their parents compared to 56 percent of infants who enter care at 10–12 months of age.[7]

Developmental Impact of Child Abuse and Neglect on Very Young Children

The developmental impact of child abuse and neglect is greatest among the very young. Infants and toddlers are extremely vulnerable to the effects of maltreatment. Its impact on their emotional, developmental and physical health can have life-long implications if not properly addressed. Research shows that young children who have experienced physical abuse have lower social competence, show less empathy, have difficulty recognizing others' emotions, are more likely to be insecurely attached to their parents, and have deficits in IQ scores, language ability, and school performance.[8] Without intervention, by the time these children reach school age, they will also likely be at risk for social problems and learning deficits. Compounding the problem, one third of the individuals who were abused and neglected as children can be expected to abuse their own children.[9]

According to one longitudinal study, being abused or neglected as a child increased the likelihood of arrest as a juvenile by 59 percent, as an adult by 28 percent, and for a violent crime by 30 percent.[10] Abused and neglected children are also more likely to have mental health concerns (suicide attempts and posttraumatic stress disorder); educational problems (extremely low IQ scores and reading ability); occupational difficulties (high rates of unemployment and employment in low-level

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[1] Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

[2] Bruner, C., Goldberg, J. and Kot, V. (1999). The ABC's of early childhood: Trends, information and evidence for use in developing an early childhood system of care and education. A joint publication of Iowa Kids Count and the Iowa Forum for Children and Families.

[3] Dicker, S., Gordon, E., Knitzer, J. (2001) *Improving the odds for the healthy development of young children in foster care.* New York: National Center for Children in Poverty.

[4] Ibid.

[5] Wulczyn, F., Hislop, K., & Harden, B (2002). The placement of infants in foster care. *Infant Mental Health Journal, 23(5),* 454–475; Oser, C. & Cohen, J. (2002). *America's babies: The ZERO TO THREE Policy Center data book.* Washington, DC: ZERO OT THREE Press.

[6] Wulczyn, F. & Hislop,K. (2002). Babies in foster care: The numbers call for attention. *ZERO TO THREE Journal,* (22) 4, 14–15.

[7] Ibid.

[8] Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

[9] National Research Council. (1993). *Understanding child abuse and neglect.* p. 223.

[10] Widom, C., & Maxfield, M. (2001). *An update on the "Cycle of Violence",* Research in Brief, Washington, DC: U.S. Department of Justice, Office of Justice Programs, National Institute of Justice.

service jobs); and public health and safety issues (prostitution in males and females and alcohol problems in females).[11] However, research confirms that the early years present an unparalleled window of opportunity to effectively intervene with at-risk children. And intervening in the early years can lead to significant cost savings over time through reductions in child abuse and neglect, criminal behavior, welfare dependence, and substance abuse. It is critical that child well-being be the first priority in all child welfare cases.

Promoting the Health and Well-Being of Infants and Toddlers: Infant-Toddler Court Teams

I am going to briefly describe one approach that offers promise by building on the existing collaborative approach of the National Council of Juvenile and Family Court Judges Model Courts and the expertise of ZERO TO THREE: National Center for Infants, Toddlers and Families in translating the science of early childhood into resources for parents, professionals and policymakers. Multidisciplinary Court Teams, with a specific focus on the needs of infants and toddlers, could be a vehicle for implementing ZERO TO THREE's policy recommendations, described below. By partnering legal expertise with the science of early childhood development, these Court Teams could work to raise awareness, increase knowledge and skills, and change practice and policy regarding the needs of infants, toddlers, and their families involved in the judicial system.

This model envisions Court Teams co-led by a judge and in infant mental health/ child development expert in partnership with key community stakeholders who serve the very youngest children, including community leaders, Court Appointed Special Advocate, and guardians *ad litem*. By bringing together the knowledge and skills from the judicial system with the training and expertise of the child development field, this collaborative, coordinated model has the potential to promote child well-being by improving systems, services and funding.

