TEXAS CHILDREN'S JUSTICE ACT THREE YEAR ASSESSMENT 2015-2018

May 29, 2015

Strengthening Partnerships and Improving Systems to Better Serve Maltreated Children

Contents

Executive Summary

The purpose of this assessment is to (1) review the state of child protection in Texas and significant activities undertaken in the last three years; (2) provide an overview of relevant research and promising practices in the field of child protection within identified priority areas; and (3) make recommendations for systems' improvements. During the 2012 assessment, the CJA Task Force identified six priority areas which led to the 2012-2015 Task Force recommendations and served as a starting point for the 2015 re-assessment. CJA staff and the ad hoc Task Force Three Year Assessment Committee appraised each priority area and described any related activities and/or policy reforms which took place in the State over the last three years. Through this process, the Task Force further refined the priority areas to five that are core to the purpose of the CJA program and towards which CJA resources should be strategically directed to make the greatest impact. In each of these five areas, CJA staff reviewed existing research and relevant reports and interviewed key stakeholders from around the state. Based on these findings, the Task Force recommends the following:

1. **Multidisciplinary Team Response and Coordination**

The multidisciplinary team approach to child abuse is a child-centered approach. The MDT approach provides a coordinated, joint response facilitating cooperation across disciplines, preventing unintentional working at cross purposes and allowing for consistency from case to case. It also improves the system's efficiency by eliminating duplicative efforts. Multidisciplinary teams in Texas provide coordination at the beginning stages of a child abuse investigation and improve both Child Protective Services' and Law Enforcement's response.

Investigations involving serious child abuse and neglect require both law enforcement and child welfare because their responsibilities and their areas of expertise differ. While the laws mandating joint investigations of Priority 1 cases of child abuse, joint training of law enforcement and CPS investigators, mandating cross-reporting, and encouraging co-location have been in place since 2005, the actual implementation of these laws has been varied. Recent high profile child death cases in Texas as well as other states have shown that the failure of CPS and law enforcement to effectively collaborate can endanger children's lives. In spite of mandates for joint investigations and existing memoranda of understanding between law enforcement agencies and CPS, collaboration and communication between law enforcement and CPS is not occurring on a consistent basis throughout the state. In addition to the

importance of collaboration between law enforcement and CPS, it's also important that qualified medical professionals be included early in the investigation stages of serious cases. Children under age two who suffer head or abdominal trauma or who have rib fractures might display no external signs of injury. Many injuries in young children will only be discovered via imaging screening. Medical experts consider skeletal surveys to be mandatory in infants with reported bruising as these so-called "sentinel injuries" can be highly indicative of abuse. To improve the accurate investigation of these cases, CPS professionals should communicate with medical providers early in serious cases so that both sides can effectively collaborate and share information to get a clearer, more accurate picture of the families under investigation in order to fully evaluate elements of safety and risk.

Recommendations

The CJA Task Force recommends supporting policies and programs that will promote a consistent, coordinated multidisciplinary response to serious cases of child abuse and neglect as well as improve the coordination between the criminal justice system and the civil child protection system.

Examples of strategies supported by CJA may include:

- Promote the continued use of local child advocacy centers for multi-disciplinary team coordination to improve the cooperation and collaboration between agencies involved in the investigation, assessment and disposition of serious cases of child abuse/neglect. Encourage co-location of CPS and law enforcement at local CACs whenever possible. Continue to work with Children's Advocacy Centers of Texas to provide training, technical assistance and facilitation of MDTs statewide.
- Support the launch of the MDT Enhancement Program with CACTX, particularly focusing on evaluation of the program's implementation and impact at local centers.
- Encourage ongoing, joint training for law enforcement and CPS to achieve a level of competency, consistency, and quality in child abuse investigations across the state. Training should focus on protocols, investigative processes, roles/responsibilities, and improving communication.
- Support training for attorneys to enhance the effectiveness and quality of the prosecution of child abuse cases.
- Encourage medical assessments of children, particularly children under age two with allegations of physical abuse by supporting and enhancing interagency collaboration between child abuse

pediatricians and CPS investigators. The Task Force understands that CPS Transformation is changing worker training as well as the way that safety and risk are assessed. We will monitor this process to ensure that we do not work at cross purposes.

- Support training to ensure that medical professionals have the necessary knowledge and resources to accurately recognize abuse and understand proper medical evaluations for suspected abuse.

2. **Victim Advocacy**

Children who have suffered abuse or neglect should not be further traumatized by the systems intended to protect them. There has been an increased awareness that systems should be child-centered and many positive changes have been occurring. The state has increased funding for mental health, continued to support trauma-informed care for children and families impacted by abuse and neglect, encouraged collaboration between domestic violence service providers and child protective services, and authorized DFPS to conduct an alternative response for certain less severe cases. Children's Advocacy Centers throughout the state have also worked to strengthen their family advocacy component which facilitates services and support for non-offending family members. The Task Force recognizes that this important work is still in its nascent stage and will continue to support its growth.

Research suggests that, nationwide, youth commit one-quarter of all sex offenses and more than one-third of sex offenses against juvenile victims. According to reported incidents of sexual assaults, this is true in Texas. Children and youth with sexual behavior problems do not constitute a homogenous group and are different than adult offenders. Most youth with sexual behavior problems have a history of traumatic experiences, though not necessarily sexual abuse. Youth are more likely to respond positively to treatment, particularly immediately following their detection by the criminal justice system, and are much less likely to reoffend over time. The ideal solution for these children and youth is community-based and family-centered with active multidisciplinary team involvement at case and systems level. Unfortunately, there are not enough of these programs throughout the state. A report from November 2011 issued by Texas Juvenile Probation Commission entitled *Identifying the Shortage of Licensed Professionals Available to Serve Juvenile Offenders* found that a total of 177 (70%) of Texas' 254 counties had no licensed sex offender treatment provider as of September 2010 and only 37 counties (15%) had

three or more of these professionals. The absence of providers is particularly prevalent along the Texas-Mexico border, West Texas, and the Panhandle. This shortage of providers means that many youth are not getting the ideal community-based, family-centered treatment. In some cases, it may mean that youth are not getting any treatment. Multiple systems are involved in these cases but not all together and not consistently. CPS, law enforcement, juvenile probation, and the courts need to be educated on the importance of effective identification, investigation, and intervention in cases of children and youth with sexual behavior problems to so that these cases are consistently managed across the state to both ensure treatment for offenders and safety for victims.

Recommendations:

The CJA Task Force recommends supporting programs and policies to ensure consistent, high quality resources and services to child victims and their non-offending caregivers.

Examples of strategies supported by CJA may include:

- Training for MDT members on family engagement, respect for caregivers, alternatives to removal, support of non-offending caregivers, etc.;
- Resources and training for courts, DFPS, and juvenile probation on the importance of appropriately assessing and treating children and youth with sexual behavior problems; and
- Support for children's advocacy centers to assist in handling cases involving children and youth with sexual behavior problems.

3. Child Maltreatment Victims with Disabilities or Special Healthcare Needs

Studies examining patterns of child maltreatment have found that children with disabilities experience higher rates of maltreatment than children without disabilities. Studies (Jonson-Reid, Drake, Kim, Porterfield & Han, 2004; Lightfoot, Hill, & LaLiberte, 2011; Sullivan & Knutsen, 2000) have found that, while children with all types of disabilities experience abuse at a greater rate, children with emotional or behavioral disorders are particularly susceptible to abuse. Some studies have shown that children with disabilities are more likely to experience neglect as well as unique forms of disability-related

maltreatment such as withholding medication or not providing personal care. Prevalence studies as well as reports that are more anecdotal point to neglect as the most common type of maltreatment experienced by children with disabilities. One study (Sullivan and Knutson, 2000) found that children with disabilities were 3.76 times more likely to be victims of neglect than children without disabilities.

In order to be in compliance with CAPTA, Texas is reporting the number of children investigated by CPS each year who have a disability, however, it is unlikely that that number accurately reflects reality. In fact, it's difficult to understand the NCANDS disability numbers for any of the states. For example, in 2013 eight states reported that less than 5% of their investigations involved children with disabilities (Texas reported 1.9%) while eight states reported that more than 25% of their investigations involved children with disabilities. Lack of child welfare training in identifying children with disabilities coupled with a lack of standardized definitions of disabilities used across states make the accuracy of federally reported data suspect. The lack of empirical knowledge about the prevalence of children with disabilities or special health care needs involved the child welfare system is a significant barrier to addressing risk and how to best serve clients. Reviews of child fatalities in Texas as well as in other states and countries have found that children born premature, with low birth weight or with early medical issues die because of abuse, accident, co-sleeping, or SUIDs at a substantially higher rate than other children. It's vital the CPS workers accurately gauge child safety and risk. They are unable to do this unless they are also prepared to recognize disabilities/medical needs, appropriately assess for safety based on individual needs associated with disability, and provide families with relevant, necessary services. Failure to fully appreciate the importance of the interplay of multiple risk factors in a family and how to best serve the family in order to keep the child safe means that the child/family will keep coming to the attention of the various systems as the untreated problems get increasingly worse.

Recommendations:

The CJA Task Force recommends supporting policies and programs to improve awareness of the increased risk of abuse for children with disabilities and children with primary medical needs as well as promote interagency collaboration to improve system response to these cases.

Examples of strategies supported by CJA may include:

- Encourage improved data collection on the prevalence of children with disabilities and primary medical needs with child maltreatment allegations in Texas;

- Training for caseworkers on the necessity of in-depth investigations in cases involving children with primary medical needs, particularly infants. Particular care should be taken in cases where a child has primary medical needs and a health care professional has reported medical neglect. The Task Force understands that CPS Transformation is changing worker training as well as the way that safety and risk are assessed. We will monitor this process to ensure that we do not work at cross purposes;
- Training/resources for medical providers to improve awareness of the increased risk of abuse for children with primary medical needs, children with neonatal abstinence syndrome, and children with disabilities;
- Training/resources for WIC program staff, or other social service agencies who might come in contact with families, on the risk of abuse and neglect for children with disabilities or primary medical needs;
- Training/resources to improve communication and collaboration between CPS caseworkers, disability services providers and medical professionals to ensure better support for at-risk families.

4. **Child Maltreatment-Related Fatalities**

Texas DFPS investigates roughly 27% of the child fatalities in the state each year. Local Child Fatality Review Teams (CFRTs) cover 200 of Texas' 254 counties and, according to the State Child Fatality Review Team (SCFRT) Report from 2013, they reviewed 54.2% of the child deaths in those 200 counties. To fully understand the circumstances and risks leading to a child death, identify trends, and implement effective prevention activities, 100% of child deaths need to be reviewed and recorded. Additionally, Texas needs to use multiple data sources (vital statistics, death certificates, uniform crime reports, child death review, etc.) to enhance surveillance and measurement of child abuse fatalities.

The cause of death in a child case is difficult to determine. High quality death investigations, including standardized response by first responders, death scene investigations by law enforcement and justices of the peace, standardized autopsies conducted by trained forensic pathologists with knowledge of pediatric pathology, and open communication between law enforcement, CPS, healthcare professionals, coroners, and medical examiners, are necessary in order to make the correct

determination in a child death case. If any of these critical areas is inadequate, the system runs the risk of failing. In these cases in particular, joint investigations are critical. When child deaths are not reported to CPS in a timely manner or not at all, the case disposition might be entirely based on law enforcement and medical examiner findings. The evaluation would miss out on possibly critical information. When first responders are not trained on how to appropriately manage unexpected infant death, the investigation may be compromised. If law enforcement and coroners across the state are not using consistent, standardized protocols to investigate infant and child death, the outcomes of investigations may be not be achieving justice. Death certification will not and cannot be accurate without an adequate scene investigation. As stated earlier, child abuse fatalities are less attributable as homicide from the outset and initial circumstances may show no obvious cause of death. This might be true even after an autopsy. In order to keep the appropriate data about child abuse and neglect fatalities, those children must first be identified at the investigations stage. Consistency in every level of the investigation is critical. To what extent this is happening consistently throughout the state is unclear.

Recommendations:

The CJA Task Force recommends supporting policies and programs to improve the quality and consistency of data collection, investigation, and certification of cases of child death in Texas.

Examples of strategies supported by CJA may include:

- Review existing CFRTs and promote increased standardization as well as data collection capacity;
- Regular training and tools should be provided to law enforcement and prosecutors involved in these cases including developments in the law and latest advancements in investigative and forensic techniques;
- The Commission to End Child Abuse and Neglect Fatalities (CECANF) mission is to develop a national strategy and recommendations for reducing fatalities across the nation from child abuse and neglect. It is likely in the next few years the Commission will recommend the following:
    - Standardized, cross-system data sharing on child fatalities;
    - Develop standardized best practice guidelines for child death scene investigation and death certification.

- Develop nationally standardized child death investigation protocol.
- The adoption of child autopsy protocols.

The Task Force supports these strategies but does not wish to duplicate efforts or work at cross purposes with the Commission. We will continue to monitor the development and implementation of the recommendations states above.

