Intentional Death Prevention

(Unapproved) Minutes December 3, 2012

In attendance: Dr. Elaine Cabinum-Foeller, Michelle Hughes, Matt Anderson, Dr. Molly Berkoff, Sarah Currier, Sen. Stan Bingham, Deanna Fleming, Rep. Dale Folwell, *Rep. Craig Horn*, *Tina Huckswar, Jinx Keenan,* Kevin Kelley, Maria Kinnaird, Earl Marett, Karen McLeod, Kristin O'Connor, Scott Proescholdbell, Cathy Purvis, Grant Scott, Meghan Shannahan, Angie Stephenson

Italics indicates by phone

Michelle Hughes welcomed participants.

Karen McLeod moved and Kevin Kelley seconded approval of the September and October minutes which were unanimously affirmed.

Ms. Hughes reiterated that IDPC focuses on specific types of child death and the broader prevention efforts that can help reduce risk these violent deaths: homicide by parent or caregiver, youth homicide and youth suicide.

Child Medical Evaluation Program (CMEP)

Dr. Molly Berkoff, Medical Director of the CMEP described this 35 year old program designed to help assure that children who were alleged abused or neglected received the expert medical evaluation they need, regardless of county of residence. Her full presentation is on the CFTF website under Intentional Death Prevention.

CMEP provides clinical services, training, and infrastructure support.

Clinical services include detailed medical and mental health assessments, including comprehensive physical exam, behavioral/mental health assessment, detailed medical record review (to determine patterns or past injuries of concern) and interviewing with the child and family members. The mental health evaluation and the child and family evaluation (CFE) will also include collateral interviews to ensure viewing of the totality of the concerns. This comprehensive medical assessment takes about 1.5**-2** hours to complete, plus additional time to follow-up, write reports, etc. This type of assessment takes training and time above and beyond what is possible in general pediatric or family practice settings. Every county has access to a specially trained medical provider and county-specific funds are not used. Instead, the State provides a supplemental fund to support access to the needed evaluations when children are not covered by Medicaid. Clinical services are provided at the county level; the administrative portion of the program helps to assure proper training of the providers, quality oversight, and second opinions free of charge to CPS. CMEP professionals must be willing to testify in court if needed and medical records are written to communicate medical information to a non-medical audience.

CMEP provides the training for medical professionals not only to do quality assessments, but also to explain and present the results and findings in a way to be helpful to CPS workers, courts and others making key decisions about the life of the child.

In addition to training medical professionals, CMEP provides a training for workers in CPS, Area Health Education Centers, as well as judges, attorneys, mental health provider and others. All new investigative CPS social workers

are required to receive the CMEP training covering the medical aspects of child abuse. CMEP works closely with other key NC child abuse agencies. For example, CAC NC has been very generous is assisting with sponsorship for training of CEMP medical providers.

CMEP also provides the infrastructure support to assure quality oversight, help link county CPS (or others) with qualified professionals, and identify and fill gaps in service. CMEP receives high satisfaction scores. Many respected experts are involved with CMEP.

CMEP uses a mix of state and federal funding to cover its professional staff, provide training and support and pay for exams for children who do not have Medicaid. Thus, their detailed data covers only children with Medicaid. The vast majority of children for whom they pay for exams suffer from alleged sex abuse. Medicaid pays an estimated 80% of medical evaluations. The cost of the mental health evaluations are covered only by CMEP.

Rep. Horn asked who ordered CMEP evaluations and to whom the report goes. Dr. Berkoff replied that if CPS requested the exam, then CPS "owns" the report. For example, an assessment done at UNC will go to CPS but not be put in the child's larger medical **record** even if they were seen at the hospital before. This is to assure information that is confidential and owned by CPS will not be accessible to those who do not have authorization to view the materials. Most importantly, it is to ensure the child's safety.

Rep. Horn also had concerns about children who witnessed domestic violence and feared for themselves or an (abused) parent. Was law enforcement informed in such situations? The law mandates that doctors (and all others) report child abuse and neglect. In CMEP cases, the referral comes through CPS so law enforcement should have already been notified when appropriate. CMEP does not withhold any information. Mandated reporting applies for CEMP medical and mental health providers. Even though the records are owned by CPS, the reporting guidelines apply to all examiners.

Michelle Hughes asked if there was a way to get Medicaid data on child diagnosis, etc., given the large percentage of children paid through Medicaid. CMEP is working with providers to submit either a summary or a sample of Medicaid case reports. (Since the reports are quite long, it could be burdensome for a provider to supply full reports on all children seen.) All CMEP paid medical cases are submitted to CEMP. All mental health cases are submitted to CMEP.

Rep. Folwell asked how cases were closed. Kevin Kelley said that the majority of cases are closed administratively without findings of abuse or neglect needing services. All findings are confidential. Rep. Folwell confirmed that all allegations of sex abuse are investigated and followed up asking about false reports. Dr. Berkoff said that information obtained through CMEP, such as in cases of high conflict divorce, can be helpful in such cases. CPS manages the storage of the medical and mental health reports in their case files. A shadow copy of the report is typically maintained by the examiner as well.

