The Texas Statewide Blue Ribbon Task Force

Final Report

Dr. Christopher S. Greeley
Chair

Madeline McClure
Vice Chair

Annette Burrhus-Clay

James Castro

Dr. Nancy S. Harper

Adriana Benavides Maddox

Janetta Michaels

Pamela Russell

Mary Tipps

Respectfully Submitted
December 1, 2012
# Table of Contents

## Introduction and Key Messages .................................................................2

### Section 1

- The Current State of Child Abuse and Neglect in Texas...........5
- State Prevention Funding .................................................................9
- State Prevention Structure ...........................................................18

### Section 2

- Prevention Strategies Overview .............................................................25
- Home Visitation .................................................................................28
- Respite Care .......................................................................................38
- Teen Pregnancy .................................................................................40
- Parenting Support .............................................................................40
- Child Sexual Abuse ..........................................................................44
- Child Sex Trafficking .......................................................................47
- Bullying ..............................................................................................49
- Impact on Mental Health ...................................................................52

## Moving Forward .......................................................................................54

## Appendices, Biographies and Acknowledgments .................................61
Texas Statewide Blue Ribbon Task Force

Introduction

The Texas Statewide Blue Ribbon Task Force (SBRTF) was initially constituted as a result of SB2080 passage during the 81st Legislative session with the intent of collaborating Texas experts to assess, evaluate and create a strategic plan to address child abuse and neglect in Texas. Most members of the initial Task Force were reappointed to serve when the SBRTF resumed as a result of SB1145 passage during the 82nd Legislative Session. The current SBRTF expanded upon the earlier work by assessing strategic goals for prevention and evaluating specific programmatic tactics for the larger strategy. This report is a synthesis of many months of study, testimony, discussion and debate. The SBRTF met in 2012 more than 7 times in Houston, Dallas, San Antonio and Austin and conducted countless conference calls among the group members, National and local experts, providers, legislative and agency staff and others. We received written and oral testimony and materials from community stakeholders, academic scholars, legislators, philanthropic funders, local and statewide policy-makers, and advocates. Our goal was to present a comprehensive and meaningful assessment of the issues and potential solutions for child abuse and neglect (CA/N) within our state.

This report is broken into two main sections. The first section provides the reader a sense of the scope of the problem in the state. Broadly, CA/N is divided into four main categories: physical abuse, sexual abuse, emotional abuse and neglect. The first section uses state data to display the magnitude of the problem of CA/N in the state and report on trends within the state. This section also reports the funding sources, mechanisms and amounts that are utilized within the state for CA/N prevention. The current structure of the state prevention efforts is reported with some recommendations for improvement and streamlining.

The second section reports current prevention strategies, most of which are utilized within the state, but some which the state should evaluate for incorporation. These strategies and efforts were identified as future directions by the initial SBRTF. The specific strategies do not represent an exhaustive compendium of strategies or concerns, but they are areas which the SBRTF has received testimony from state experts or identified as areas which require attention by the state.
Texas Statewide Blue Ribbon Task Force

The report ends with suggestions for moving forward. The recommendations include a reframing of prevention efforts by the state and its agencies, rethinking how similar prevention efforts can be streamlined for efficiency and how to maximize and leverage funding revenues, including engaging the private, business and philanthropy sectors in a more meaningful way.
Key Messages

- Texas’ child abuse prevention funding has decreased while our child population has increased.
- There needs to be a permanent commission overseeing and coordinating Texas’ efforts for the prevention of child abuse and neglect. This can be done by the creation of a prevention advisory council as part of the TDFPS Advisory Council, or a part of one of several other offices within THHS or TDSHS.
- TDFPS should employ a process by which the evidence behind funded practices and programs is continually assessed and interpreted.
- Home Visitation (HV), such as the Nurse-Family Partnership (NFP) and other high quality HV programs, should be supported and expanded.
- Parenting support programs (such as Triple P and NFP) should continue to be explored and incorporated into a broad, state-wide CA/N prevention strategy.
- Prevention of bullying and other forms of peer victimization is a critical key to prevention of child abuse and neglect as violence experienced during the school age years and adolescence is associated with violence and criminality in adulthood.
- The limited availability of qualified mental health professionals who can provide care to children presents a profound future burden of limited economic production and increased medical, mental health and law enforcement financial burden. The SBRTF feels strongly that scarcity of mental health professionals available for children is a dire need which needs to be prioritized.
The numbers of children affected by CA/N in Texas are mindboggling. Simply reporting the numbers of children or rates in text do not represent the importance in a meaningful way. We chose to represent the data on the scope of CA/N in Texas mostly graphically as this more accurately captures the information and the implications of the data in a more accessible manner. Each of these graphs represents data from the Texas Department of Family and Protective services.