5. Medical Evaluations for Child Maltreatment Victims

Healthcare professionals are a critical part of the reporting, investigation, assessment and prosecution of child abuse cases. Medical personnel were the number one source of completed child abuse investigations in Texas in 2013 (17.6%) and the number two source, second to teachers, in 2014 (17.5%). This percentage is more than double the national average of child abuse reports from medical professionals. However, in spite of continued effort, the child abuse medical expertise in Texas has not successfully been able to extend to the poorer, more rural areas of the state. Texas does not have enough primary care doctors in 126 of its 254 counties. The majority of these counties are rural. 73% of hospitals are located in urban areas and 63 counties in Texas have no hospital. There is also a potential for a difference in the diagnosis that a child will receive when seen by a child abuse pediatrician versus a pediatrician without child abuse expertise. There is a need for medical child abuse expertise for physicians, CPS and law enforcement throughout the state yet the majority of this knowledge is available only in select, urban areas.

Medical expertise is particularly critical in cases that involve a criminal component. It's challenging to distinguish between intentional and unintentional injuries. There is no single test that can prove or disprove child abuse. No single injury or symptom is synonymous with child abuse but rather it takes a combination of features to make the correct diagnosis. It's one that is often difficult for doctors to make. Court cases are also increasingly dependent on scientific evidence and expert witnesses are playing a bigger role. These cases point to the need for additional research to develop and refine the tools and technologies to improve the diagnostic accuracy of abuse related injuries.

Recommendations

The CJA Task Force recommends support for programs to increase the consistency and accuracy of the medical diagnosis of child abuse and neglect as well as support for programs to improve access to quality medical evaluations for suspected victims of child maltreatment, particularly in rural and underserved areas.

Examples of strategies supported by CJA may include:

- Research and data collection to improve the consistency and accuracy of the diagnosis of child abuse to strengthen the investigation and prosecution of these cases;
- Training for medical providers and attorneys on medical evidence in child abuse cases and courtroom testimony;
- Effective dissemination of best practices in the medical diagnosis of child abuse and enhanced collaboration between child abuse pediatricians, CPS, law enforcement, and medical professionals in Texas.

Overview of the Methodology

Pursuant to the federal program instructions, every three years the CJA Task Force must conduct a comprehensive evaluation of the State systems responsible for the investigative, administrative, and judicial handling of child abuse and neglect cases and make policy and training recommendations for improvements. During the 2012 assessment, the CJA Task Force identified the following areas of interest:

- Enhancing Multidisciplinary Team Response and Coordination
- Improving Access to Quality Victim Advocacy and Mental Health Services for Child Maltreatment Victims and Caregivers
- Improving Multidisciplinary Response to Child Maltreatment Victims with Disabilities or Special Healthcare Needs
- Improving Multidisciplinary Response to Suspected Child Maltreatment-Related Fatalities
- Improving the Recognition and Response by the Education System to Suspected Victims of Child Maltreatment
- Improving Access to Quality Medical Assessments for Child Maltreatment Victims

These areas served as a starting point for the 2015 assessment. In spring and summer of 2014, CJA staff begin collecting and compiling data to describe any related activities and/or policy reforms that took place in the state since 2012. CJA presented on the assessment at the July 2014 Task Force meeting, discussed the planned approach for Texas, and received the Task Force's approval. Additionally, staff created a survey through SurveyMonkey for all Task Force members to give input on CJA priorities. The CJA Task Force Three Year Assessment Committee was appointed by the Executive Committee in August of 2014 and met for the first time by conference call on August 19th to review this information. This Committee consisted of Task Force members representing a variety of disciplines who provided input and oversight of the assessment process. The Committee discussed each of the priorities in detail, highlighting areas of strength and potential areas of improvement. During this conference call, the Committee determined that the Task Force did not need to continue with the following priorities:

- Improving Recognition and Response by the Education System to Suspected Victims of Child Maltreatment;
- Improving Access to Mental Health Services for Child Maltreatment Victims and Caregivers.

Education System

The 83rd Legislative Session passed bills (SB 460 and SB 831) which implemented new requirements for mental health intervention strategies in schools that are intended to help teachers reach out to students who show signs of distress and required the creation of a list of mental health, substance abuse, and suicide prevention programs that may be selected for implementation by public schools. SB 939 ensured that charter school employees are required to report child abuse and neglect; provides that the training on child abuse previously required for new employees must also be provided to existing employees; requires schools to prominently post a sign that includes the state toll-free number to report child abuse and neglect; requires child abuse/neglect training for higher education employees and includes higher education employees as mandatory reporters; and requires TEA adopt a schedule for the training of all employees. HB 1205 clarified the reporting requirements and penalties for professionals who fail to report abuse making it a Class A misdemeanor if a professional is required to make a report and knowingly fails to do so with the penalty elevated to a state jail felony if it is shown that a professional intended to conceal abuse or neglect.

Since the enactment of legislation from the 83rd session, the Texas Education Code mandates that district and charter schools are required to provide all employees with training concerning prevention techniques for and recognition of sexual abuse and other maltreatment of children. A mandatory training schedule has been adopted by Commissioner Rule in the Texas Administrative Code. Additionally, district and charter schools are required to maintain records that include the name of each employee who participates in training. Darkness to Light provides free online or in-person sexual abuse prevention training. Local Children's Advocacy Centers have been active in providing online and in-person training for education professional on identifying and reporting child abuse. For example, ChildSafe, the CAC for Bexar County, has developed a website, training videos, and educational materials in both English and Spanish for mandatory reporters. With CJA funding, Dallas Children's Advocacy Center also developed an online training in recognizing and reporting child abuse. Austin CAC, the Center for Child Protection, received support from CJA and local foundations to develop extensive education programs on recognizing and reporting abuse. Children's Advocacy Centers of Texas worked in coordination with TEA to develop a poster to help schools satisfy the statutory mandate that requires all schools to post the child abuse hotline telephone number on each school campus in locations that are readily available to students. The poster is available for download on the CACTX website. DFPS has also developed a free, online 1 hour training program on child abuse and neglect and mandatory

reporting requirements. DFPS also provides online print resources. Numerous online trainings have been created to fulfill training requirements on recognizing and reporting child abuse for child care facilities. Prevent Child Abuse Texas has also developed an in-person, six-hour workshop for child care professionals and school personnel.

The CJA Task Force feels that significant progress has been made in this priority area since the last Three Year Assessment. Anecdotally, we've heard that teachers and school personnel feel that they have a good understanding on the law and reporting requirements. Hopefully, through training required by the new laws passed in 2013, education professionals will obtain a greater understanding of the manifestations of trauma and this will improve capacity to recognize abuse victims. The Task Force Three Year Assessment Committee decided that the training of education professionals on recognizing and reporting child abuse was no longer a priority for CJA and it was removed from the 2015 assessment.

Mental Health

As discussed in the 2012 3YA, Texas ranked 50th in the nation on mental health spending and suffered from one of the highest rates of uninsured children. Additionally, the state faced critical mental health workforce shortages. These shortages were particularly acute along the border and in rural areas. The provider workforce in these areas was not representative of the state's ethnic diversity resulting in a particularly critical lack of culturally competent mental health care for the children who live there. As of November 2013, 207 of Texas' 254 counties were designated by the federal government as whole or partial Health Professional Shortage Areas for mental health.

During the 2013 (83rd) legislative session, Texas lawmakers made mental health care a priority and approved roughly $300 million more than in the 2011 session, some of the largest budget increases for mental health in the nation. The 2014-2015 state budget contains $2.6 billion for the public mental health system. This will put Texas closer to the national median on per capita expenditures for mental health services. The supplementary budget funds were allocated to eliminate wait lists for community health services by serving an additional 6,500 adults and children per year and increasing substance abuse services to an additional 948 individuals per year and increasing provider reimbursement rates. By mid-2014, Texas had drastically reduced its substantial waitlists for community mental health services to zero for children and to 285 adults (down from 7,234). Additionally, a new substance abuse initiative

allocated 6,000 slots for services to parents involved with DFPS, residential treatment services for parents involved with DFPS, as well as assistance for individuals who are homeless or at risk of being homeless. Legislators also filed more than 300 mental health related bills. One of those bills, HB 1023, required the Department of State Health Services to conduct a study and produce a report on the mental health workforce shortage in Texas. Another important piece of legislation, Rider 80, directed HHSC and DSHS to expand the Youth Empowerment Services (YES) waiver statewide. The expansion of the waiver will allow more youth with serious emotional disturbance to access intensive community behavioral services with the hope of decreasing the number of children relinquished to DFPS solely to access mental health services. DSHS is also funding 10 beds in private Residential Treatment Centers for youth at risk of parental relinquishment due to severe emotional disturbance and inability to access RTC services. Because of high demand, 3 more beds were added.

HB 1023 of the 83rd Legislature charged the Texas Health and Human Services Commission (HHSC) with making recommendations regarding that state's mental health workforce shortage. HHSC issued a report in September 2014. Texas continues to suffer from mental health provide shortages. Much of the state, especially rural and border areas, lack suitable mental health professionals. An additional problem is the lack of ethnic and cultural diversity in the mental health workforce. This lack of diversity in the workforce results in a shortage of providers with the training, skills, and knowledge to serve patients who speak languages other than English or racial/ethnic minority populations. In FY14, CJA funded the project *Transforming Trauma Treatment for Texas Children* through Serving Children and Adults in Need (SCAN). This project's goal was to increase the number and capacity of therapists in the border region of the state to implement Culturally Modified Trauma-Focused Cognitive Behavioral Therapy (CM-TF-CBT). During the grant year, SCAN trained a total of 142 clinicians in four cities in South Texas. After receiving training, participants immediately identified children that would be appropriate for the model and began implementing it. The cases that were presented on consultation calls indicated that training participants were implementing the model with fidelity and children were experiencing a reduction in traumatic stress. Training participants overwhelmingly expressed interest in continuing to develop their skills.

The Hogg Foundation for Mental Health has a number of initiatives to address the gap between demand for and availability of well-trained mental health workers in Texas. The Foundation has committed almost $2.2 million to develop American Psychological Association-accredited psychology internships over five years. The funded programs will train an estimated 62 interns by 2017. The Hogg Foundation

also supports scholarships to increase cultural and linguistic diversity in the Texas mental health workforce; scholarships for graduate social work students; and sponsors a professional network for African American mental health professionals in Texas.

Under the Affordable Care Act, treatment for mental health and substance abuse is mandatory for insurance plans offered in the federal marketplace. A new parity rule issued by Health and Human Services in November 2013 required that insurance plans not restrict mental health benefits more than coverage of physical illness. This rule went into effect in July 2014. Unfortunately, Texas decided not to expand Medicaid to cover poor adults. Texas has among the country's strictest requirements for Medicaid eligibility (less than $5,000 per year for a family of four) which means that many of those most in need of services will be ineligible for assistance.

Trauma-informed care (TIC) is an organized treatment framework and strengths-based delivery approach that incorporates understanding, recognizing, and appropriately responding to the emotional impact of trauma. TIC has continued to take root in Texas and every effort has been made to ensure that the system serving children and families impacted by abuse or neglect is trauma-informed. There are trainings, education, and outreach at every level of the system from CPS to mental health to the court system to juvenile justice to law enforcement to CASA to the schools. The hope is that awareness of an individual's trauma-inducing experiences can avoid re-traumatization that may occur in the child welfare system. The 83rd Legislative Session expanded required education on trauma and trauma-informed care to include educators, school administrators, and juvenile justice staff. CACTX has trained 160 clinicians in Trauma Focused-Cognitive Behavioral Therapy (TF-CBT) and continues to work diligently with its clinicians to ensure fidelity to the model. Texas leads the nation in the most therapists certified in TF-CBT. TF-CBT is evidence-based and has been shown to significantly decrease post-traumatic stress scores in children receiving the treatment. There has been no evaluation yet of the effects of TIC training on the outcomes of children and families served by the various systems or to measure the behavior change of those trained since this massive training effort has taken place but one is anticipated in the near future.

Because of the increased funding and attention to improving mental health services for children and families statewide as well CJA's focus on the early stages of a CPS case (investigation, assessment and prosecution), the Task Force Assessment Committee decided not to continue with this priority.

The Assessment Committee and CJA staff presented the preliminary Committee recommendations at the CJA Task Force meeting in October 2014. The Task Force approved the Committee's work.

CJA staff made several trips to meet with Assessment Committee members in their regions to conduct interviews with stakeholders on issues related to the assessment in order to help further refine the recommendations. CJA staff also met with grantees in person and by phone to get additional information from their work in the field to inform the assessment. Staff met with CACTX, TMPA, SafePlace, Texas Council on Family Violence, Harris County Institute of Forensic Science, and University of Texas Health Science Center Houston. These organizations and institutions met with their staff and stakeholders to answer our questions about strengths and weaknesses in Texas. Staff also met with the Children's Commission/CIP to fully understand their work and priorities. Throughout late fall, winter and early spring, CJA staff reviewed existing research, relevant reports, data and studies and continued to hold discussions with Task Force members and relevant stakeholders. The CJA Program Director also participated on a number of child welfare stakeholder committees in order to gain information and understanding of the work being done around the state as well as the issues needing attention.

The CJA Program Director emailed a full draft of the assessment and recommendations to the Assessment Committee and the Task Force Executive Committee prior to the April 24th, 2015 Task Force meeting. The Program Director also met with the Task Force Chair and the Chair-Elect to review the recommendations on April 23rd. The draft of the assessment and recommendations was presented to the full Task Force for discussion on April 24th. Following the discussion on the 24th, the Program Director made revisions to the assessment and recommendations and sent the document to the Assessment Committee by email for comment. After receiving and incorporating Assessment Committee changes to the document, it was sent to the full Task Force for review.