Sen. Bingham wondered if law enforcement could go back and look in closed cases to see if there was a malicious pattern or other concern. Angie Stephenson said there was a process for automatic referrals to law enforcement in a variety of situations. She would need to look into the legalities of it, but that it could likely be accomplished with a subpoena. Earl Marett added that he was familiar with cases that had been assessed retroactively, such as when adults came forward to allege past abuse against someone newly alleged to have abused a child.

Dr. Cabinum-Foeller asked for clarification on funding. Dr. Berkoff noted that Medicaid covered the in-person cost of the majority of the medical assessments, but that CMEP paid for those medical assessments not paid by Medicaid, as well as all mental health assessments. CMEP receives an allotment through the state appropriation process, plus DSS fills in with additional funds. CMEP also has a training contract with DSS to cover the cost of training new investigative social workers in regards to the medical aspects of child abuse.

Dr. Cabinum-Foeller said that she had submitted an application for the CFTF to endorse maintained funding of CMEP. Such funding had been endorsed by CFTF in the past and the CMEP approach was advanced by the DSS Director's Association, Pediatric Society Child Abuse and Neglect Committee and others.

Earl Marett said that CMEP was vital for CPS and enthusiastically moved that IDPC recommend to the CFTF an endorsement for maintained funding for CMEP. The motion was seconded by Karen McLeod and unanimously affirmed.

Child Advocacy Centers (CAC)

Cathy Purvis presented on her application regarding endorsement of funding of $625,000 for CACs. CACs are child focused place where child protective services investigators, medical experts, law enforcement and others can come together to respond appropriately to alleged child abuse and neglect. Accredited centers must meet a variety of standards. They coordinate and consolidate services, often in one co-located area. This means, for example, that a child victim does not need to tell his/her ''story'' multiple times, which can result in re-traumatization for many children. The approach also promotes and enhances information sharing between DSS, law enforcement, medical professionals and others.

There are currently 25 accredited CACs in NC. They are currently funded $375,000 out of the Social Services Block Grant (SSBG). CAC requests support for funding of $25,000 for each local CAC for total funding of $625,000 from state funds. This would help provide necessary supports, such as training in forensic interviewing skills, which are not covered by grants. The requested funding is lower than funding levels provided by many surrounding states and less than provided to domestic violence and other similar centers. Federal funds for CACs are declining, potentially being cut 17% in FY13.

Dr. Cabinum-Foeller moved that the CFTF endorse state funding of $625,000 for CACs. It was seconded by Earl Marett and unanimously affirmed.

Children's Trust Fund

Kristin O'Connor updated the group on the Children's Trust Fund, the only source of state funding for child maltreatment prevention in North Carolina. Her full presentation is available on-line.

DSS recently awarded $1.2 million over 3 years to 4 programs. Grants were a maximum of $100,000 and represent a varied approach to building protective factors in families. Programs must demonstrate strong evidence undergirding to the approach (either evidence-informed or evidence-based) and an ability to implement well (with fidelity to the approach). Programs must be grounded in Strengthening Families protective factors and work with community partners with a similar dedication to evidence-informed practice. The short and intermediate term goals are to build protective factors in families to offset risks related to child abuse and neglect.

Programs are focused on the youngest children (aged 0 to 5) for whom there are serious concerns about abuse or neglect, as evidenced by reports of abuse or neglect from neighbors, school staff, doctors or others, including families recommended for services by their local DSS.

Sarah Currier reported that the first Children Trust Fund was established in Kansas in 1980, in response to a national advocacy movement to assure strong state prevention infrastructure. Experts noted that prevention funds were often swept to provide direct services, thereby eroding the benefits of prevention programs and requiring re-establishing infrastructure supports if proven effective prevention efforts were re- funded. CTF were intended to provide the base infrastructure for implementing prevention efforts in an on-going, systematic way.

NC adopted this strategy early. In 1983 legislation appropriated $250,000 annually to the Department of Public Instruction. Additionally, the CTF received a portion of the marriage license fee as funding for prevention efforts.

By 1999, the fund had $1.7 million accumulated. Of that, $1.3 million was swept to help fill shortfalls elsewhere in the state budget. At that time, the CFTF supported efforts to create a Kids First plate to provide some dedicated funding to the CFTF. Fiscal notes at the time estimated $4,500 would be generated for the fund. In 2009, the on-going appropriation was eliminated and the fund was moved from DPI to DSS.

Over the past several years, the license plates have generated about $25,000 for the CTF. In FY13, there was $336,000 in the fund, down substantially from the almost $2 million available in 1999.

Ms. Currier reported that this systematic reduction in funding was concerning. By ratcheting down funding for primary prevention, the state ends up incurring tremendous human and fiscal costs. Prevent Child Abuse NC supports long term opportunities to build the fund.