The incidence of child abuse and neglect in Texas is at an epidemic rate. In 2011, The Texas Department of Family Protective Services (DFPS) received 255,575 “intakes” or reports of child abuse or neglect (CA/N). Of those, 175,421 alleged incidents were investigated (68.7% of intakes) and 65,948 Texas children were subsequently confirmed for maltreatment (37.6% of investigations): On average, 181 Texas Children were confirmed each day for abuse/neglect in 2011. (See Figure 1).
Texas Statewide Blue Ribbon Task Force

**Figure 2: 2011 Profile of Confirmed Child Abuse/Neglect Victims**

**Characteristic Of Confirmed Victim**
The predominance of victims of abuse are aged 0-3 (39.9%) with slightly more male victims at younger ages between 0-6 years and more female victims between ages 7-17 years. Importantly, females were abused at a 55% higher rate than males between ages 13-17, which may reflect a higher incidence of female sexual abuse in the teenage years.

**Figure 3: Type of Abuse (2011)**

**Allegation confirmed**
The predominant type of confirmed abuse incidence in 2011 was Neglectful Supervision (65%) followed by Physical abuse (16.3%), then Sexual Abuse (7.9%) and Physical Neglect (6.8%). Only .7% of cases confirmed were from Emotional Abuse. Including Medical Neglect, 74.1% of all confirmed CA/N incidents were Neglect-related.
Person Reporting Abuse/Neglect
School Professionals (17.7%) were the most frequent reporter of CA/N followed by Medical professionals (16.5%), law enforcement and relatives, (15.2% and 12.1% respectively).

Geographic Distribution
The 5 major metropolitan areas accounted for 63.3% of all confirmed incidences: Dallas-Fort Worth (Arlington) 24.6%, Houston-14.8%, San Antonio-12.4% and Austin 11.5%. When including the fourth highest incidence (Edinburgh: 12.2%) the top 5 DFPS Regions account for 75.7% of all confirmed CPS cases.
Child Fatalities
231 children died due to CA/N in 2011 vs. 227 children in 2010, a 1.8% increase. The Texas child population grew from 5,618,202 in 1997 to 6,663,942 in 2011, an 18.6% increase while child abuse fatalities increased an astounding 124% from 1997 to 2011, over this same period.

Figure 7: 12-month Recidivism of Children

<table>
<thead>
<tr>
<th>Year</th>
<th>Family Preservation</th>
<th>Family Reunification</th>
</tr>
</thead>
<tbody>
<tr>
<td>2001</td>
<td>7.6%</td>
<td>16.9%</td>
</tr>
<tr>
<td>2002</td>
<td>7.8%</td>
<td>14.4%</td>
</tr>
<tr>
<td>2003</td>
<td>5.9%</td>
<td>17.9%</td>
</tr>
<tr>
<td>2004</td>
<td>8.8%</td>
<td>16.5%</td>
</tr>
<tr>
<td>2005</td>
<td>9.6%</td>
<td>16.6%</td>
</tr>
<tr>
<td>2006</td>
<td>9.2%</td>
<td>18.2%</td>
</tr>
<tr>
<td>2007</td>
<td>9.3%</td>
<td>18.1%</td>
</tr>
<tr>
<td>2008</td>
<td>8.6%</td>
<td>17.5%</td>
</tr>
<tr>
<td>2009</td>
<td>9.3%</td>
<td>17.5%</td>
</tr>
<tr>
<td>2010</td>
<td>7.2%</td>
<td>17.5%</td>
</tr>
<tr>
<td>2011</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
According to the U.S. Department of Health and Human Services 4th National Incidence Study of Child Abuse and Neglect (2004-2009), only 50% of actual CA/N incidents are investigated by CPS systems on average nationwide. Applying the NIS findings to Texas, TDFPS’s findings likely underestimate the true incidence rate of CA/N victims in Texas such that the more accurate number of Texas children abused and/or neglected is estimated to be 131,600 children in 2011\(^2\), more than 360 victims per day, 15 confirmed child abuse cases per hour. In 2011, the most common relationship of the perpetrator to the child was as follows: Parent (78.2%) Gender: Female (56.2%) Age: 26-35 (38.3%) Marital Status: Married (27.2%).

**Funding for Child Abuse Prevention Efforts**

The University of Houston’s 2007 cost analysis of child abuse and neglect yielded a conservative estimate of over $6.25 billion spent per year on the aftereffects of abuse and

---

\(^2\) 2006 is the latest data available for comparison  
\(^3\) Applying the NIS CPS under-investigation of 50% would result in 350,000 investigations and applying the 37.6% confirmation rate in Texas would result in over 135,500 confirmed victims (175,000 x 2) = 350,000 x .376 = 131,600).
Texas Statewide Blue Ribbon Task Force

**neglect.** These include the CPS costs and foster care costs as well as hospital, law enforcement, court costs, mental health costs as well as the longer-term consequential costs of the increased substance abuse, mental health, juvenile delinquency, and adult corrections costs found in populations abused and neglected as children.