Analysis of Task Force Recommendations

Enhancing Multidisciplinary Team Response and Coordination

The multidisciplinary team approach to child abuse is a child-centered approach. The MDT approach provides a coordinated, joint response facilitating cooperation across disciplines, preventing unintentional working at cross purposes, and allowing for consistency from case to case. It also improves the system's efficiency by eliminating duplicative efforts. Multidisciplinary teams in Texas provide coordination at the beginning stages of a child abuse investigation and improve both Child Protective Services' (CPS) and law enforcement's response. Investigations involving child abuse and neglect require both law enforcement and child welfare because their responsibilities and their areas of expertise differ.

The Texas Code of Criminal Procedure (Art. 2.27) and the Texas Family Code (Sec. 261.301 H) require that CPS and law enforcement investigate cases jointly when a report to the Department of Family and Protective Services (DFPS) alleges that a child has been or may be the victim of conduct that constitutes a criminal offense that poses an immediate risk of physical or sexual abuse of a child that could result in the death of or serious harm to the child. The Family Code also stipulates that DFPS shall, in consultation with law enforcement, develop guidelines and protocols for joint investigations as well as provide joint training for CPS investigators and law enforcement officers (Sec. 261.3011). This section of the code also requires that investigative protocols include the use of forensic methods to determine the occurrence of child abuse. Forensic methods include a medical exam, critical analysis and explanation of a child's injuries, SANE exam, photographs of the scene, photographs of the injury, and forensic interview of the child victim.

Texas Family Code (Sec. 216.105) states that all reports received by a local or state law enforcement agency that allege abuse or neglect by a person responsible for a child's care, custody, or welfare shall be referred immediately to the department. If DFPS initiates an investigation and determines that the abuse or neglect does not involve a person responsible for the child's care, custody or welfare, the department shall refer the report to a law enforcement agency for further investigation.

In order to ensure that cases of abuse or neglect of a child by a person other than a person responsible for a child's care, custody, and welfare are investigated, *all* reports of abuse received by Statewide Intake must be emailed or faxed to the local law enforcement agency with jurisdiction over a case.

Texas Family Code (Sec. 261.3101) states that DFPS shall, subject to funding, employ or contract with medical and law enforcement professionals who shall be strategically placed throughout the state to provide forensic investigation support and to assist caseworkers with assessment decisions and intervention activities. Additionally DFPS shall employ or contract with subject matter experts to serve as consultants and designate persons who shall act as liaisons within the department whose primary functions are to develop relationships with local law enforcement agencies and courts.

In each county, to the extent possible, the Family Code (Sec 261.3126) states that DFPS and local law enforcement officers that investigate child abuse in the county shall co-locate in the same offices to improve the efficiency of child abuse investigations. With the approval of the local children's advocacy center, investigators from law enforcement and DFPS shall attempt to co-locate at the center.

Issues

Joint Investigations

While the laws mandating joint investigations of Priority 1 cases of child abuse, joint training of law enforcement and CPS investigators, cross-reporting, and encouraging co-location have been in place since 2005, the actual implementation of these laws has been varied. There are many reasons for the struggle with implementation. While joint training of law enforcement and CPS is mandated, the law does not provide funding for that training nor does it establish a training committee or a lead agency that will take responsibility for ensuring the joint training of all new officers and new investigators. In 2007, DFPS worked with law enforcement and Children's Advocacy Centers of Texas to develop guidelines for conducting joint investigations and began contracting with the Shaken Baby Alliance to deliver training on joint investigations. Shaken Baby Alliance is still the primary contractor. Their current training is the Serious Physical Child Abuse and SIDS Program. While this is a high quality training and reviews essential forensic and medical aspects of investigations into cases of serious physical child abuse, it does not cover some of the more basic but central aspects of a joint investigation that the CJA Task Force, through our grantees as well as discussions with CACs, law enforcement and CPS, have identified as currently lacking. These critical aspects include the role of law enforcement in a child abuse investigation, explanation of the Penal Code as it relates to child abuse and neglect, the role of CPS, CPS timelines as dictated by state and federal law, explanation of the Family Code as it relates to child abuse and neglect, discussion of the effect of a criminal charge on a child welfare case, why joint investigations are important, etc.

There are a number of consequences of the current lax approach to joint investigations. The most extreme result is the death of a child. Colton Turner, a two year old boy from the Austin area, was found dead in September of 2014. During his two years of life, CPS received six reports that Colton had been abused or neglected and conducted four investigations. The CPS caseworker did not arrange for a joint investigation with law enforcement or involve law enforcement on this case nor did law enforcement, who received notifications of this case through Statewide Intake, ever recognize the seriousness/criminal aspects of this case and engage in an independent investigation. This is not a problem that is unique to Texas. While most states have laws that authorize or mandate the use of multidisciplinary teams/joint investigations, these states have also struggled with the implementation and had the same dire consequences. Vermont was shaken by two tragic child abuse fatalities in February 2014 and April 2014. Both deaths involved children who had been in state custody and were recently reunified with their families. The Citizen's Advisory Board Child Death Review Report following these two fatalities noted insufficient investigation by law enforcement as well child welfare, inadequate communication and information sharing between agencies and the failure to appropriately refer cases to the multidisciplinary team. Minnesota recently completed a comprehensive evaluation of its child protection system after the death of a four year old, Eric Dean, who had been the subject of fifteen child abuse reports before being killed by his stepmother in 2013. In this case, the state child mortality report found that child protection workers failed to follow the law when they did not investigate or notify law enforcement when the boy was reported to have visible injuries. In Arizona, in a review released in November 2014 of a case of a near fatality due to neglect, it was found that reports involving criminal conduct were never forwarded to police. There are similar cases and reviews from 2014 from New Mexico, Kansas, Massachusetts, Delaware, Florida, etc. The commonalities in these cases are striking. Among the similarities is the failure, on the part of child welfare and law enforcement, to appropriately assess risk and determine when a criminal act had been committed as well as failure by child welfare to follow the law and refer cases to law enforcement for joint investigation, compounded by the failure of law enforcement to refer cases to CPS. These systemic problems are in no way contributable to malintent on the part of child protection workers or law enforcement officers. However, it does point to a critical need for additional training to clarify the importance of joint investigations and delineate the role of law enforcement and child welfare in a child abuse investigation.

Research studies have indicated that child welfare workers fear that law enforcement would use heavy-handed, punitive tactics making it difficult to protect children and unite families while law enforcement

professionals are concerned that child welfare workers will interfere with evidence collection and criminal investigations. (Cross, Finkelhor, & Ormrod, 2005). However, child abuse allegations are often complex and criminal law as the well as the family code is often ambiguous. As a result, professional discretion is a necessary feature of both police work and child protection. Determining whether a given child maltreatment report could constitute a crime requires some interpretation and judgment, as there are limits to how literally a community wants to apply a law. Agencies that have poor communication and collaboration, that have a Memorandum of Understanding in place that gives the appearance of collaboration rather than agencies that put forth sincere efforts to make collaboration a reality, can wind up inadvertently hurting the communities and families that they serve. Effective and consistent communication between law enforcement and CPS is critical to ensuring that joint investigations are effective. The success of any protocol or collaborative arrangement lies in its day-to-day implementation (Sedlak, Schultz, Wells, Lyons, Doueck & Gragg, 2005).

Texas Penal Code (Sec. 22.041) defines abandoning or endangering a child as leaving a child in any place without providing reasonable and necessary care, under circumstances under which no reasonable adult would leave a child of that age or ability; intentionally abandoning a child (under age 15) in any place under circumstances that expose the child to an unreasonable risk of harm; intentionally, knowingly, recklessly, or with criminal negligence, by act or omission, engages in conduct that places a child younger than 15 in imminent risk of death, bodily injury, or physical or mental impairment. It is presumed that a person engaged in conduct that places a child in imminent danger of death, bodily injury, physical or mental impairment if the person manufactured, possessed, or in any way introduced into the body of any person the substance methamphetamine in the presence of the child; if the person's conduct related to the proximity or accessibility of methamphetamine and an analysis of a specimen of the child's blood, urine or hair indicates the presence of the substance methamphetamine in the child's body; or the person injected, ingested, inhaled or otherwise introduced a controlled substance into the human body when the person was not in lawful possession of the substance. Both abandonment and endangerment are state jail felonies.

The way law enforcement interprets and enforces child endangerment/abandonment in a community is important because it can drive a CPS case. When police officers respond to calls involving potential child endangerment, the officers' training as well as the department's relationship with CPS can greatly influence their decision-making. For example, in Austin on March 23rd of this year, police responded to a child endangerment call where a two year old girl, wearing only a diaper, had gotten out of her mother's

apartment while her mother was asleep and was found wandering around the complex. Law enforcement called CPS. Once her mother was located, the child was returned to her mother and CPS is investigating without law enforcement's continued involvement. This is likely the way most of these cases are resolved across the state. However, from tracking newspaper articles over the past year, there are numerous reports of very similar situations where the parent or caregiver ends up in jail. For example, in Lubbock in March of 2014 police responded to a call where a two year old girl, wearing only a diaper, was seen running around outside. Police found the mother asleep and arrested her for endangering a child. The grand jury indicted her on the charge. There are also cases of parents or caregivers being arrested for dirty houses or even dirty cars, for failing to properly secure a child in a car seat, and in one case, for the failure to have a blanket to properly keep an infant warm while the parent shopping in Walmart.

Whether a child abuse case has a concurrent criminal investigation varies greatly throughout the state and it depends not as much on the type of case as it does on the particular community involved. The variability of the involvement of law enforcement on a child abuse case may have a great deal to do with agency priorities, budgets, staff training and experience. The differences between communities in rates of criminal investigations for the same offenses raise serious questions of equity for children and families.

In the one of the only studies on criminal investigations in child protection cases, (Cross, Chuang, Helton, Lux, 2014) researchers reviewed 4,255 CPS cases from 82 communities across 30 states to try to determine the frequency and correlates of criminal investigations of child maltreatment in cases investigated by CPS using national probability data. The study found that a criminal investigation was conducted in 11% of neglect cases, 24% of physical abuse cases, 54% of sexual abuse cases, and 16% 0f other forms of maltreatment. However, the percentage of cases criminally investigated varied significantly across communities. 28% of communities had investigation rates less than 20% while 14% of communities had investigation rates greater than 40%. The percentage of cases criminally investigated within each community ranged from 0% to 75%. This wide range could not be attributed to small numbers of cases per community because the wide distribution was maintained even when only including those communities with 10 or more cases.

> "Criminal investigation is a consequential intervention that law enforcement undertakes in about 27% of all cases investigated by CPS in the United States and about 28% of cases in which

> the criminal investigation is likely to focus on child maltreatment, a meaningful minority of cases. Perhaps our most important finding is the variability in the criminal investigation. No form of child maltreatment was consistently criminally investigated or not criminally investigated, and no single factor determined that a case was criminally investigated. This suggests that engagement of law enforcement in a criminal investigation depends on the specific policies, procedures, practice standards, and/or professional discretion that apply in a given case. Clearly there is much to learn about why and how child maltreatment cases are criminally investigated." (Cross, et al. 2014)

A criminal case can have a profound effect on a CPS case. Parents' attorneys may be hesitant to have a parent participate in services or testify in a child welfare case because admissions can be used in the criminal trial. Therefore parents' attorneys often prefer that criminal proceedings are resolved first so that clients can fully participate in CPS proceedings. However, the Family Code requires that all CPS cases must have a final order within 12 months from the date CPS was named temporary managing conservator or 18 months if an extension in granted. A parent who does not cooperate with the child welfare proceedings in a timely manner could end up at a termination hearing without having been able to demonstrate compliance with a reunification plan. Also, an accused parent might not be able to afford to bond out of jail and might be detained prior to trial. This would be an additional barrier to participating in a CPS case plan.

In the opposite case, when CPS caseworkers fail to arrange for joint investigations for P1 cases or when a law enforcement agency mistakenly believes that child maltreatment investigations are the purview of CPS, serious cases of child abuse can fall through cracks and the system ultimately fails.

In a variety of states and in a multitude of studies, it has been shown that law enforcement/CPS collaboration can improve the outcomes in both criminal justice and CPS cases. Each brings specific skills and improved communication can bring about better investigations, better evidence, and more accountability. If law enforcement and CPS interfere with or do not support each other, each agency will have a more difficult time achieving its outcomes. Each will have less evidence, more uncertainty about decisions, and less ability to act and follow through. Child removal might be either less frequent if communication difficulties impeded investigators' ability to decide and act, or more frequent if police impatience was unduly swaying decisions or if communication difficulties interfered with the implementation of alternatives (Cross, Finkelhor, Ormrod, 2005).

Forensic Investigations

CPS should include qualified medical professionals in the investigation stages of serious cases. Substantiation of a case of abuse or neglect is sometimes easy and straightforward, such as in cases where the signs of abuse or neglect are severe and blatant. But in many cases, the situation is more ambiguous and the case requires more evidence gathering and expertise to be able to appropriately assess the situation. Children under the age of two who suffer head or abdominal trauma or who have rib fractures might display no external signs of injury. Many injuries in young children, such as rib fractures or head injuries, will only be discovered via imaging screening. These injuries, called occult injuries, are identified on skeletal surveys in approximately one-third of physical abuse victims under age two (Wood, Feudtner, Medina, Luan, Localio and Rubin, 2012). A CPS worker who goes to investigate a report of physical abuse to a child under two might see no injuries and easily make the erroneous assumption that the report is unsubstantiated. It is vitally important that CPS investigators and law enforcement understand the truly difficult nature of these cases and involve medical professionals. Medical professionals are able to identify internal injuries and head trauma in younger children that might go undetected otherwise. Nearly 75% of victims have evidence of one or more older injuries when finally diagnosed with abusive head trauma. It's also important to involve medical professionals in order to get a more in depth picture of a family when there is ambiguity.