Dr. Cabinum-Foeller asked if there were evidence based interventions to prevent sex abuse. Ms. Currier noted that data can be nebulous, which makes evaluation challenging. (Without a good baseline for prevalence, it's hard to tell if the prevalence is changing.) Some family strengthening programs seem to target risk factors for future perpetration and show promise in reducing the likelihood that a child will grow up to perpetrate child sexual abuse. There are also community-based interventions designed to raise public awareness and shift social norms about sexual abuse which are critical to the prevention of maltreatment.

Ms. Hughes noted that Ms. Currier was asked to present with an eye towards tracking and monitoring the CTF – the only state funding solely aimed at on-going, sustainable infrastructure for prevention.

Rep. Folwell moved and Ms. McLeod seconded that the IDPC recommend to the CFTF that the CFTF track and monitor use and funding of the Children's Trust Fund.

Summary

Dr. Cabinum-Foeller summed up.
The CFTF has already agreed to endorse efforts by Prevent Child Abuse to recommend to the Medical Board that medical professionals be trained to recognize and report child abuse and neglect. The CFTF further recommends to PCA that the word ''all'' be deleted from the final draft. (The original proposal called for ''all'' medical professionals to be trained to recognize and report abuse and neglect. **)**

Recommendations to be presented from IDPC to the CFTF on December 10 include

- Support funding for the Child Treatment Program at $2 million
- Endorse maintaining funding for CMEP
- Endorse $25,000 per accredited CAC for total CAC state appropriate of $625,000
- Track and monitor funding and use of CTF

Loss of Federal Funds

Following up from the previous meeting, Earl Marett reported that it looked like total funding lost through federal re-calculations of IV-E money would be about $12 million, which would have a significant impact on the ability of county DSS to serve abused and neglected children, especially efforts to keep them safe in their own homes.

Kevin Kelley reported that IV-E was the primary federal funding stream and mostly affected children in foster care. The calculation issue has to do with the candidacy of children for foster care. Following a review of North Carolina, The US Administration on Children, Youth and Families (ACYF) found that some of the cost claiming procedures used in North Carolina were not compliant with federal regulations. Please see minutes and presentations from October meeting for additional information. With state and local match, it seems that the loss will be about $24 million. The division and departmental leadership is having a discussion with counties regarding the losses in federal funding for child welfare.

Ms. McLeod asked what the impact was on increasing the number of children in foster care and losing DSS workers. That was not yet known.

Mr. Marett reported that in Johnston County they are seeing a decrease in kinship care and other safety resources.

Ms. McLeod remarked that it would be helpful for counties to gather information. Initial reports sound as if the situation is highly concerning, but that needs to be confirmed.

Dr. Cabinum-Foeller reminded participants that at the October meeting, the discussion focused on the likely impact being that more children would come into foster care. Ms. Hughes added that without such funds, there was no way to assure the safety of children. When children are substantiated as abused or neglected, to keep them safe, DSS can either place them in foster care or, when appropriate, provide services in the home to assure the safety of children and help resolve the abusive situation. Foster care is much more expensive and disruptive than home-based care. She was concerned that the safety of children could be jeopardized because of the loss of the federal funds.

Mr. Marett said that the $12 million - $24 million loss was coming on top of a $36 million loss in federal TANF (Temporary Assistance to Needy Families) funds as well. This will have a big impact on our ability to protect children. Counties have very limited ability to fill in lost funds.

Ms. Hughes asked the committee if there was anything they would like to do in response to this information, such as tracking and monitoring funding for child welfare financing with particular attention to the federal cuts.

Ms. McLeod expressed concern that monitoring did not allow for sufficient action. If no funding was provided, there would be nothing to track. This loss of funding has concerning long-term impact. She suggested stronger action was needed, as was more information from the Association of DSS Directors.

Dr. Cabinum-Foeller asked legislators what sort of information would be helpful to them. Rep. Folwell noted that detailed information, especially at the county level, was often compelling.

Ms. McLeod noted that we need information about the connection between the cuts and other actions to determine the impact of the cuts.

Mr. Kelley remarked that there were many variables which made it hard to predict how many children would come into care because of these cuts.

Rep. Folwell encouraged conservative, believable assumptions. He also encouraged focus on avoiding perverse incentives through funding streams (or otherwise) and promoting what was best for the children (regardless of funding stream). He asked if the crisis was similar to the current situation with group homes.

Mr. Kelley said that both were driven by federal rules, but otherwise there did not seem to be much overlap. Rep. Folwell encouraged DSS to pay attention and see if there were any lessons to be learned in how to approach the solution.

Ms. McLeod moved and Mr. Marett seconded that the IDPC recommend to the full CFTF that the CFTF support allocation of $12 million in state funds to offset loss of federal dollars. The motion was unanimously affirmed.

Rep. Folwell encouraged participants to order a Donate Life license plate to support organ donation.

Ms. Hughes thanked committee participants for their work throughout the meeting series. Special thanks were offered to Rep. Folwell who would not be returning to the CFTF in 2013.