This Infant-Toddler Court Team model is based on the pioneering work of Judge Cindy Lederman and Dr. Joy Osofsky who have partnered to develop a groundbreaking effort to address the well-being of infants and toddlers involved in the Miami-Dade Juvenile Court. In this court, all infants, toddlers and mothers receive screening and assessment services. All babies are screened for developmental delays and referred for services. A parent-infant therapeutic intervention is available to a select number of mothers. An Early Head Start Program connected to the court is the nation's first designed specifically to meet the needs of maltreated children.

One factor that makes the Court Teams approach relevant to the Baltimore case is the intergenerational nature of many abuse and neglect cases. Judge Lederman was motivated to develop this approach after observing children who had come into her court as victims of abuse and return later as abusive parents. They were unable to be good parents because they had never been adequately parented themselves. A major goal of the Court Teams project is to break this cycle of abuse by giving these young mothers the skills they need to understand and respond to their infants and toddlers in a positive way.

Research is confirming the effectiveness of the approach used in the Miami-Dade Juvenile Court. Three years of data in the Miami-Dade Juvenile Court show substantial gains in improving parental sensitivity, child and parent interaction, and behavioral and emotional parental and child responsiveness. The children showed significant improvements in enthusiasm, persistence, positive affect and a reduction of depression, anger, withdrawal and irritability. There have been no further acts of abuse or neglect, and 100 percent of infants were reunified with their families.

One promising intergenerational success story that emerged from the Miami-Dade Juvenile Court is that of Katrina. Katrina was removed from her home for the first time at the age of 10 for chronic emotional neglect. She remained in care for a year and then returned home. Almost two years later, Katrina was removed again. She was found to be dirty and begging for good and her home was identified by police as a frequent site of drug related activities. Katrina went to live with an aunt while her younger siblings were placed in foster care. Katrina became a child mother. She was living in foster care with her own baby; however, at the age of 14 months, her baby was removed from her care. She did not understand why her baby couldn't live with her and was unable to care for him. Because she was still under the jurisdiction of the court as a dependent child, the court would see her on a regular basis. The court seemed to think she had the capacity and desire to accept services and work with the court in order to have her baby return to her care. Six months after

[11] Ibid.

her baby was removed, she was served with a petition for termination of parental rights. The court begged her to go back to school and to agree to live in a foster home, she agreed. She enrolled in school and in parenting classes and continued to have visitation with her baby. In addition, she was receiving individual counseling.

Katrina and her son Charles (now 2 years, 11 months) appeared for an evaluation. Charles was found to be within the extremely low range of functioning. During the play session, there was minimal play interaction between Katrina and her son. Katrina appeared unable to allow Charles to explore and initiate himself. Charles' day care teacher expressed frustration with Charles' aggressive behavior. She stated that he is active and hits and bites other children. Charles was referred to an early intervention program operated by the school for a full evaluation for adequate preschool placement and services. He was also referred to the Miami Juvenile Court Early Head Start Program. In addition, Charles and Katrina began dyadic therapy initiated by the court through its IMHPP program. Katrina continues to come to court and is lauded for her accomplishments. She is actively involved in school, maintains a B average and wants to become a chef. Reunification with Charles appears to be imminent.

ZERO TO THREE's Policy Recommendations

1. **Prevent multiple placements for infants and toddlers in foster care.**

In the first year of life, babies need to have the opportunity to develop a close, trusting relationship or attachment with one special person. The ability to attach to a significant caretaker is one of the most important emotional milestones a baby needs to achieve in order to become a child who is trusting, confident, and able to regulate their own stress and distress. Babies form strong attachments and rely on their parents for security and comfort. For babies in foster care, forming this secure attachment is difficult. When a baby is removed from home, or never has the chance to "bond" with a parent (e.g. when a baby is placed in foster care immediately after birth), the baby is not able to form an attachment or an emotional connection to a parent/caretaker. Multiple foster care placements present a host of traumas for very young children. When a baby faces a change in placement, fragile new relationships with foster parents are severed reinforcing feelings of abandonment and distrust. Babies grieve when their relationships are disrupted and this sadness adversely effects their development. Children who have experienced abuse or neglect have an even greater need for sensitive, caring and stable relationships. In order to prevent placement disruption, foster parents need sufficient support and training. They may need assistance in how to read the infants' emotional cues as they are often unclear, to understand the importance of attachment and how to develop an emotional connection to the child, to understand how the infants' prior experience, particularly maltreatment and placement experiences, have affected them, and to adapt their own parenting styles to meet the unique needs of these vulnerable young children.[12] All placement decisions should focus on promoting security and continuity for infants and toddlers in out-of-home care.