Texas’ child abuse prevention programs mostly reside within the Prevention and Early Intervention Division (PEI) of TDFPS. Funding for total child abuse and juvenile delinquency prevention within Texas PEI division has actually *decreased* in the last decade. The 2012-2013 total PEI appropriation of $61.9 million is 32% less than the 2002-2003 biennium budget totaling $91.8 million. The 2012-13 appropriation is down from the previous 2010-11 biennium’s $93.5 million allocation, which was further reduced to $88.1 million in 2010 due to statewide budget deficits. Importantly, the $17.5 million line item for evidence-based competitively procured child abuse and juvenile delinquency programs was reduced 74% by the 82nd Texas Legislature. Of the Total $61.9 million biennium PEI budget, **less than $15 million will go towards child abuse prevention**, with the bulk of the funds going towards juvenile delinquency prevention or other programs (See chart of PEI funding history, [Appendix 1](#)).

Although juvenile delinquency prevention is important, it is not child abuse prevention. While the full PEI budget dropped by 30% over the biennium, funding for *child abuse* prevention dropped more, by 44%.

Prior to the most recent budget cycle when all Texas agencies were forced to cut their expenditures due to the deficit. Most HHSC agencies saw an increase in funding each biennium over the previous decade to keep pace with population caseload growth. However, these increases were not realized by PEI, even before the current great recession and budget deficits.

While the Texas child population increased 10% from 5,986,708 to 6,584,709 between 2002-2010, the PEI budget was reduced by 4%. With a projected 7,336,929⁴ Texas children by 2013, the Texas child population will have grown by 22% since 2002 while over this same period, the PEI budget will have dropped by 32%.

More importantly, Texas spends over $370 million annually on foster care costs while spending only 2% of that amount on preventing children from entering the foster system to begin with. With Texas funding only $7.5 million per annum in child abuse prevention programs within

---

⁴ Texas Department of Health and Human Services retrieved on 7/31/11: [http://www.hhsc.state.tx.us/research/dssi/popstats/projectionstx_agegrpschild.html](http://www.hhsc.state.tx.us/research/dssi/popstats/projectionstx_agegrpschild.html)
PEI, it is not improbable that we will see ever increasing expenditures for foster care and an increase in the number of Texas children ravaged by the horrors of child maltreatment unless a shift in funding strategies takes place.

**Texas’ child abuse prevention funding has decreased while our child population has increased.**

Funding of child abuse prevention programs is crucial to breaking the intergenerational pattern of abuse that has had a tremendous impact to our state, both monetarily and socially. When compared with the funding amounts for CPS, prevention efforts pale in comparison. As outlined in Appendix 4 prevention efforts account for less than 4% of overall funding as compared with CPS funding. The primary source of funding from the federal government is the Community Based Child Abuse Prevention (CBCAP) funds. Texas leaves millions of uncollected federal dollars by not leveraging our CBCAP funds. In fact, Texas is one of the last in leveraging Federal matching funds for child abuse prevention. Additionally, the SBRTF has concerns that Texas has not maximized the funding available both in the federal as well as the private sectors. During our activities, we met with many across the state who had experience and expertise regarding child abuse prevention funding at the state and national levels. Over the past 36 months we regularly heard from stakeholders and experts who voiced concern that there were significant gaps and inefficiencies in how Texas funds its child abuse prevention efforts. Dr. Katherine Barillas (from One Voice, Houston) provided the SBRTF invaluable information throughout both formations of the task force. Dr. Barillas was able to provide a comprehensive analysis of the federal funding mechanisms for child abuse prevention and how areas where Texas excels or lags (Appendix 4). As noted earlier, the largest source of federal funding dedicated to child abuse prevention is CBCAP. CBCAP funding is a federal match funding source which depends upon a number of factors. One of the critical features for leveraging federal CBCAP funding is the amount a state puts forward for leverage. Given the state of the state, **Texas leverages a disproportionately small amount of federal CBCAP dollars**, due primarily to the small amount of state (or private) dollars put forward for leverage. The SBRTF readily recognizes the need to leverage more funding for this line item. The SBRTF has heard testimony from and about many local and regional funding bodies (philanthropies or corporate grants) which remain unleveraged. This leaves money “on the table” that Texas would be able
Texas Statewide Blue Ribbon Task Force

to use for prevention services. To use dollars already spent in the state as leverage for funds which would otherwise be allocated to another state is a squandered opportunity. For example, dollars being utilized in the state by philanthropies or grants could be leveraged as “pass-through” dollars. There is currently no realistic mechanism for the state to capture any private pass-through funding. The SBRTF believes this to be a significant oversight and should be addressed. We make suggestions to remedy this oversight, below. **In addition to improved leveraging of current resources to pull down more federal funds, there are additional potential funds which the state should investigate.** During our meetings with policy makers and members of the Legislative Budget Board it became apparent that there were limited efforts to maximize the federal funding streams which Texas has access to. We found at least two other streams of funding which were currently not being utilized by the state for child abuse prevention efforts: Social Security Act §426(1)(A) Demonstration Grants and Child Abuse Prevention and Treatment Act (CAPTA) §105(b)(5) Grants to States, Tribes, and Public or Private Agencies and Organizations.