"Sentinel injuries" are seemingly insignificant injuries that can be early warning signs of abusive behavior. Many children who are victims of abuse do not experience it as a single event but rather a recurrent cycle. A retrospective study of 200 infants confirmed for abuse at one hospital found that in almost 1 in 3 children sentinel injuries preceded more severe abuse. Medical experts consider a skeletal survey necessary for infants under 6 months if they have any bruising, regardless of location and recommended for children under 12 months if there is bruising in particular locations. Any bruises on infants and bruises on soft tissue areas in ambulatory children tend to be indicative of abuse. Failure to identify a sentinel injury as being caused by abuse may result in further harm to the child and even death. It's important that injuries to young children, especially infants, are being treated with the utmost care. In a study of infants under six months with apparently isolated bruises who received additional diagnostic testing, 42.5% (62/146) had fractures identified and 36 out of the 62 had multiple fractures identified. 40 out of the 133 who obtained CT scans had a skull fracture, subdural hematoma, subarachnoid hemorrhage, cerebral contusion, subgaleal hemorrhage, cerebral edema, or intra-

ventricular hemorrhage. 4 of the children had liver lacerations (Harper, 2014). In Texas in cases of fatal child abuse where the family had previous involvement with CPS, investigators failed to recognize the significance of bruising (Austin American Statesman, 2015). This occurred in the previously mentioned case of Colton Turner. When the child was still an infant, CPS received reports of the infant being bruised. There was no medical evaluation in that case. In the case of Adrian Langlais in Fort Worth who died on March 18, 2015, neighbors reported seeing the toddler bruised on multiple occasions. Both investigations were unsubstantiated. The child died on his second birthday, a little more than a month after CPS closed their last investigation. If CPS communicates with medical professionals earlier in a case, both sides can effectively collaborate and share information to get a clearer, more accurate picture of the families under investigation in order to fully evaluate elements of safety and risk. While CPS is charged with responding to a case once abuse has occurred and usually after a family is in crisis, health professionals are better positioned to identify problems earlier and increased communication between CPS and members of the medical community could lead to improved identification of children who are likely to suffer significant harm.

In a review of cases of child abuse fatalities (Austin American Statesman, 2015) where CPS had previously investigated the family, a startling number of the cases involved prior allegations of medical neglect of either the child who died or the child's siblings. These allegations were almost all unsubstantiated. While it's unclear whether CPS consulted with medical professionals in these cases, it is clear that this medical neglect should be fully evaluated and considered a warning sign of a troubled family. In a review of serious case reviews (child fatalities) in the UK, researchers noted that one-third of the children had a history of missed medical appointments (Brandon, Sidebotham, Bailey, Belderson, Hawley, Ellis, et al., 2012). Another UK study found that 52% of children who were abused had missed appointments. CPS investigators are required to establish a "preponderance of evidence" in order to confirm an allegation of abuse or neglect. Without including medical professionals in the investigation, it's unlikely that the preponderance of evidence standard can be met.

The multidisciplinary team approach should be encouraged in cases involving any report of sexual abuse, bruises on a child younger than five, injuries to the head, burns or fractures in a child of any age, reported malnutrition or failure to thrive, and reported medical neglect. The MDT approach promotes a more comprehensive investigation, reduces the risk of additional trauma to the child, and facilitates the collection of evidence. In a prospective study of children born in California (Putnam-Hornstein, Cleves, Licht, & Needell, 2013), it was found that, after adjusting for other risk factors after birth, a previous

report to CPS (regardless of disposition) was the strongest predictor of death by injury during a child's first five years of life. A previous report to CPS was associated with both intentional and unintentional death by injury. In particular, an allegation of physical abuse signals the greatest risk of injury death. It would make sense that particular protocols to take an extra step to ensure the safety of children ages zero to five in cases where physical abuse is alleged would be justified.

Promising Changes

MDT Enhancement Program

Through a survey of 6 CPS regions, CPS Statewide Intake found that most law enforcement agencies were not able to effectively utilize the notifications that were being sent to them by fax or email. The reasons included the large volume of faxes/emails, inability to sort through reports for allegations that might include a criminal component, a misconception that the CPS investigator will make contact directly when a case necessitates law enforcement's involvement, and a misconception within CPS that the fax/email going to law enforcement generates an actual police report. Of the reports sent to law enforcement on an annual basis by Statewide Intake, approximately 18,000 are deemed a non-DFPS matter but may involve a criminal offense. This is in addition to the reports sent to law enforcement for which CPS is opening an investigation. Based on the survey, there is reason to believe that law enforcement is not beginning an investigation in many of these cases. The Children's Advocacy Centers of Texas (CACTX) was asked to partner with CPS and Statewide Intake to explore solutions to remedy the current situations. The proposed solution was for local CACs, with additional staffing, to receive the incoming reports from Statewide Intake to better facilitate joint investigations, assist MDT partners by offering administrative support, and help ensure that reports of child abuse are not falling through the cracks. CJA was approached to provide funding for the initial pilot project at the Children's Advocacy Center of Smith County in Tyler, Texas. The initial pilot took place from August 1, 2014 to November 30, 2014 and was tremendously successful. During that time the number of forensic interviews increased by 82%, the number of children who accessed evidence-based, trauma-focused therapeutic services at the Center increased significantly, and communication between CPS, law enforcement, and CAC staff improved considerably. The Intake Coordinator position quickly went from part-time to full-time. Because of the success of the initial pilot, CJA agreed to fund the continuation of the pilot in Smith County as well as two additional pilots at local CACs in Travis County and Hidalgo County. The outstanding data from these pilots has led the Texas legislature to approve $6 million in additional funding to CACTX to roll out the MDT Enhancement Program in local CACs statewide. The Task Force is

confident that this investment by the State will dramatically improve the facilitation of joint investigations between law enforcement and CPS for cases that involve both civil and criminal component as well as ensure that all reports of child abuse receive proper consideration by CPS and/or law enforcement to determine if an investigation should be initiated.

Through the CJA funded project *Increasing Access to Medical Evaluations for Child Maltreatment Victims*, CACTX discovered through focus groups that many partners were unaware of the mandates of the various disciplines that make up an MDT. This knowledge has galvanized CACTX to go "back to basics" with its training and ensure that its members have the core resources and knowledge necessary for a functioning team.

CPS Transformation

In 2014, the Texas Department of Family and Protective Services underwent the Sunset Process which is a legislatively required assessment of the continuing need for a state agency's existence. The Sunset process works by setting a date on which an agency will be abolished unless legislation is passed to continue its functions. This creates an opportunity for the Legislature to look closely an agency and make fundamental changes to its mission or operations if needed. As a result of recommendations made by the Sunset Advisory Commission, CPS is undergoing a Transformation that began in August 2014 and targets three priorities: to develop a professional and stable workforce; ensure child safety, permanency, and well-being; and establish effective organization and operations. As a part of Transformation, CPS has redesigned the new worker training module to include mentoring, revised classroom "CPS professional development" training and expanded field-based specialty training. Additionally, CPS is rolling out Structured Decision Making for both safety and risk assessments. The safety assessment tool assists investigation caseworkers during first contact with a child and family to evaluate all available information, identify the most important issues related to safety, and support the caseworker's decisions to ensure child safety. The risk assessment tool is an actuarially-sound tool used by workers to assess the likelihood of future abuse and neglect. The implementation of the Structured Decision Making safety assessment was completed on March 29, 2015. There is also an audit of Child Safety Specialists currently underway to strengthen these subject matter experts' role in addressing child safety. The Task Force hopes that these changes will enhance CPS investigators understanding of the particular risk for children under age two in cases of alleged physical abuse or medical neglect and improve the collaboration with medical professionals in these cases.

Joint Investigations

CJA has funded Texas Municipal Police Department to develop and provide training for Texas Peace Officers on child abuse and neglect. The Task Force has identified this has an urgent need in the state. The training for officers provided by the Texas Commission on Law Enforcement has not been updated since 2002. The curriculum developed through the CJA is updated every year, includes interactive exercises, is taught over the course of three days, and is provided at no cost to participants. We have made a particular effort to reach out to officers in more rural areas of the state who might not otherwise have access to training. This grant year, the CJA Task Force instructed the program to make an effort to involve CPS investigators and special investigators in the training. Both CPS and TMPA have developed an excellent working relationship and more and more CPS professionals are attending the trainings. These joint trainings have been well received by both disciplines.

The 84th Texas Legislature has also recently passed HB 2053 (Colton's Law). This bill relates to the protection of certain children who may be subject to child abuse or neglect through the operation of the child safety check alert list; it amends the Texas Family Code. The child safety check alert list is maintained by the Texas Crime Information Center. This bill requires DFPS to notify Department of Public Safety (DPS) if during DFPS' investigation into child abuse or neglect the location of the child or the child's family is unknown. DPS is then required to conduct an investigation to locate the child or the child's family; if DPS find the child or its family, DPS must notify DFPS. No court order is required to add the child or the family to the child safety check alert list. Information required on the child safety check alert list is expanded and listed in the statute. An officer who finds the child or its family now has the authority to immediately detain all individuals in the officer's presence and take temporary custody of the child who subject to a report of child abuse or neglect. Officers are given further authority over motor vehicles, required to notify DFPS of the detention including location, and required to hold everyone at the location of initial contact with the officer. DFPS has six hours in which to make contact with the child or family at the location of initial detention. If DFPS cannot respond within six hours, the officer must obtain the child's current address and any other relevant information, report that information to DFPS, and release the detained individuals and motor vehicles. This law will ensure CPS and law enforcement work together to find children that CPS deems "Unable to Locate."

Recommendations

The CJA Task Force recommends supporting policies and programs that will promote a consistent, coordinated multidisciplinary response to serious cases of child abuse/neglect as well as improve the coordination between the criminal justice system and civil child protection system.

Strategies may include:

- Promote the continued use of local child advocacy centers for multi-disciplinary team coordination to improve the cooperation and collaboration between agencies involved in the investigation, assessment, and disposition of serious cases of child abuse/neglect. Encourage co-location of CPS and law enforcement at local CACs whenever possible. Continue to work with Children's Advocacy Centers of Texas to provide training, technical assistance, and facilitation of MDTs statewide.
- Support the launch of the MDT Enhancement Program with CACTX, particularly focusing on evaluation of the program's implementation and impact at local centers.
- Encourage ongoing, joint training for law enforcement and CPS to achieve a level of competency, consistency, and quality in child abuse investigations across the state. Training should focus on protocols, investigative processes, roles/responsibilities, and improving communication.
- Support training for attorneys to enhance the effectiveness and quality of the prosecution of child abuse cases.
- Encourage medical assessments of children, particularly children under age two with allegations of physical abuse by supporting and enhancing interagency collaboration between child abuse pediatricians and CPS investigators. The Task Force understands that CPS Transformation is changing worker training as well as the way that safety and risk are assessed. We will monitor this process to ensure that we do not work at cross purposes.
- Support training to ensure that medical professionals have the necessary knowledge and resources to accurately recognize abuse and understand proper medical evaluations for suspected abuse.

Victim Advocacy

Children who have suffered abuse or neglect should not be further traumatized by the systems intended to protect them. There has been increased awareness that systems should be child-centered and many positive changes have been taking place.

One of the positive changes is the increased cooperation in the state between the domestic violence service providers and CPS. CJA has provided funding to the Texas Council on Family Violence (TCFV), the statewide coalition of domestic violence service providers offering technical support, training, and multi-level systems and policy advocacy on a range of issues impacting survivors and programs. TCFV is working with CPS at the state level on policy and practice to improve its work with survivors of domestic violence with children as well as facilitating enhanced collaborations at the local level between domestic violence service providers and CPS workers. TCFV and CPS have worked closely together over the past year to review issues related to dispositional findings against survivors of family violence. TCFV and CPS were able to leverage funding from the Governor's Office to further these collaborative efforts. Two staff positions have now been funded to implement the recommendations related to policy and practice. This funding has allowed TCFV and CPS to have staff members dedicated to working in tandem on training related to child abuse and domestic violence, on continuing to review and refine policy and practices, and to further develop areas of collaboration. Another example of success was the creation of a CPS Domestic Violence pilot unit, in collaboration with TCFV and local family violence programs, which implemented many changes in practice for CPS cases involving domestic violence. The new practices implemented in the pilot are based on the principle that the safety of the children is enhanced when CPS partners with and supports the safety of the adult victim of domestic violence. Many of these practices are being incorporated into statewide CPS practice.

The 83rd Legislative session enacted SB423 which amended the Texas Family Code to authorize DFPS to conduct an alternative response (AR) to an investigation that otherwise meets the criteria for a CPS investigation. An AR intervention involves an assessment of the family, including a safety assessment, and agreed upon provision of services and supports as well as CPS involvement for a limited period of time. There will be not be a formal finding about whether abuse or neglect occurred, there will be no one added to the central registry, and family engagement will be undertaken in a less adversarial, more collaborative approach. A case in alternative response can be reassigned to the investigation track if the caseworker determines it to be necessary. CPS is initially rolling out AR in three regions of the state. CJA has provided funding to DFPS to develop and deliver supervisor and caseworker training on AR, conduct

needs assessment of resources and services in the pilot regions, and provide technical assistance to the pilot sites. AR has been fully implemented in its initial regional site. AR caseworkers have reported an increase in morale stating that it gives them the ability to work with families on a deeper basis, to better meet the family's needs in the long run, and gives them a greater sense of satisfaction knowing they are helping these families become successful.