2. **Use evidence based models to prevent child abuse and neglect.**

Abuse and neglect during the first years can have serious consequences on later developmental outcomes. Research shows that young children who have experienced physical abuse have lower social competence, show less empathy for others, have difficulty recognizing others' emotions, are more likely to be insecurely attached to their parents, and have elevated rates of aggression, apparent even in toddlers. They have been found to have deficits in IQ scores, language ability, and school performance. In addition, young children who are victims of physical abuse may experience psychosomatic disorders, anxiety, fears, sleep disruption, excessive crying, and school problems. By the time these children reach school age, they will be at risk for social problems and learning deficits. Compounding the problem, one-third of the individuals who were abused and neglected as children, without intervention, can be expected to abuse their own children.[13] Research on model programs reveals that well-designed services with explicitly defined goals can be effective in changing parenting practices and influencing parent-child interactions.[14] It is clear, therefore, that prevention is a critical strategy for protecting at-risk babies and their families.

[12] Clyman, R., Harden, J., & Little, C. (2002). "Assessment, intervention and research with infants in out-of-home placement." *Infant Mental Health Journal,* 23(5), 435–453.

[13] National Research Council. (1993). *Understanding child abuse and neglect*. p. 223.

[14] Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

3. **Assure comprehensive, developmentally Appropriate Health Care for infants and toddlers in foster care.**

Nearly 40 percent of young children in foster care are born low birthweight, premature, or both, two factors that increase their likelihood of medical problems and developmental delay.[15] They are more likely to have fragile health and disabilities and far less likely to receive services that address their needs.[16] More than half of these children suffer from serious health problems, including elevated lead bloodlevels, and chronic diseases such as asthma.[17] Sadly, a significant percentage of children in foster care do not receive even basic health care, such as immunizations, dental services, hearing and vision screening, and testing for exposure to lead and communicable diseases.

4. **Ensure access of infants and toddlers referred to child protective services to the Early Intervention Program ("Part C") of the federal Individuals with Disabilities Education Act (IDEA).**

Infants and toddlers in foster care are more likely to have fragile health and disabilities and are far less likely to receive services that address their needs.[18] They may show signs of delays in language acquisition, cognition and behavior. In fact, infants and toddlers in foster care have rates of developmental delay approximately 4 to 5 times that found among children in the general population.[19] Therefore, there must be a strong connection between the child welfare/child protection systems and Part C to ensure early access to services will provide significant benefits to children. The National Research Council/Institute of Medicine recommends that infants and toddlers who are referred to a protective services agency for evaluation of suspected abuse or neglect be automatically referred for a developmental-behavioral screening under Part C.[20]

A provision of The "Keeping Children and Families Safe Act of 2003" that amended the Child Abuse Prevention and Treatment Act (CAPTA) (PL 108–36) requires that each state develop "provisions and procedures for referral of a child under the age of 3 who is involved in a substantiated case of child abuse or neglect to early intervention services funded under Part C of the Individuals with Disabilities Education Act (IDEA) (section 106(b)(2)(A)(xxi))." Although this new requirement is a step in the right direction, states will face new challenges in trying to ensure that the Part C system is able to respond to these new referrals. Impacts will vary substantially from state to state because of significant differences among states' Part C systems. In some states, very large increases in workload for providers of Part C evaluation, assessment and intervention services are likely as a result of this legislation. In all states, a need to enhance the capacity of the Part C system to respond to social-emotional and behavioral problems (early childhood mental health) is likely. And in most or all states, the cost of responding to this federal mandate will be a problem, given very tight state budgets, unless the federal government significantly increases funding for Part C.