**Texas Child Abuse and Neglect Trust Fund**

**Current Collections**

The one dedicated General Revenue accounts created to fund primary CA/N prevention programs is the Child Abuse Neglect Prevention Trust Fund, General Revenue Account 5085([Appendix 5](#)). The trust fund collects fees earned from marriage licenses and declarations of informal marriage applications filed as well as funds from the interest earned on the trust account. Section 40.105 of the Texas Human Resource Code states that, “all marriage license fees and other fees collected for and deposited in the trust fund and interest earned on the trust fund balance shall be appropriated each biennium only to the operating fund for primary child abuse prevention programs.” The operating fund that receives the appropriated funds is the Child Abuse Neglect and Prevention Operating fund, General Revenue Account 5084. Many state’s Children’s Trust Funds collect fees on marriage licenses, with fees collected ranging from $3 to $38 across the country. In Texas, the Trust Fund collects $20 of the $60 fee from each marriage license, and $12.50 of the $25 fee from each declaration of information marriage. Texas has seen a slight increase in the filing of marriage applications and informal declarations over the past few years. In 2009, some combination of 177,084 marriage licenses and
declarations were filed, a slight decrease from the 177,318 filed in 2008, however, in 2010, this number increased to 178,663. The funds deposited into the Trust Fund account due to marriage license fees has steadily increased by approximately one million dollars in the last decade, as seen in Figure 1. For the FY 2002, revenue from these fees was just under $2,500,000 compared to the revenue of $3,667,496.66 in marriage license fees for the FY 2012.

In addition to the revenue from marriage license fees, the Trust Fund also collects interest, which gets deposited into the account and used for child abuse prevention operations, as seen in Figure 2. The Trust Fund is currently earning interest through the Interest on State Deposits and Treasury Investments-General, Non-Program Account (General Revenue Account 3851). The revenue from interest earned over the last decade reflects the fluctuations in treasury interest rates, peaking in 2007 at $1,690,997.91 dropping to $114,747.17, it's lowest point since 2002.
The total trust fund revenues from fees and interest has shown a relatively slight decrease since 2007, given that marriage license fee growth has marginally offset the sharp interest revenue decline as seen in Figure 3.
According to the Fees Schedule for FY 2012-2013,\(^5\) the estimated revenue from marriage license fees and earned interest is predicted to total $7,228,000, $3,782,243.83 of which has been collected for FY 2012, with an estimated $3,445,756.17 in projected collections for FY 2013. If this estimate is accurate, the total revenue earned for the Trust Fund will have shown a decrease for the fourth consecutive year.

**Trust Fund Balance and Transfers**

As previously noted, the revenue from interest earned and marriage license fees is deposited into the Trust Fund account, which is the money that is then used as the revenue for the Prevention Operating fund, GR Account 5084, through a cash transfer between funds or accounts. The balance in the Trust Fund hit its peak in 2007, at $34,198,720.33, but has since been slowly declining by a few million dollars each fiscal year. At the end of the FY 2012, the balance in the trust fund was down to $18,752,576.24 (Figure 4).

**Figure 4**

---

As seen below in Figure 5, the amount transferred to the Prevention Operating fund (GR Account 5084) each year has no consistency, vastly fluctuating from year to year. Although the Trust Fund is the deposit fund for the interest earned and marriage license fee revenue, the beneficiary agency for the funds is the Department of Family and Protective Services, who then administers the funds to the Prevention Operating fund. DFPS may make transfers to this account at any time, however, the funds transferred are not to exceed the amount appropriated for the Prevention Operating fund for that fiscal year. The legislature with the Legislative Budget Board decides on the amount of the appropriation from the trust fund to the operating account every biennium during the budget process. It is not apparent to the members of the SBRTF exactly how the funds are allocated or how the amounts of funding is determined. As apparent from Figure 5 the amounts transferred fluctuate markedly. Additionally, it is unclear to the SBRTF how the Trust Fund dollars are allocated to specific programs (i.e. how is it decided which programs receive Trust Fund dollars). This is a significant obstacle to any meaningful prevention strategy. Without being able to anticipate how much funding is available and specifically how that funding can be spent, no comprehensive CA/N prevention plan will be successful. **To this end, the amount of funding allocated to the Operating account (5084) of the Trust Fund, and specifically how these funds are to be spent needs to be clearly outlined and articulated by DFPS and the LBB.**
Potential Revenue Sources