The Issue

Family Advocacy

Abuse experienced in childhood can have consequences that last a lifetime. Not all children who experience abuse will experience long-term consequences but they may have increased susceptibility. Child abuse has been linked to negative health outcomes in adulthood including chronic disease (Springer, Sheridan, Kuo, & Carnes, 2007). Children who experience maltreatment are at increased risk for alcohol and drug abuse as adults as well as engaging in high-risk sexual behaviors (Felitti et al., 1998). Additionally, adults abused as children report higher rates of depression, anxiety disorders, eating disorders, sexual dysfunction, personality disorders, and dissociative disorder (Kessler, McLaughlin, Greif, Gruber, Sampson & Zaslavsky, 2010). Adult survivors of child physical or sexual abuse are more likely to be admitted to a psychiatric hospital; have earlier, longer and more frequent admissions; are more likely to self-harm and to try and kill themselves (Read, Bentall & Fosse, 2009). However, there are number of adults who do not experience deleterious long-term impacts from child abuse. Studies have shown that differences in parent-child relationships may influence the long-term mental and physical health among survivors. For example, one study (Chandy, Blum & Resnick, 1997) found that the perception of at least one parent caring decreased risky behaviors such as suicidal ideation and drug use among male high school students who reported being sexually abused. Additional studies have documented that strong family functioning, community support, and the mental health of non-offending caregivers appears to offer important supports for abused youth (Drake & Pandey, 1996; Paradise & Rose, 1994). Another study (Schafer, Morton, & Ferraro, 2013) found that while physical and emotional maltreatment has the potential for long-term adverse health effects, adults who reported negative parental relationships also reported a greater number of chronic physical conditions, physical symptoms, and lower self-rated health. Lack of parental support for the child victim is associated with greater psychopathology for the victim as well as higher rates of out of home placement.

Providing support for non-offending parents and caregivers in situations of domestic violence and sexual abuse is critical for lessening the long-term impact and trauma on the child. Parental substance use and/or mental health issues are barriers to a parent or caregiver's ability to effectively protect and support his or her children. Strengthening the bond between the non-offending parent and the children has the biggest impact on increasing resiliency in children exposed to domestic violence (Brancroft, Silverman, 2002).

As described above, Texas is working to increase support and services to families in the hopes of improving outcomes for children. The Task Force supports the continuation of this work throughout the state.

Children and Youth with Sexual Behavior Problems

In Texas in 2013, reported incidents of sexual assault involved 18,612 victims. The age group with the highest number of victims was in the 10-14-year-old bracket. There were 18,812 offenders involved in incidents of sexual assault in Texas in 2013. The age group with the highest number of offenders was the 15-19 year old bracket with roughly 3,100 offenders. The 0-14 year old bracket had roughly 1,700 offenders. In Texas, children age 10 and older can be found legally culpable for their behavior. Research suggests that youth commit one-quarter of all sex offenses and more than one-third of sex offenses against juvenile victims (Finkelhor, Ormrod, & Chaffin, 2009).

Children and youth who sexually offend do not constitute a homogeneous group and they are different from adult sex offenders. Adult sex offenders are often shown to be among the criminals with the highest likelihood of sexual re-offense. According to a study by the US Department of Justice, of 9,691 sex offenders released from prison, sex offenders were four times more likely than non-sex offenders to be rearrested for a sex crime. While a small percentage of juvenile offenders reoffend in adulthood, many adult sex offenders begin offending in adolescence, and an earlier age of first offense is a strong predictor of recidivism (Becker & Abel, 1985; Knight, Ronis, & Zakireh, 2009). However, adolescents are more likely to respond positively to treatment than adults, particularly immediately following their initial detection by the criminal justice system and are much less likely to reoffend over time (Carpentier & Proulx, 2011). This indicates that this group represents an excellent opportunity for prevention of future harm as well as intervention efforts. Additionally, offenses often escalate in severity and frequency over time indicating that youth and adolescence are the appropriate times to target intervention. It's also vitally important that the Texas justice system be very cautious in certifying juveniles charged with sex

offenses and with no prior offenses as adults. Treating juveniles as adults in the legal system cuts off their access to the necessary treatment and greatly reduces the potential for rehabilitation.

Most sexually abusive youth have a history of traumatic experiences, though not necessarily sexual abuse. Typically 40% of sexually abusive adolescents report having a history of sexual abuse though some studies have found rates as high as 79% and 86%. Some studies have found that a combination of multiple types of abuse are common experiences in the lives of sexually abusing youth, with some studies finding up to 75% of the youth having experienced multiple trauma (Hutton & Whyte, 2006; McMackin, Leisen, Cusack, Lafratta, & Litwin, 2002). In their meta-analysis comparing 3,855 male adolescent sex offenders with 13,393 nonsexual offenders, Seto and Lalumiere (2010) found that sexually offending youth were almost three times more likely to have been sexually abused and also significantly more likely to have experienced physical abuse or neglect. Other traumas experienced by sexually abusive youth include: threats to one's life, severe injury, witnessing the death of another, and gang violence (McMackin et al. 2002). Among all offender groups, youth who molested children were more likely to have witnessed domestic violence while rapists reported experiencing significantly more death and abandonment (Ford & Linney, 1995). In one study, over half of the sample of adolescent sex offenders (ages 13 to 18) witnessed domestic violence perpetrated against their mother (Caputo, Frick, & Brodsky, 1999). Research by Carpentier and Proulx (2011) found four variables significantly predicted sexual recidivism in a sample of offenders: parental abandonment, childhood victimization, association with significantly younger children, and having victimized a stranger. Positive family support can play a significant role in mitigating the effects of the traumatic childhood experiences that may influence an individual to develop sexually abusive behavior.

Juveniles in Texas who have been charged with a sex offense can be placed under supervision, on Texas Juvenile Justice Department (TJJD) parole, in TJJD secure facilities, or in residential treatment facilities. A professional who provides treatment to a juvenile who has been convicted of sex offenses must be licensed by the Council on Sex Offender Treatment, have a Master's degree, and 1,000 hours of clinical experience. A report from November 2011 issued by Texas Juvenile Probation Commission entitled *Identifying the Shortage of Licensed Professionals Available to Serve Juvenile Offenders* found that a total of 177 (70%) of Texas' 254 counties had no licensed sex offender treatment provider as of September 2010 and only 37 counties (15%) had three or more of these professionals. The absence of providers is particularly prevalent along the Texas-Mexico border, West Texas and the Panhandle. There is no information readily available about the specifics of the services provided by these treatment providers.

The ideal solution is community-based, family-centered with active multidisciplinary team involvement at case and systems level. Effective treatment not only targets the risks and needs of the child but must also include the family or primary caregiver in the process. Unfortunately, there are not enough of these programs in Texas to serve the number of offenders. The toughest cases are those that are intra-family. The victim and the perpetrator must immediately be separated to ensure the victim's safety but the family's ultimate goal will likely be reconnection. Parents will need to ensure that both the child victim and the perpetrator receive treatment. The parent will likely also need support when facing this crisis. Decisions made regarding reunification will need to be done with a treatment team to ensure that the all members of the family are ready.

Evaluations of the efficacy of treatment interventions among children with sexual behavior problems have found that sexual behavior problem cognitive behavioral therapy (SBP-CBT) has proven to be effective for relapse prevention. Since many juvenile offenders also have a trauma history, it's important that the treatment they receive also focus on their own victimization and trauma (Trauma-Focused Cognitive Behavioral Therapy). Studies have also demonstrated the prevalence of youth with autism spectrum disorder in the juvenile justice system due to sex offenses. These youth need to be identified and receive specialized, appropriate treatment.

There are a number of problems in understanding and treating this problem. There is no standard identification of a sexual behavior problem. Additionally, juvenile sex offender registration policies have had an unintended effect of reducing the likelihood that youth are held accountable for sexual offenses. Two studies (Letourneau, Bandyopadhyay, Sinha & Armstrong, 2009; Letourneau, Armstrong, Bandyopadhyay & Sinha, 2013) examined prosecutorial decisions following the implementation of juvenile sex offender registration and notification policies. Over a 15 year period, there was a 41% decline in prosecution of these cases. Additionally, there was a 124% increase in plea bargains leading to non-sex offense charges from the period predating registration to the period following the initial enactment of the registration. This act of seeming generosity also reduces the likelihood that youth will receive sex offender treatment services. Families may also be less likely to ask for help in order to protect the offending child from spending years on the sex offender registry.

Multiple systems are involved in these cases but not all together and not consistently. It's often not clear what system is responsible for intervening or when. For example, if Statewide Intake (SWI) receives a call regarding child-on-child sexual abuse, depending on the circumstances of the case, the individual

taking the call may or may not decide that CPS has jurisdiction to take the case. In such a case, as with all other cases of abuse called in, the abuse report will be faxed or emailed to county law enforcement for follow-up. However, as has been learned recently, local law enforcement is not always aware that they are receiving these reports or that follow-up would be required on any reports coming to them from SWI. While CJA is supporting pilot projects with local Children's Advocacy Centers to try and improve this situation, it's currently only improved in a couple of counties. Additionally, law enforcement and CPS, without additional education, may not be aware which system is actually responsible for these cases, particularly in the cases of sibling abuse. There can also be a lack of collaboration or coordination among providers and systems. Another problem is the myth or misperception that sexual behavior problems in youth is the same as pedophilia or psychopathy in adults and that treatment will require years of intensive residential care. As a result, the risk associated with youth with sexual behavior problems is misperceived. The long-term risk among children with sexual behavior problems is low, especially given correct treatment. However, children and youth do require appropriate treatment. The courts also need to be educated on youth offending to provide a level of consistency in the management of cases across the state.

CPS workers may lack the training on children with sexual behavior problems that is needed to ensure effective identification, investigation, and intervention on these cases. Workers also need to be particularly vigilant to identify sexual behavior problems in youth in foster care to ensure the appropriate treatment and accommodation of these youth as well as to minimize the risk to other children. The need for training is also acute for DFPS residential child care licensing (RCCL) employees in Texas. Child Care Licensing is currently charged with investigating allegations of abuse in foster care. CCL workers are trained to look for licensing violations but have little training in investigations. Former foster youth in Texas having been speaking out for years about the sexual abuse they suffered while in care as well as the lack of appropriate investigation on the part of DFPS. In the Texas Foster Care Alumni Study published by Casey Family Programs in 2012, 23.4% of survey participants reported having experienced sexual abuse at some point during their time in foster care. In its 2014 Pulitzer winning investigation of residential treatment centers across the country, the Chicago Tribune uncovered the scope of abuses at these facilities. Treatment staff often dismiss sexual contact between youth as consensual and the degree to which CCL investigate these acts or police are involved in these investigations in Texas is unclear. Steps need to be taken to ensure that children with sexual behavior problems taken into CPS custody are promptly identified so that appropriate treatment can begin. DFPS also needs to make

certain that the workers charged with investigating alleged sexual assaults of youth in care take immediate and appropriate action to ensure the safety of child victims.

Promising Changes

During the 84th Legislative Session (2015), Texas passed HB 1144 which establishes a task force to examine adjudication, disposition, and registration of juvenile sex offenders. The Task Force on Improving Outcomes for Juveniles Adjudicated of Sexual Offenses will make policy recommendations to improve the outcomes for juvenile sex offenders after studying:

- the adjudication and disposition processes and programs for juvenile sex offenders;
- counseling, mental health, or other services provided by the state or local juvenile probation departments to juvenile sex offenders;
- the sex offender registration process for juveniles; and
- any other issue related to improving the outcomes for juvenile sex offenders.

A representative from Children's Advocacy Centers of Texas will be participating on the Task Force as will a representative from the Department of Family and Protective Services. The Task Force will prepare a report of their findings and recommendations that will be due no later than December 1, 2016. This report and the work of the Task Force should help inform and direct any work that CJA does on this issue.

Recommendations

The CJA Task Force recommends supporting programs and policies to ensure consistent, high quality resources and services to child victims and their non-offending caregivers.

Possible strategies include:

- Training for MDT members on family engagement, respect for caregivers, alternatives to removal, support of non-offending caregivers, etc.;
- Resources and training for courts, DFPS, and juvenile probation on the importance of appropriately assessing and treating children and youth with sexual behavior problems;

- Support for children's advocacy centers to assist in handling cases involving children and youth with sexual behavior problems.

Improving Response to Child Maltreatment Victims with Disabilities or Special Healthcare Needs

Studies examining patterns of child maltreatment have found that children with disabilities experience higher rates of maltreatment than children without disabilities (Crosse, Kaye, & Ratnofsky, 1992; Sullivan & Knutson, 2000). According to the Bureau of Justice Statistics Report *Crime Against Persons with Disabilities 2009-2012*, among persons ages 12-15, the unadjusted rate of violent victimization was nearly three times higher for persons with disabilities than for persons without disabilities. Among persons ages 16 - 19, the rate of violent victimization was 2.5 times higher for persons with disabilities than without. Persons with cognitive disabilities had the highest unadjusted rate of violent victimization. Other studies (Jonson-Reid, Drake, Kim, Porterfield & Han, 2004; Lightfoot, Hill, & LaLiberte, 2011; Sullivan & Knutsen, 2000) have found that, while children with all types of disabilities experience abuse at a greater rate, children with emotional or behavioral disorders are particularly susceptible to abuse. Some studies have shown that children with disabilities are more likely to experience neglect as well as unique forms of disability-related maltreatment such as withholding medication or not providing personal care. Prevalence studies as well as reports that are more anecdotal point to neglect as the most common type of maltreatment experienced by children with disabilities. One study (Sullivan and Knutson, 2000) found that children with disabilities were 3.76 times more likely to be victims of neglect than children without disabilities. Another study (Crosse et al., 1992) found that children with disabilities were more likely to be medically neglected but less likely to be physically neglected than children without disabilities.