5. **Assure early childhood mental health assessment and access to early childhood mental health services for babies and toddlers in foster care.**

Early childhood mental health is the capacity of the child from birth to age 5 to experience, regulate and express emotions; form close and secure interpersonal relationships; and explore the environment and learn. Early childhood mental health is synonymous with healthy social and emotional development. Because maltreatment and repeated and often traumatic separation from caregivers may place infants and

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[15] Halfon, N.; Mendonca, A.; & Berkowitz, G. (1995) "Health status of children in foster care: The experience of the Center for the Vulnerable Child." *Archives of Pediatric and Adolescent Medicine*, 149(4), 386–391.

[16] Dicker, S., Gordon, E., & Knitzer, J. (2001). *Improving the odds for the healthy development of young children in foster care.* New York: National Center for Children in Poverty. Oser, C. and Cohen, J. (2003). Improving early intervention: Using what we know about infants and toddlers with disabilities to reauthorize Part C of IDEA. Washington, DC: ZERO TO THREE Policy Center.

[17] Halfon, N.; Mendonca, A.; & Berkowitz, G. (1995) "Health status of children in foster care: The experience of the Center for the Vulnerable Child." *Archives of Pediatric and Adolescent Medicine*, 149(4), 386–391.

[18] Dicker, S., Gordon, E., Knitzer, J. (2001) *Improving the odds for the healthy development of young children in foster care.* New York: National Center for Children in Poverty.

[19] Dicker, S. & Gordon, E. (2000). Connecting healthy development and permanency: A pivotal role for child welfare professionals. Permanency Planning Today, 1(1) 12–15.

[20] Shonkoff, J., & Phillips, D. (Eds.). (2000). *From neurons to neighborhoods: The science of early childhood development.* Washington, DC: National Academy Press.

toddlers in foster care at risk for mental health disorders, mental health supports for babies in foster care, their birth families, and their foster care families is critical. Untreated mental health disorders in early childhood can have disastrous effects on children's functioning and future outcomes.

There is an enormous disconnect between what we know about very young children and their mental health, and what we do for very young children in the child welfare system. Over the past 20 years, much has been learned about the mental health of young children in foster care and how to provide early childhood mental health services. However, this knowledge has not reached the child welfare system. Early childhood mental health expertise, providers, and services for infants and toddlers in the child welfare system as well as in other systems (Part C early intervention, child care, Early Head Start) is non-existent and the need is severe! In addition to improving mental health aspects of the child welfare system, training for mental health and other early childhood providers is needed. It is critical that early childhood providers understand not only the unique needs of infants and toddlers, but also, the unique needs of very young children who have been victims of abuse/neglect and who have been separated from their families. These early childhood mental health services should be integrated and delivered via early learning experiences at home, in center-based programs, or both. Federal and State policy must support early identification, screening and evaluation of emotional development, improving the service array for diagnosis, treatment and prevention of early mental health problems, and increasing mental health supports for parents and foster parents in the existing child welfare system and other systems that serve these children.

6. **Ensure that infants and toddlers in foster care have access to quality early care and learning experiences.**

Infancy and toddlerhood are times of intense growth and development in all areas, including rapid changes in motor development, cognition, and emotions.[21] All babies and toddlers need positive early learning experiences to foster their intellectual, social and emotional development and to lay the foundation for later school success. Infants and toddlers who have been abused or neglected, and are at increased risk for adverse outcomes as a result, need additional supports to promote their healthy growth and development. Quality early learning experiences can provide very young children in foster care the opportunity to form secure attachments with teachers and/or child care providers who can provide consistent, positive environments. Early childhood training programs that promote small groups, continuity, and individualized care, such as the Program for Infant Toddler Caregivers (PITC), can help young children who have been abused and neglected develop these essential early relationships. These early relationships are associated with adaptive social development.[22]

High-quality early care and education programs can also support foster, kinship, and biological parents by directing them to other support systems, providing information, and connecting them with other parents that they may turn to for advice and support.[23] Comprehensive early childhood programs, such as Early Head Start, that combine home visitation, comprehensive services and technical assistance, can provide the specialized services that very young children in the child welfare system need. In addition, therapeutic child care programs that address issues faced by abused and neglected children, such as attachment disorders and depression, can ensure that these young children are receiving specialized treatment and attention.