Currently, the Trust Fund collects fees solely from marriage license fees and deposits made on the interest earned on the Trust Fund. There are numerous other potential funds that should be considered to provide additional funding for the Prevention Trust Fund. In addition to the marriage license fees and earned interest, many states receive funding from the following additional sources:

- State General Fund
- Birth & Death Certificate Fees
- Divorce Filing Fees
- License Plate Sales
- State Income/Property Tax Check-off
- Special Events
- Endowments
- Foundation Grants and
- General Donations
Texas Statewide Blue Ribbon Task Force

Many states use a popular source of trust fund revenues from birth certificate fees, with a handful of states also collecting death certificate fees and other vital records. While fees on general birth certificates are often implemented, more states are collecting fees on heirloom birth certificates. The current Heirloom fee in Texas is $60. Such fees collected on birth certificates for other state’s CTF range from $1 to $10. In the state of Texas, the current birth certificate fee is $22, $2 of which is collected by the state’s Comptroller’s office. In 2011, 1,004,522 certified copies of birth certificates were issued. Collecting even a small fee from these vital records would generate significant funds for the Trust Fund. The rationale in collecting fees on birth certificates is clear. The birth of a new baby should be matched by a practical effort to make that baby’s life free from CA/N and keep the family healthy and intact. (An example of the funding for this effort is outlined in Appendix 7).

Another innovative strategy that could be an additional source of funding for the Trust Fund would be to collect fees from revenue earned on the state liquor tax. The state liquor tax was last raised in 1985 when the tax increased from $2.00/gallon to $2.40/gallon. Currently, Texas has the 6th lowest tax rate on liquor in the country, and raising the tax even slightly could generate funds for the Prevention Trust Fund, and keep Texas well below the medium state liquor tax in the U.S., which is $3.75/gallon. The highest liquor tax rate is in Alaska at $12.80/gallon, which they jumped to in 2002 from $5.60/gallon. Illinois has the next highest rate of $8.55/gallon, with three states following at over $6.00/gallon, Florida, New Mexico, and New York. For the FY 2012-13 the state is estimated to collect $137,993,000 from the liquor tax which at $2.40/gallon accounts for about 57,497,080 gallons of liquor. Increasing the liquor tax by a mere $0.05 would keep Texas as the 6th lowest state for liquor taxes and could provide an additional $2,874,854 in revenue for the Trust Fund each biennium. The connection between parental alcohol and substance abuse, discussed earlier in this paper is clear. Child Protective Services estimate that approximately 80% of child abuse cases involve substance abuse.

An additional strategy that could be of use to add an additional funding source to the trust would be to impose and collect fines for crimes against minors. Mississippi is currently the

---

6 Department of State Health Services [http://www.dshs.state.tx.us/vs/reqroc/certified_copy.shtm](http://www.dshs.state.tx.us/vs/reqroc/certified_copy.shtm)
only state that is using such strategy, but it has proved successful for them. Mississippi’s CTF largest source of revenue and sustainability comes from a collection of $1,000 for each crime against a minor, which is supplemented with a $1 fee collected on each birth certificate.

Prevention Structure

Currently, Texas has one of the highest rates of child abuse fatalities in the Nation at 4.05 deaths per 100,000 children; nearly double the national average. Addressing this problem in a comprehensive and thoughtful manner will require continuous attention and a long-term vision. The current duties for CA/N prevention fall upon the Division of Prevention and Early Intervention (PEI) within the Department of Family and Protective Services (DFPS). The PEI division was created in 1999. The intention of the creation of PEI was:

1) **plan, develop**, and administer a comprehensive and unified delivery system of prevention and early intervention services to children and their families in at-risk situations;
2) **improve the responsiveness** of services for at-risk children and their families by facilitating **greater coordination and flexibility in the use of funds** by state and local service providers;
3) **provide greater accountability** for prevention and early intervention services in order to demonstrate the impact or public benefit of a program by adopting **outcome measures**; and
4) **assist local communities in the coordination and development** of prevention and early intervention services in order to maximize federal, state, and local resources.