There are hundreds of different definitions of disability used at the federal, state, and local levels. The 2010 reauthorization of CAPTA required states to include child disability in their abuse and neglect incidence and prevalence reporting. According to the CAPTA reauthorization, a child is considered to have a disability based on the thirteen categories used in the Individuals with Disabilities Act (IDEA). These categories for children aged 3 through 21 are: autism; deaf-blindness; deafness; emotional disturbance; hearing impairment; intellectual disability; multiple disabilities; orthopedic impairment; other health impairment; specific learning disability; speech or language impairment; traumatic brain injury; or visual impairment (including blindness).

Issues

Children with disability or special healthcare needs are particularly vulnerable and CPS professionals need to develop disability competency. A basic understanding of the prevalence of children with

disabilities involved in child welfare services, based on the best data available, is essential in order to develop this competency. Unfortunately, this is an area where Texas is lacking. In order to be in compliance with CAPTA, Texas is reporting the number of children investigated by CPS each year who have a disability, however, it is unlikely that that number accurately reflects reality. In fact, it's difficult to understand the reality of the NCANDS disability numbers for any of the states. For example, in 2013 eight states reported that less than 5% of their investigations involved children with disabilities (Texas reported 1.9%) while eight states reported that more than 25% of their investigations involved children with disabilities. Lack of child welfare training in identifying children with disabilities coupled with a lack of standardized definitions of disabilities used across states make the accuracy of federally reported data suspect. In a report by Bruhn (2003), the 1999 AFCARS data set for one state reported that none of the children in foster care in the state had a disability while other states reported rates of disability as high as 46.7%. It seems unlikely that the vast differences are due to wildly different rates of children with disabilities between states. As a state, Texas does not do a good enough job tracking the number of children with disabilities and special needs who are alleged or confirmed victims of maltreatment. The lack of empirical knowledge about the prevalence of children with disabilities or special health care needs involved the child welfare system is a significant barrier to addressing risk and how to best serve clients.

It's vital the CPS workers appropriately gauge child safety and risk. They are unable to do this unless they are also prepared to recognize disabilities/medical needs, appropriately assess for safety based on individual needs associated with disability, and provide families with relevant, necessary services. In 2013, there were 16 child abuse fatalities where the family had been investigated by CPS more than three times (Austin American Statesman, 2015). In 6 of those 16 cases, or 38% of the cases, the child killed had a disability or special health care need. In 2 cases, the deceased child's sibling or siblings were disabled or have a primary health need which means that 50% of these cases involve this particular risk. All but three of the cases (81%) involved previous allegations of medical neglect. This is not a new problem. In its 2010 report, the State Child Fatality Review Team recommended that CPS develop a protocol for assessing and meeting the needs of children with special healthcare needs who are referred for abuse and neglect. The report states, "Review of CPS child death cases reveals that CPS cases involving medically-fragile children with special health care needs are not often given the special attention required to meet the child's need for protection." Additionally, Citizen Review Team Reports from Region 6 in both 2011 and 2013 address a lack of communication between CPS caseworkers and

medical providers for children with special needs and the need for caseworkers to have additional training regarding child vulnerability, safety factors, and case documentation. Health professionals can assist in the early identification of risk in these cases. The potential for harm is best understood by health service professionals.

The overwhelming number of cases that DFPS investigates each year deal with allegations of neglect. Research has shown that particular groups of children may be at higher risk for neglect – children born to mothers who use substances, have mental health problems or suffer domestic abuse, low birth weight babies/babies with early medical problems, children with disabilities, and children whose parents perceive them as difficult to care for. A study (Sidebotham et al., 2003) found that children born with low birth weight were more than twice as likely to suffer from abuse as were children born of normal birth weight. A population based study (Spencer et al., 2006) found that low birth weight and premature babies were at greater risk for all types of abuse compared to babies of normal weight. Babies who are born premature or sick have neuro-developmental immaturity that results in increased crying, irritability, and disorganized sleep patterns. Mothers of these infants experience more mental health issues including depression and anxiety. The ability to recognize early warning signs in the relationship between the caregiver and their child is critical to secure positive outcomes for the child. Children in families with chronic neglect cases often have complex or chronic health needs, missed health appointments, and emotional and behavioral problems. The families display complex problems with multiple needs. Without intervention, the problems with become more entrenched. Additionally, pre-term, low birth weight, and sick babies have a higher risk of developmental delays. This risk is increased in families with low social economic status. In a survey by Action for Children (UK) of professionals asking why they did not intervene in cases of neglect, the most common answers given by child welfare workers were lack of resources, lack of services, and lack of appropriate skills & knowledge. Compared to law enforcement, health professionals, and teachers, child welfare professionals were the most likely to feel powerless to intervene in a case of child neglect. This corresponds to work done by SafePlace with a CJA grant educating multidisciplinary team members about working with children with disabilities. SafePlace found that CPS workers felt that they did not have enough knowledge of available resources and services to effectively work with families whose children had disabilities. They also commonly felt that they did not have the training/knowledge needed to identify disabilities in children to effectively assess for risk.

Additionally, babies born premature or substance exposed are also at a greater risk to die from sleep-related causes. Virginia's State Child Fatality Review Team published a report in March 2014 analyzing 119 sleep-related deaths from 2009. 28% of those infants were born premature and 24% had low birth weights. 25% of the infants spent some time in a Neonatal Intensive Care Unit. More than one in five mothers used alcohol or drugs while pregnant. The Fetal Infant Mortality Review Team in Milwaukee issued a report on 2009-2011 infant deaths and found that 80% of Milwaukee mothers who experienced an infant death during this time period delivered preterm and prematurity was seen in 50% of all 2009-2011 SIDS/SUID/Accidental Suffocation infant deaths.

More than 30% of the children in DFPS who are placed in adoptive homes each year are described as having a disabling condition. At least 10% of the children in foster care each year will be placed in Residential Treatment Centers, hospitals or state schools. From the information available on children in foster care, it's clear that a high percentage of children who are removed from their homes have disabilities or special needs. It's also clear children with medical, behavioral, and developmental problems are at an increased risk of being killed by abuse or neglect (Harbert, Tucker-Tatlow, 2010). Studies have also found that children with mild disabilities (Verdugo et al., 1995) and only slight development problems were at a greater risk for maltreatment than those with more severe disabilities. Also, in a review of sexual abuse against children and adolescents with intellectual disability, those with mild-to-moderate intellectual disabilities were more likely to suffer abuse than those with severe intellectual disabilities (Balogh et al., 2001). Children with mild disabilities are not detected as easily and may display behaviors that, while related to the disability, may be mistakenly attributed to the child's character (Fisher et al., 2008). One of the problems with the inadequate education around the enhanced risk factor for this population is that deaths that could be due to neglect are attributed to natural causes and not fully investigated.

Failure to fully appreciate the importance of the interplay of multiple risk factors in a family and how to best serve the family in order to keep the child safe means that the child/family will keep coming to the attention of the various systems as the untreated problems get increasingly worse. In the Structured Decision Making Model that is to be adopted by Texas CPS to enhance the assessment of risk and safety, there are numerous questions about whether the child in the investigation is limited by a disability. However, without a consistent definition of a disability, training to recognize disabilities, training around the particular risks to infants with special health care needs, etc., it's unlikely that an investigator will be able to perform an accurate assessment.

Cross agency collaboration and communication needs to be improved between health professionals, disability service organizations and CPS. Child welfare workers cannot become experts in disability services, medical needs of infants nor can they be expected to screen for disabilities. However, they need to know enough about disabilities to recognize when to refer a child for screening and to know who to collaborate with in the disability field.

Recommendations:

The CJA Task Force recommends supporting policies and programs to improve awareness of the increased risk of abuse for children with disabilities and children with special healthcare needs as well as promote interagency collaboration to improve system response to these cases.

Strategies may include:

- Encourage improved data collection on the prevalence of children with disabilities and special health care with child maltreatment allegations in Texas;
- Training for caseworkers on the necessity of in-depth investigations in cases involving children with primary medical needs, particularly infants. Particular care should be taken in cases where a child has special health-care needs and a health care professional has reported medical neglect. The Task Force understands that CPS Transformation is changing worker training as well as the way that safety and risk are assessed. We will monitor this process to ensure that we do not work at cross purposes;
- Training/resources for medical providers to improve awareness of the increased risk of abuse for children with primary health needs, children with neonatal abstinence syndrome and children with disabilities;
- Training/resources for WIC program staff, or other social service agencies who might come in contact with families, on risk of abuse and neglect in disabled or infants with primary medical needs and children;
- Training/resources to improve communication and collaboration between CPS caseworkers, disability services providers and medical professionals to ensure better support for at-risk families.

Improving the Multidisciplinary Response to Suspected Child Maltreatment Fatalities

Child fatalities from maltreatment usually result either from chronic neglect or abuse or from a single, severe incident of abuse or neglect (Cage, et al, 2010). In Texas, DFPS confirmed 156 cases of child abuse and neglect fatalities in 2013 compared to 212 cases in 2012. Part of the 26% decline in confirmed cases is "due to a more consistent disposition of fatalities involving cosleeping, drownings, firearms, suicides and hot cars between DFPS regions". Certain deaths that were previously confirmed as neglect deaths would no longer be considered neglect. In 53% of the cases, the family had no prior CPS history and the family/child is considered "unknown". 81% of the children were 3 years old or younger at the time of their death.

The Issue:

Up until this year, DFPS did not release much information about child abuse and neglect fatalities. However, DFPS has a new website for its Office of Child Safety, created in September 2014 to address and reduce child abuse, on which it shares fatality reviews, data charts and all child fatalities assigned for investigations through the current fiscal year. The data on current child fatality investigations includes the county of the child fatality, the date of death, the child's age, a public posting statement about the child's death, the status of the investigation, and if abuse/neglect is confirmed as the cause of fatality. This information sharing is a huge step forward. However, there is a still problem with the accuracy of data regarding child deaths

In FY2012, DFPS investigated 882 child fatalities and confirmed 212 cases. However, according to the Texas Department of State Health Services (DSHS), there were 3,178 deaths of children 15 years old and younger. According to the most recent State Child Fatality Review Team (SCFRT) report from 2013 which covers child deaths from 2011, local CFRTs in Texas reviewed 54.2% of deaths in counties with CFRTs. The voluntary nature of local CFRTs makes it difficult to enforce levels of participation (2013 State CFRT Report). There were 3,625 child deaths (children 17 and younger) in Texas in 2011 and DFPS reviewed 27% of those cases. In 2010, the local CFRTs reviewed 62% of the 3,795 child deaths. DFPS also reviewed 27% of those cases. The SCFRT 2014 child fatality report has not yet been released so we do not have the comparable numbers for 2012; however, we can presume they will be similar. In 2013, there were 73 active local CFRTs covering 200 of Texas' 254 counties and 94% of Texas children live in the 200 counties with a CFRT.

Based on the number of child death cases being investigated by DFPS and reviewed by local CFRTs, it's clear that there a number of deaths that are not being reviewed by either agency. To fully understand the circumstances and risks leading to a child death, identify trends, and implement effective prevention activities, the SCFRT recommends that all Texas counties participate in CFR and 100 percent of child deaths be reviewed and recorded (SCFRT 2013 Annual Report). It's unlikely that there are a large number of abuse cases that are missed, but it is likely that the State does not have a clear picture of how, why, and where children are dying. Because cases of neglect are so difficult to define, there's a good chance that unreviewed cases are being misclassified. Additionally, Texas is not using vital statistics data, law enforcement data, or medical examiner data to compile accurate data on child deaths. States that have developed and evaluated surveillance programs to identify children who have died from abuse or neglect by linking records from multiple data sources have been able to better identify child maltreatment deaths (Medina, Sell, Kavanaugh, Curtis & Wood, 2012). Along these lines, it's important the child abuse and neglect fatalities in Texas be redefined as an issue of public health instead of an issue that is the sole purview of Child Protective Services. The majority of children who died from abuse or neglect in Texas in 2013 were not previously known to CPS prior to their death. This more than anything points to the fact that focusing solely on DFPS to try and correct the many issues involved in child maltreatment fatalities will be a failure. Were the 53% of the children in families known to law enforcement? Were the 53% seen by health professionals at some point in their short lives? What do we know about these children and their families that can improve the way our state manages cases in the future? Do we have the proper systems in place to gather and share this information? If not, what needs to be done? Information is being collected by different disciplines across the state, but that information is not being shared and, for the most part, agencies are not working together effectively to proactively communicate.