7. **Ensure developmentally appropriate visitation practices for infants and toddlers in foster care.**

One of the major challenges faced by young children in foster care is maintaining attachment relationships with their parents. In order for young children in foster care to maintain attachment relationships with their biological parents, parental visitation schedules are developed by the social worker in conjunction with the court and the biological parents. Foster parents are expected to cooperate with the child's visitation plan to help with transportation to and from the visits. Current visitation practices usually consist of brief encounters that occur anywhere from once a month

[21] Lederman, C., Osofsky, J., & Katz, L. (2001). When the bough breaks the cradle will fall: Promoting the health and well being of infants and toddlers in juvenile court. *Juvenile and Family Court Journal,* (52)4, 33–37.

[22] Lederman, C., Osofsky, J., & Katz, L. (2001). When the bough breaks the cradle will fall: Promoting the health and well being of infants and toddlers in juvenile court. *Juvenile and Family Court Journal,* (52)4, 33–37.

[23] Dicker, S., Gordon, E., & Knitzer, J. (2001). *Improving the odds for the healthy development of young children in foster care.* New York: National Center for Children in Poverty.

to once or twice a week. For very young children, infrequent visits are not enough to establish and maintain a healthy parent-child relationship. Infants and toddlers build strong attachments to their biological parents through frequent and extended contact. One month in the life of a baby is an eternity. Visits should occur frequently, in a safe setting that is comfortable for both parent and child, and should last long enough for a positive relationship to develop and strengthen. For very young children, visits with parents can be upsetting and disruptive to their development.

8. **Assure ongoing adoption services and supports for adoptive families.**

Adoptive parents often face significant challenges in the day-to-day parenting of very young children. Foster children who have been adopted tend to have challenging behaviors and emotional issues as well as medical conditions that may impact their development—often due to a history of maltreatment and extended stays in foster care. Adoptive families facing this kind of stress are at increased risk of adoption failure—referred to as disruption before an adoption is legalized and as dissolution after an adoption has been finalized.[24] Services and supports for the family prior to, during, and after the adoption can help to stabilize and preserve adoptive placements and can help in recruiting adoptive parents.[25] The assurance of the availability of services and supports after adoption has been found to play a critical role in many potential adoptive parents' decisions to move forward with the adoption of a child in foster care.[26] These supports may also reduce the likelihood of adoption disruption and are cost-effective as they help prevent the child from reentering foster care.

Conclusion

We must ensure that infants in the child welfare system are healthy and safe. During the first years of life, children rapidly develop foundational capabilities—cognitive, social and emotional—on which subsequent development builds. The amazing growth that takes place in the first three years of life creates vulnerability and promise for all children. These years are even more important for maltreated infants and toddlers. We know from the science of early childhood development what infants and toddlers need for healthy social, emotional and cognitive development. We also know that infants and toddlers in the child welfare system are at great risk for poor outcomes. We must continue to seek support for services and programs that ensure that our nation's youngest and most vulnerable children are safe and that promote and improve their emotional, social, cognitive and physical health and development.

It is simply unacceptable that we wait until the safety of very young children is put at-risk before proper investments are made to address their needs. We cannot wait for an infant in the child welfare system to die before we provide states with adequate funds to ensure the safety, permanence and well-being of children in or at risk of needing foster care. Policies and funding must be directed to preventing harm to maltreated young children. I urge the Subcommittee to make the investment to ensure that the current ill-equipped child welfare system receives adequate funding to better protect our nation's most vulnerable children.

Thank you for your time and for your commitment to our nation's at-risk infants and toddlers.

[24] National Conference of State Legislatures. (2002). Post-Adoption Services: Issues for Legislators. Retrieved February 26 from http://www.ncsl.org/programs/cyf/PASI.htm.

[25] Casey Family Services. (2001). *Strengthening Families and Communities: An Approach to Post-Adoption Services.* Casey Family Services.

[26] Ibid.