While PEI was carved out as an entity on-par with CPS it clearly is not, de facto, so. Prevention energies continue to be held in a low regard in both deed and function. This is most evident by the proposed (and enacted) cuts in funding which PEI has suffered in the past multiple 10 years. While prevention efforts suffered a 44% cut in the last biennium (82nd Legislative Session, see last BRTF Report, 2011), the LAR presented to the SBRTF by DFPS for the upcoming 83rd Legislative Session included a zeroing out of PEI funding. Prevention funding was 12th out of 13 items requested to be re-instated. The SBRTF fully appreciates the pressures that DFPS is under with regard to the immediate financial needs of CPS and of the foster care system, but *prevention has continued to be relegated to a marginalized position*. For Texas to reduce the number of child abuse victims who require expensive and human-resource intensive CPS intervention services, foster/adopt/kinship subsidies, private provider costs, family preservation

---

Texas Statewide Blue Ribbon Task Force

and/or reunification services, and the plethora of administrative and other overhead costs, we must contain and reduce the enormous economic burden on taxpayers by focusing efforts on prevention. To improve its CA/N prevention efforts, there needs to be increased emphasis and attention to effective, evidence-based prevention and a body (or even position) which will be an active, forward-thinking, steward and guardian of both the spirit and body of CA/N prevention. The role of the PEI division was to (a) set policy for prevention programs, (b) develop a state plan to expand funding for CA/N prevention efforts, (c) develop eligibility criteria for funding recipients, and (d) establish funding priorities for CA/N prevention programs. The current function of PEI appears to the SBRTF to be little more than a contracts administration office. The contract management function is a direct result of PEI being placed (in 2004) within the Purchased Client Services Division within DFPS. It was at this time that the Council on Child Abuse and Neglect Prevention was abolished. This body was responsible for setting CA/N prevention policy, developing a state plan and developing funding strategies. Currently PEI represents 2% of the overall DFPS budget (3% of the overall CPS budget). This is hardly adequate for a state of such size, complexity and profound need. Child abuse and neglect prevention needs to been seen as truly valuable endeavor for it to have even a marginal chance of meaningful impact.

In order to accomplish this, the SBRTF strongly feels that a Permanent (Advisory) Commission to Reduce Child Abuse & Neglect would be required. The state will be unable to make any meaningful advances with the current structure. While those currently employed with PEI are making the most of scarce resources and support, only a permanent, independent commission will be able to elevate prevention to the position required for it to be successful. This Commission would be best positioned as a public – private, non-profit entity made up of at least nine members. Each member should have experience or expertise in prevention, policy, children’s health, epidemiology, child abuse prevention advocacy or similar disciplines. The members would be appointed by the Governor, Lieutenant Governor, Speaker and Chair of the Senate Health and Human Services as well as the Chair of House Human Services for their expertise in the field of child well-being or CA/N prevention. The members would be compensated for their time and travel, and would serve four year terms, with options for reappointment. The terms would be long enough to ensure they span at least two biennia. This

---

http://www.statutes.legis.state.tx.us/Docs/HR/htm/HR.40.htm#40.102
Texas Statewide Blue Ribbon Task Force

will allow for development of longer strategies and afford the members to shepherd these plans. Officers elected by the membership would include a Chair and Vice-Chair. The SBRTF has recognized that the most effective state models include leadership who can remain independent of the state bodies. Therefore, these positions would not be held by members who are responsible directly to PEI, DFPS or THHS officials. In this way, the leadership of the advisory committee (commission) can remain impartial and visionary.

There needs to be a permanent commission overseeing and coordinating Texas’ efforts for the prevention of child abuse and neglect. This can be done by the creation of a prevention advisory council as part of the TDFPS Advisory Council, or a part of one of several other offices within THHS or TDSHS.

As a public-private partnership, the Commission would be a quasi-governmental body and report directly to the Texas Legislature. It would create a biannual report on the practices and programs in place while always moving in the direction of implementing the most effective proven prevention strategies. The report would be submitted to the Governor, Lieutenant Governor, the House Speaker and all Texas State legislators 60 days prior to the beginning of a new session. Staff support for the Commission may be derived from any one or a number of sources, such as: State Health Services Council, Governor’s Health Care Policy Council, Health and Human Services Council, Family and Protective Services Council, The Council on Children and Families or the Task Force for Children with Special Needs. One or more of these bodies would share staffing responsibilities either to provide the necessary support to conduct business for this Commission. The Commission would have the flexibility to collaborate with other related State Departments, as well as local and regional stakeholders, in a more nimble manner as a public-private partnership. For example, the Commission would be able to collaborate with the TDFPS, as well as join the stakeholders “on the ground”, to ensure proper oversight and implementation of the Strategic Plan for Child Abuse and Neglect Prevention Services submitted in 2008 as a result of HB 662. This would ensure the greatest amount of efficiency of time and funds.