The cause of death in a child case is difficult to determine. The first year of life is the most common age for a child to die. Most deaths occur shortly after birth and are the result of premature birth or congenital defects. While older child victims may have injuries that make cause of death determination easier, infant homicide may occur from suffocation with no visible injury and no possible detection from the autopsy. Less force is required to kill a child so the signs of trauma may be subtle. High quality death investigations, including standardized response by first responders, death scene investigations by law enforcement and justices of the peace, standardized autopsies conducted by trained forensic pathologists with knowledge of pediatric pathology, and open communication between law

enforcement, CPS, healthcare professionals, coroners, and medical examiners, is necessary in order to make the correct determination in a child death case. If any of these critical areas is inadequate, the system runs the risk of failing. In these cases in particular, joint investigations are critical. When child deaths are not reported to CPS in a timely manner or not at all, the case disposition might be entirely based on law enforcement and medical examiner findings. The evaluation would miss out on possibly critical information. When first responders are not trained on how to appropriately manage unexpected infant death, the investigation may be compromised. If law enforcement and coroners across the state are not using consistent, standardized protocols to investigate infant and child death, the outcomes of investigations may be not be achieving justice. As stated earlier, child abuse fatalities are less attributable as homicide from the outset and initial circumstances may show no obvious cause of death. This might be true even after an autopsy. In order to keep the appropriate data about child abuse and neglect fatalities, those children must first be identified at the investigations stage. To what extent this is happening consistently throughout the state is unclear. The SCFRT has recognized year after year that the lack of standardization in infant death scene investigations affects the quality of data that they are able to collect.

The examination of a death scene and subsequent collection of potential evidence require special skill and knowledge. The manner in which a death scene is investigated may be the critical factor in successfully determining cause of death. While Texas has a number of well-trained law enforcement officers, coroners, and first responders who have a high level of understanding of the complexities inherent in child death investigations, there is also no required mandatory training on child deaths. Texas has a number of law enforcement officers and coroners who have opted to receive specialized training in child death investigations, but the training is not mandatory, standardized protocols are not required, use of protocols in the state is unknown, and there is no data to give a clearer picture of how these variations in practices affect decisions and outcomes. While some officers have received training on the SUID protocol and utilize doll reeneactment, it is not consistently used across the state. It is unclear which jurisdictions use the protocol and which do not. Currently, death investigation and reporting protocols are inconsistent from county to county.

In an investigation into child abuse deaths by the Austin American Statesman, it was found that 1 out of every 5 child abuse beating or strangulation deaths in Texas has been left unsolved. As of November 15th, 2014, 16 criminal cases against defendants accused of killing children remained pending for three or more years after the deaths. The successful prosecution of child abuse homicides requires sufficient

evidence which requires an excellent investigation, which necessitates a secure crime scene, which needs quick identification of a crime. Thus many systems – emergency responders, medical/hospital, law enforcement, medical examiners, social services – must collaborate effectively for prosecutors to present a case (North Carolina Child Advocacy Institute Issue Brief, 2005). Physical evidence is often lacking or imprecise and inconclusive autopsy results can cause cases to fall apart. Uncertainty in medical results does not necessarily mean that a crime has not been committed, but it does mean that a criminal case cannot move forward. The death scene investigation may provide vital information to the pathologist prior to his or her examination. Death certification will not and cannot be accurate without an adequate scene investigation. National forensic pathologists have identified the SUIDI "top 25" data critical to collect at the scene investigation in order for the pathologist to properly determine cause and manner of infant death.

Unlike other states, Texas does not have required autopsy protocols and the state does not require board certification in forensic pathology for professionals conducting autopsies or accreditation for laboratory facilities. There are wide disparities in the state regarding the qualifications and training of medicolegal death investigators and there is no statewide oversight body to ensure minimum standards. The components of a medicolegal death investigation include history, circumstances, witness accounts, medical records, scene investigation, autopsy, and lab work. All of these are necessary to properly investigate a case. At this time, there is no sense of where in the state this is being done successfully or unsuccessfully and the lack of data makes it difficult to make recommendations for improvement.

There are 13 county medical examiner's offices in Texas. In counties without a medical examiner (ME), elected Justices of the Peace (JPs), similar to the position of coroners in other states, conduct medicolegal (MDL) death investigations. However, unlike a coroner, death investigation is a very small part of their job duties. JPs also preside over small claims courts for minor offenses, may issue warrants for search and arrest, and conduct preliminary hearings. The training that JPs receive pertaining to death investigations in typically limited to death certification completion and procedures for holding inquests. While medical examiner offices have a staff including MDL death investigators, JPs do their own investigations. A paper published in the Journal of Forensic Sciences in March 2015 comparing the two systems of death investigations in Texas (Drake, Cron, Giardino, Trevino & Nolte, 2015) found significant differences in the implementation of death investigation roles between MEs and JPs. For example, while the recommended practice for MDL death investigation is that forensic providers should conduct investigations and determine conclusions independent of law enforcement, JPs indicated that physical

examination and evidence collection is not their responsibility but the responsibility of law enforcement. Conversely, ME's offices indicated policies regarding evidence collection and handling. There were other questions that demonstrated variation in the understanding and implementation of essential death investigation services between JPs and MEs. MEs offices more frequently embraced formalized and standardized procedures and understood as well as exercised their authority to investigate deaths from non-natural, sudden and unexpected, or healthcare treatment-related causes. As a best practice, MDL death investigators should have a minimum knowledge of autopsy protocol and procedure. The role of the MDL death investigator is to facilitate the determination of the cause and manner of death. The role is recognized as distinct from law enforcement's investigation. The death investigator has responsibility for the body at the scene and must perform a thorough assessment including photographing the deceased, documenting wounds or injuries, rigor and livor mortis, body position, condition of the body, and the environment. The complete medical history of the child must be obtained and shared with the forensic pathologist prior to the autopsy. The MDL death investigator is charged with investigating the scene of death, examining the body of the deceased at the scene, estimating time of death, and determining whether to perform an autopsy. Death investigation in smaller counties in Texas must be made more uniform, standardized and efficient to ensure equality of outcomes.

An autopsy is mandated in deaths where the deceased is a child younger than six and the death is determined to be unexpected. The JP in a county can select the autopsy provider and can also determine that a complete autopsy is unnecessary and order a partial autopsy. While it might not be readily admitted, saving county dollars may be a motivating factor for the 241 counties in Texas without a ME's office and counties may work to seek out the least expensive, not necessarily the most qualified, autopsy provider. There are a number of private companies that provide autopsies for Texas counties and it's incredibly difficult to track them all. The quality of autopsies is critical in infant death cases. Some of the most controversial autopsy cases in Texas have been child death cases. Travis, Harris, Nueces, and Tarrant counties have all had cases where infant deaths were initially ruled homicides, followed by prosecution and conviction of a suspect, followed by a ME changing the cause of death and defendants left fighting their convictions. As stated previously, child deaths can pose particular difficulties for forensic pathologists and require a high degree of expertise. The entire diagnosis is of Abusive Head Trauma/Shaken Baby Syndrome is now being called into question and referred to as "junk science" due to flawed autopsies. The stakes are incredibly high.

Looking at issues related to child maltreatment related fatalities only as a child welfare/CPS problem means that strategies to address the problem will be planned in isolation, only focusing on what that one agency can accomplish, and missing so many pieces of a much larger puzzle. Consistency in every level of the investigation is critical. It's clear that Texas lacks consistency, but it's also clear that the state has no grasp to what extent that lack of consistency exists, affects case outcome, or affects child fatality data.

Promising Changes

The 83rd Legislative Session (2013) created the House Select Committee on Child Protection and the Protect our Kids Commission. The Commission is charged with studying the incidence of abuse and neglect fatalities in Texas and making recommendations to protect children. The duties of the Commission include studying the relationship between child protective services and child welfare and the rate of child abuse and neglect fatalities.

Recommendations:

The CJA Task Force recommends supporting policies and programs to improve the quality and consistency of data collection, investigation, and certification of cases of child death in Texas.

Strategies may include:

- Review existing CFRTs and promote increased standardization as well as data collection capacity;
- Regular training and tools should be provided to law enforcement and prosecutors involved in these cases including developments in the law and latest advancements in investigative and forensic techniques.
- The Commission to End Child Abuse and Neglect Fatalities (CECANF) mission is to develop a national strategy and recommendations for reducing fatalities across the nation from child abuse and neglect. It is likely in the next few years the Commission will recommend the following:
    - Standardized, cross-system data sharing on child fatalities;
    - Develop standardized best practice guidelines for child death scene investigation and death certification.
    - Develop nationally standardized child death investigation protocol

- The adoption of child autopsy protocols

The Task Force supports these strategies but does not wish to duplicate efforts or work at cross purposes with the Commission. We will continue to monitor the development and implementation of the recommendations states above.

Improving Medical Response to Child Abuse

Healthcare professionals are a critical part of the reporting, investigation, assessment and prosecution of child abuse cases. In 2006, the American Board of Medical Specialties approved the child abuse pediatrics subspecialty and the American Board of Pediatrics issued the first certification exams in November 2009. In 2014, there were 275 doctors who had earned board certification in the subspecialty. Texas has 18 of the total board certified child abuse pediatricians. The National Association of Children's Hospitals and Related Institutions (NACHRI) has worked to highlight and better define the key role of child abuse teams at children's hospitals (Defining the Children's Hospital Role in Child Maltreatment, Second Edition). In 2009, the Texas legislature appropriated $2.5 million in 2009 and 2010 and $5 million in 2011 and 2012 for the Medical Child Abuse Resources and Education System (MEDCARES) grant program. The purpose of this program is to help develop and support regional initiatives to improve the assessment, diagnosis and treatment of child abuse and neglect. The grant is intended to strengthen cross-sector relationships to enhance referrals for medical assessment. MEDCARES contracts with a hospital, academic health center or health facility that supports regional initiatives to improve assessment, diagnosis, and treatment of child abuse and neglect and have expertise in pediatric health. They currently have three basic contractors and eight advanced contractors.

Basic Contractors:

- Texas Tech University Health Science Center, Lubbock
- Trinity Mother Francis Health System, Tyler
- CHRISTUS Health Southeast Texas, Beaumont

Advanced Contractors:

- Children's Medical Center of Dallas
- CHRISTUS Santa Rosa Children's Hospital, San Antonio
- Cook Children's Medical Center, Fort Worth
- Dell Children's Medical Center, Austin
- Driscoll Children's Hospital, Corpus Christi
- Texas Children's Hospital, Houston
- University of Texas Health Science Center at Houston
- El Paso Children's Hospital

In addition to providing direct services, MEDCARES grant recipients provide education and training to law enforcement, CPS, the judiciary as well as members of the public and other medical professionals. Pediatricians with child abuse expertise also coordinate case reviews with input from physicians, CPS investigators, and supervisors. From June 2012 to May 2014, MEDCARES contractors had 4,210 inpatient consultations and confirmed 2,317 cases of abuse. They also had 21,606 outpatient exams (including ER).

While the MEDCARES program has increased the number of services provided and patients served, the program has faced the challenges of lack of funding, shortages in specialized medical staff, and difficulty providing education and outreach to expand services throughout the state. MEDCARES funds supplement salaries at contractor sites but there is a significant lack of resources throughout the state to support clinic staff, particularly physicians. The lack of staffing has prevented sites from being able to provide as much community outreach and education as is needed. Expanding services and expertise throughout the state has also been difficult because it requires the buy-in of local doctors at mentee sites and this has not always been forthcoming. Outreach to stakeholders, particularly due to turnover in CPS and law enforcement, must be a continuing activity and resources must be made available to ensure that this investment does not diminish.

In 2006, DFPS contracted with the University of Texas Health Science Center at Houston (UTHSCH) to create the Forensic Assessment Center Network (FACN) to improve DFPS staff access to medical professionals with expertise in child abuse in underserved areas of the state. Through a network of subcontractors from six medical schools in Texas, all with strong academic and clinical resources, the FACN provides medical expertise, particularly in underserved areas of the state, to DFPS caseworkers when local pediatric abuse and neglect expertise is not available. FACN also provides ongoing education concerning medical aspects of child maltreatment to CPS workers. FACN is not designed to be a direct medical care services initiative or to provide consultation to agencies other than CPS involved in child maltreatment. According to the FACN website, as of 2008, FACN physicians had served over 4,000 children from 158 counties.

Child Advocacy Centers (CACs) represent another important capacity in the medical assessment of children who have been victims of abuse or neglect. CACs are designed to be a one stop shop for families, providing a full array of services and facilitating multidisciplinary collaboration by providing a child friendly location for forensic interviews, as well as mental health services, crime victims'

compensation assistance, and referral to social services and support agencies. All CACs are also required to have a medical component, which may be provided on or off-site and involves connecting individuals to medical professionals who can conduct the necessary exams to evaluate the health concerns and to assess whether abuse has occurred. Most CACs in Texas refer children to a hospital or doctor off-site for these services.

Issues

Healthcare providers are a first and typically ongoing point of contact for families. Doctors and nurses have a view of family health needs over the life course, have opportunities to build therapeutic relationships with families that are usually unavailable to law enforcement and CPS, and can act as an information repository about a family. Medical personnel were the number one source of completed child abuse investigations in Texas in 2013 (17.6%) and the number two source, second to teachers, in 2014 (17.5%). This percentage is more than double the national average of child abuse reports from medical professionals.

In spite of continued effort, the child abuse medical expertise in Texas has not successfully been able to extend to the poorer, more rural areas of the state. Texas does not have enough primary care doctors in 126 of its 254 counties. The majority of these counties are rural. 73% of hospitals are located in urban areas and 63 counties in Texas have no hospital. There is also a potential for a difference in the diagnosis that a child will receive when seen by a child abuse pediatrician versus a pediatrician without child abuse expertise. While FACN should be a statewide resource for investigators, it is woefully underutilized. There is a need for medical child abuse expertise for physicians, CPS and law enforcement throughout the state yet the majority of this knowledge is available only in select, urban areas.