As a public – private, non-profit entity, the Commission would be positioned to leverage more
The objective of the Social Impact Bond is to align the interests of governments, capital markets, and nonprofits to create a replenishing source of performance-based funding that frees governments from the trap of costly remedial funding. This could include private foundation funds, both within and outside of Texas, increased federal funds and private donations from individuals, corporations or even private equity investors via the emerging growth of Social Impact Bonds\textsuperscript{10}. This would decrease the state’s sole financial burden for the Commissions’ work. This Commission would be the administrator of the Texas Children’s Trust and Prevention Fund dollars. This would ensure that the Trust Fund dollars remain focused on its legislative purpose: The primary prevention of child abuse and neglect. A commission which had a non-profit status would afford the state a number of valuable assets. Firstly, it would facilitate a more meaningful engagement with the private and philanthropy sectors across the state. As noted earlier, one benefit from this collaboration in CA/N prevention would be that any funds allocated for prevention efforts by the private sector would be potentially eligible to leverage funding for additional CBCAP funding. By engaging the private sector in a more meaningful way, the state would be able to draw down more federal funds for CA/N prevention without needing to identify any additional General Revenue funding. Currently, all dollars utilized in the private sector (including philanthropy) remain unleveraged. A partnership with a public-private prevention commission would potentially mean hundreds of thousands if not millions of additional dollars each year for CA/N prevention.

Current Sympathetic/Synergistic Structures
The current structure of Office of Health Coordination and Consumer Services (HCCS) includes three offices: Office of Program Coordination for Children and Youth (which includes Interagency Task Force for Children with Special Needs, Council on Children and Families, Children's Policy Council, Texas Systems of Care, and Family/Community-Based Alternatives), Office of Early Childhood Coordination (which includes Texas Home Visiting Program, Texas Nurse Family Partnership, Healthy Child Care Texas, and Raising Texas), and Office of Acquired Brain Injury. Many of the activities of these offices and councils would potentially blend nicely with a comprehensive CA/N prevention strategy.

\textsuperscript{10} The objective of the Social Impact Bond is to align the interests of governments, capital markets, and nonprofits to create a replenishing source of performance-based funding that frees governments from the trap of costly remedial funding.
Texas Statewide Blue Ribbon Task Force

There are other examples of efforts within the broader HHS structure which could be incorporated into a larger CA/N prevention strategic plan. This broader plan could be developed within the permanent commission and would be able to streamline current efforts into the larger framework. This would significantly improve efficiency and limit redundancy. Currently, with the primary prevention effort being housed within PEI, there appears to be limited “cross fertilization” with other offices or efforts. For example, the Early Childhood Intervention program (ECI)\textsuperscript{11} within the Department of Assistance and Rehabilitation Services (DARS) is an example of an effort, which has a lot of synergy to CA/N prevention efforts. It involves identifying children with developmental needs and provides intervention services at the home. The goals of ECI are promoting development and learning, providing support to families, coordinating services, and decreasing the need for costly special programs. These programs share synergies with CA/N prevention programs. Other sympathetic programs that the state already has in place which could be integrated into a CA/N plan include:

- Home visitation (noted in great detail below)
- Texas Health Steps\textsuperscript{12}
- Texas Healthy Baby Initiatives\textsuperscript{13}
- Texas Medcares\textsuperscript{14}

Interagency Coordinating Council for Building Health Families

**Description:** Created by House Bill 1685 of the 79th Texas Legislature, and its life briefly extended by House Bill 662 of the 80th, the Interagency Coordinating Council for Building Healthy Families (hereafter “Interagency Council”) was established for the purpose of facilitating communication and collaboration concerned creating policies for the prevention of, and early intervention in, child abuse and neglect among State agencies whose programs and services promote and foster healthy families. This was a very important and valuable effort. The Interagency Council lifespan ran from September 1, 2007, until it ceased to exist by January 1, 2010.

\textsuperscript{11} http://www.dars.state.tx.us/ecis/
\textsuperscript{12} http://www.dshs.state.tx.us/thsteps/about.shtm
\textsuperscript{13} http://www.dshs.state.tx.us/healthytexasbabies/initiatives.aspx
\textsuperscript{14} http://www.dshs.state.tx.us/mch/medcares.shtm/
The Interagency Council was charged with completing an inventory of child abuse and neglect prevention and early intervention policies, programs, and activities of each of the following State agencies:

- Texas Department of Family and Protective Services;
- Texas Health and Human Services Commission;
- Texas Department of State Health Services;
- Texas Department of Aging and Disability Services;
- Texas Department of Assistive and Rehabilitative Services / Early Childhood Intervention;
- Texas Education Agency;
- Texas Workforce Commission;
- Office of the Texas Attorney General;
- Texas Juvenile Justice Department; and
- Texas Department of Housing and Community Affairs.

The Interagency Council had been charged with evaluating State-funded child abuse and neglect prevention and early intervention programs to determine:

- The effectiveness and cost efficiency of these programs;
- The potential for streamlined funding mechanisms;
- The potential methods by which these programs could increase reliance on evidence-based practices;
- The methods for identifying opportunities for comprehensive improvements to the delivery of services; and
- The need for increased State funding for these programs in order to ensure a sustained, long-term, cost-effective investment in families.