Medical expertise is particularly critical in cases that involve a criminal component. It's challenging to distinguish between intentional and unintentional injuries. There is no single test that can prove or disprove child abuse. No single injury or symptom is synonymous with child abuse, but rather it takes a combination of features to make the correct diagnosis. It's one that is often difficult for doctors to make. Court cases are also increasingly dependent on scientific evidence and expert witnesses are playing a bigger role.

There are a variety of diseases that can mimic child abuse – such as hereditary blood disorders, metabolic disorders, connective tissue diseases, various vitamin deficiencies, Ehlers-Danlos Syndrome,

infantile rickets, etc. Diagnostic imaging cannot distinguish nonaccidental injury from accidental or from predisposing medical conditions. Doctors must consider and evaluate for mimics, however, that's not necessarily easy because there are not definitive tests to rule out every mimic. For example, the prevalence of mild platelet disorders is unknown and testing is challenging because it requires platelet aggregation testing. That test is best performed by a pediatric hematologist, requires a relatively large amount of blood, and the interpretation of the test result requires a specialist (Anderst, Carpenter and Abshire, 2013). There is currently no single panel of tests that rule out every possible bleeding disorder. Fractures that result from abuse are most commonly seen in infants (Leventhan, Martin, Asnes, 2008). The timely identification of fractures and skeletal trauma can lead to the earlier identification of abuse as these can be sentinel injuries (Ravichandiran, 2010). However, there are a number of pediatric diseases that can causes bone fragility and childhood fractures. It's critical that medical professionals be able to effectively evaluate for the medical conditions that can mimic child abuse.

Media continues to promote claims of medical controversies in the field of child abuse where no such controversies may exist.

> "The state Supreme Court has ordered a new trial for a Mississippi man convicted by testimony citing the now-disputed Shaken Baby Syndrome…."This case does fundamentally recognize if you don't have an expert, your hands are tied," said Havard's lawyer, Graham Carner of Jackson, "The science has changed."…."This case is a trend nationwide and in Mississippi with Shaken Baby Syndrome being placed under the microscope," Carner said. "The question is how do you handle forensic science in shaken baby cases?" (Clarion Ledger, 12/18/14)

This has become particularly problematic in cases of Abusive Head Trauma/Shaken Baby Syndrome. Abusive Head Trauma is the leading cause of death from child abuse in infants and young children (Selehl-Had, Brandt, Rosas, & Rogers, 2006). Presenting signs can be non-specific and external injuries are not universal (Dubowitz et al., 2014). Courts are increasingly unlikely to believe that the diagnosis of AHT/SBS is evidence-based and instead believe that it is, as the ABA Journal referred to it in December 2013, "a highly controversial diagnosis." In 2014, a federal judge in Illinois wrote that SBS is "more an article of faith than a proposition of science" (Del Prete v. Thompson, 2014). Contested issues include: the validity of the 'shaken baby syndrome' diagnosis, the accuracy of clinical estimates of the timing of head injury, doctors ability to reasonably and reliably exclude medical mimics of AHT, and the reasonableness or certainty of the diagnosis in the absence of irrefutable evidence (Dubovitz et al.,

2014). While most in the medical community may not see AHT as an area of scientific uncertainty, high profile media coverage of poorly handled cases of child injury and fatality are leading the courts to be more wary of cases of AHT. This coverage could have a chilling effect on the already low rate of criminal prosecutions of child abuse. Medical professionals who may already be reluctant and unsure about making the determination of child abuse could become more so for fear of damaging their reputations. In reviewing many of the cases in which parents were wrongfully convicted of child abuse, the problems tend to be flawed autopsies, poor understanding of the mechanisms of injury in child fatality cases, and low quality investigations. These cases point to the desperate need for more training, research, and improved coordination between systems. These cases also point to the need for additional research to develop and refine the tools and technologies to improve the diagnostic accuracy of abuse related injuries.

Promising Changes

CJA has been supporting projects to add to the published research and national standards upon which to base medical opinions and recommendations regarding child abuse and neglect. Using CJA funding in 2013 and 2014, the Harris County Institute of Forensic Science (HCIFS) in collaboration with Texas Children's Hospital-Baylor College of Medicine built a large prospective database of infant injury. The database documents all injuries observed during autopsy as well as medical history, events surrounding death, and cause and manner of death for each decedent. The bone health is now recorded as a subset of the database population based on the 2014 CJA project. The database in now completely built and started documenting cervical injury in 2015. As of May 28, 2015, the database has 307 deceased infants included in the database making it one of the largest prospective databases of infant autopsy findings in the United States. The database is valuable to researchers who wish to develop and test diagnostic models of child injury with statistically rigorous analysis. Past CJA projects with HCIFS on pediatric rib fractures and bone health have led to manuscripts published in the *Journal of Forensic Sciences*. CJA has also funded studies on patterned bruising as well as abusive head trauma to strengthen the evidence-base for the accurate assessment of child abuse. The work supported by CJA has been presented at national and international conferences.

Recommendations:

The CJA Task Force recommends support for programs to increase the consistency and accuracy of the medical diagnosis of child abuse and neglect as well as support for programs to improve access to

quality medical evaluations for suspected victims of child maltreatment, particularly in rural and underserved areas.

Strategies may include:

- Research and data collection to improve the consistency and accuracy of the diagnosis of child abuse to strengthen the investigation and prosecution of these cases;
- Training for medical providers and attorneys on medical evidence in child abuse cases and courtroom testimony;
- Effective dissemination of best practices in the medical diagnosis of child abuse and enhance collaboration between child abuse pediatricians, CPS, law enforcement, and medical professionals in Texas.

Description of Task Force Plans to Incorporate Recommendations into CJA Work

The CJA Task Force will continue to utilize our annual grants process to fund projects that are responsive to the recommendations from the Three Year Assessment. We have positive, ongoing relationships with statewide and local organizations who can assist in the implementation of the Task Force recommendations. CJA released its Request for Applications for 2015-2016 on May 19th, 2015. Applications for funding are due on June 19th, 2015. CJA staff has had a number of conversations with potential applicants about possible projects and we are confident that we will be able to fund projects that will allow us to make progress on our recommendations.

Texas is fortunate to have a number of excellent annual conferences on child abuse and neglect that attract participants from CPS, law enforcement, the court system, local CASAs, local CACs, medical professionals, mental health professionals, etc. For example, the Crimes Against Children Conference attracted approximately 3,500 participants last year and has workshops on a variety of topics that are important to CJA, including sessions on medical evaluation of child abuse, sex trafficking and exploitation, child fatality review teams; improving investigations and prosecution of child abuse with presentations on testifying in court, digital evidence, jury selection, child abuse injury investigation and reconstruction, overcoming obstacles in complex and challenging child abuse investigations, etc., supporting victims and non-offending caregivers and many more. Other valuable, multidisciplinary statewide trainings include Children's Advocacy Centers of Texas annual conference for MDTs, Prevent Child Abuse, and Texas CASA's Annual Conference. In addition, there are a number of relevant conferences that are presented for specific disciplines including conferences by Texas County and District Attorneys' Association, Texas Center for the Judiciary, Supreme Court Commission on Children Youth and Families, Pediatric Centers of Excellence, Texas Foster Families, and many others. The CJA Task Force will work with these organizations to support their existing training, assist with curriculum develop and support sessions of particular relevance to CJA's work or provide scholarships for professionals to attend trainings. The Task Force has been using this strategy effectively particularly this past year. CJA partnered with the Court of Criminal Appeals and the Texas Center for the Judiciary to support a judicial training session on forensic science in child abuse cases by our grantee, University of Texas Health Science Center Houston. CJA also started working with the Court Improvement Program/Supreme Court Children's Commission to support their trials skills training program for attorneys. We also continued our support of the Driscoll Children's Hospital's (a Pediatric Center of

Excellence in Corpus Christi) annual conference on child abuse. This conference has a particular focus on medical issues in child abuse cases. Supporting these existing programs costs relatively little money but is an effective way to disseminate the work of our grantees, build relationships with statewide membership organizations of the various disciplines represented on the Task Force, provide training funds for professionals who receive little to no funding (CPS, law enforcement, SANE nurses, CASA volunteers, etc.).

In addition, we will continue to fund small training grants (up to $5,000) in order to allow local organizations to conduct smaller trainings directed to specific disciplines, their own multidisciplinary teams, or issues particular to their region.

Finally CJA staff will continue to actively participate in collaborations with other child welfare stakeholders across the state in order to better inform others about the work of CJA and in turn receive information about current issues and priorities in the state.

Proposed Strategies by Recommendation Category

A. Activities to improve the investigative, administrative, and judicial handling of cases of child abuse and neglect…in a manner which reduces the additional trauma to the child victim and the victim's family and ensures procedural fairness to the accused;

Proposed strategies may include:

MDT Enhancement

- Continue to work with Children's Advocacy Centers of Texas to provide training, technical assistance and facilitation of MDTs statewide;
- Encourage ongoing, joint training for law enforcement and CPS to achieve a level of competency, consistency, and quality in child abuse investigations across the state. Training should focus on protocols, investigative processes, roles/responsibilities, and improving communication;
- Support training for attorneys to enhance the effectiveness and quality of the prosecution of child abuse cases; and
- Support training to ensure that medical professionals have the necessary knowledge and resources to accurately recognize abuse and understand proper medical evaluations for suspected abuse.

Victim Advocacy

- Training for MDT members on family engagement, respect for caregivers, alternatives to removal, etc.;
- Resources and training for DFPS employees, courts, and juvenile probation on the importance of appropriately assessing and treating youth with sexual behavior problems.

Child Maltreatment Victims with Disabilities or Special Healthcare Needs

- Training for caseworkers on the necessity of in-depth investigations in cases involving children with primary medical needs, particularly infants. Particular care should be taken in cases where a child has primary medical needs and a health care professional has reported medical neglect. The Task Force understands that CPS Transformation is changing worker training as well as the way that safety and risk are assessed. We will monitor this process to ensure that we do not work at cross purposes.

Child Maltreatment-Related Fatalities

- Regular training and tools should be provided to law enforcement and prosecutors involved in these cases including developments in the law and latest advancements in investigative and forensic techniques.

Medical Evaluations for Child Maltreatment Victims

- Training for medical providers and attorneys on medical evidence in child abuse cases and courtroom testimony;

B. Support of experimental, model, and demonstration programs for testing innovating approaches and techniques;

Proposed strategies may include:

MDT Enhancement

- Support the launch of the MDT Enhancement Program with CACTX, particularly focusing on evaluation of the program's implementation and impact at local centers.

Victim Advocacy

- Support for children's advocacy centers to assist in handling cases involving children and youth with sexual behavior problems.

Child Maltreatment Victims with Disabilities or Special Healthcare Needs

- Training/resources for WIC program staff, or other social service agencies who might come in contact with families, on risk of abuse and neglect for children with disabilities or primary medical needs;
- Training/resources for medical providers to improve awareness of the increased risk of abuse for children with primary medical needs, children with neonatal abstinence syndrome and children with disabilities;
- Training/resources to improve communication and collaboration between CPS caseworkers, disability services providers and medical professionals to ensure better support for at-risk families.

Child Maltreatment-Related Fatalities

- Review existing CFRTs and promote increase standardization as well as data collection capacity;

Medical Evaluations for Child Maltreatment Victims

- Research to improve the consistency and accuracy of the diagnosis of child abuse to strengthen the investigation and prosecution of these cases;

- Effective dissemination of best practices in the medical diagnosis of child abuse and enhanced collaboration between child abuse pediatricians, CPS, law enforcement and medical professionals in Texas.

C. Reform of State laws, ordinances, regulations, protocols, and procedures to provide comprehensive protection for children…

MDT Enhancement

- Promote the continued use of local child advocacy centers for multi-disciplinary team coordination to improve the cooperation and collaboration between agencies involved in the investigation, assessment and disposition of serious cases of child abuse/neglect. Encourage co-location of CPS and law enforcement at local CACs whenever possible.
- Encourage medical assessments of children, particularly children under age two with allegations of physical abuse by supporting and enhancing interagency collaboration between child abuse pediatricians and CPS investigators. The Task Force understands that CPS Transformation is changing worker training as well as the way that safety and risk are assessed. We will monitor this process to ensure that we do not work at cross purposes.

Child Maltreatment Victims with Disabilities or Special Healthcare Needs

- Encourage improved data collection on the prevalence of children with disabilities and primary medical needs with child maltreatment allegations in Texas;

Child Maltreatment-Related Fatalities

- The Commission to End Child Abuse and Neglect Fatalities (CECANF) mission is to develop a national strategy and recommendations for reducing fatalities across the nation from child abuse and neglect. It is likely in the next few years the Commission will recommend the following:
    - Standardized, cross-system data sharing on child fatalities;
    - Develop standardized best practice guidelines for child death scene investigation and death certification.
    - Develop nationally standardized child death investigation protocol
    - The adoption of child autopsy protocols

The Task Force supports these strategies but does not wish to duplicate efforts or work at cross purposes with the Commission. We will continue to monitor the development and implementation of the recommendations states above.

Medical Evaluations for Child Maltreatment Victims

- Encourage data collection to improve the consistency and accuracy of the diagnosis of child abuse to strengthen the investigation and prosecution of these cases.