In December of 2009, the Interagency Council issued its final report entitled Findings from the 2008-2009 Evaluation of Child Abuse and Neglect Prevention Programs and Services which offered 5 key recommendations:

1. Value Texas families and youth;
2. Provide comprehensive services with family-focused outcomes;
3. Continue to evaluate programs designed to prevent abuse and neglect in order to
Other State Plans

The SBRTF spent much time evaluating the experiences of other states regarding their child abuse prevention strategies. We reviewed a number of states that have had both successes and challenges with their programs. We have included summaries from a number of these states to give the reader a better sense of how other states have approached the issue of child abuse prevention. Our final recommendations include some successful strategies and initiatives which other states have embraced. The states included are Kansas, New Jersey, North Carolina, Florida, and Washington. Summaries of these state plans can be reviewed in Appendix 6.

Section 2

Prevention Strategies

Broadly, CA/N prevention is framed in three areas of focus. Primary prevention is a universal approach to prevention. This is often viewed as the “Public Health” approach for prevention. This is a strategy in which all people receive the intervention regardless of risk factors or criteria, prior to the onset of a public health or other problem/epidemic. An example of primary prevention would be the fluoridation of water. All people receive the benefit regardless of risk or screening. Primary prevention strategies have a demonstrated track record for being the most efficient and have the largest return on investment for many conditions or diseases. Primary prevention strategies for CA/N include universal parenting support, or universal day care subsidies.

Secondary prevention efforts are strategies which involve a screening process and administration of the strategy to a defined subset of people who are deemed at increased risk. By way of example, this would include cholesterol lowering medications for people with high cholesterol (to prevent a heart attack). The event has not occurred, but the person is deemed at
Texas Statewide Blue Ribbon Task Force

increased risk. Secondary prevention strategies for CA/N prevention include home visitation for at-risk families or drug treatment programs for parents addicted to drugs or alcohol. **Tertiary** prevention strategies are directed to people who have already suffered the disease or outcome and are intended to prevent recurrence. An example of this would be having someone who has recently had a heart attack take a baby aspirin per day to prevent recurrence. This prevention strategy is only utilized for people who have already had the disease. In CA/N prevention, the most common tertiary prevention strategy is parenting classes for parents who have been reported or substantiated perpetrators of CA/N. Tertiary prevention strategies are the have the smallest impact on the overall problem (whether it is heart attacks or CA/N).

Currently, the PEI division of TDFPS contracts with community agencies to provide prevention services. The FY10 PEI appropriation of $45,883,571 included child abuse and neglect prevention, juvenile delinquency prevention, and helping youth in crisis. Child abuse and delinquency prevention programs include: Texas Families Together and Safe (TFTS), Community Based Child Abuse Prevention (CBCAP), Family Strengthening Services, Community Based Family Services, Tertiary Child Abuse Prevention, Services To At-Risk Youth (STAR), Community Youth Development (CYD), Youth Resiliency, and the Statewide Youth Services Network. In reality, only three of the programs truly represent primary child abuse prevention: Texas Families Together and Safe (TFTS), Family Strengthening Services (FSS), and Community Based Child Abuse Prevention (CBCAP). These three programs have a budget of approximately $8,300,000 per year representing less than 18% of the PEI budget and less than 1% of the TDFPS budget. These programs reach only a small number of Texas families. It is estimated that in Texas only five of every 1,000 children receive prevention services compared to a national average of 44 of every 1,000 children. In 2009, the University of Houston evaluated the three programs and did find a statistically significant increase in protective factors and resiliency after completion of these program’s services as well as a reduction in validated child abuse and neglect cases in families served. It is unclear, however, if this increase continues after discharge from services as this effect was not as apparent at 6 and 12 months post-services. There are limitations in the ability to analyze the data, as few participants are available for long term follow-up. Therefore, the impact of these programs on the lives of children remains to be determined.
Given the limited funding available for child abuse prevention efforts, all care must be taken to maximize each dollar spent. To this end, metrics need to be in place to monitor and direct funds to services and practices that are based on reliable evidence of effectiveness or promise. In the medical and social sciences field, the use of “evidence-based” practices (EBP), or “evidence-informed” practices (EIP), has become the current standard. Evidence-based practices and programs traditionally have high quality scientific evidence of effectiveness in reducing risk factors, increasing protective factors, and ultimately in preventing child maltreatment. Scientific evidence of effectiveness includes published literature; the most unassailable or “gold standard” in scientific design is the randomized controlled trial. Evidence-informed practices or promising programs have some evidence of effectiveness through evaluations or studies with less rigorous design. The US Preventive Task Force has a well-established and quoted guideline, which stratifies the evidence by its quality and effectiveness from Level 1 (highest quality) to Level III (based on opinion and clinical experience). Level I evidence has at its core a body of published literature based on “at least one properly designed randomized controlled trial”. Level II evidence is further subcategorized into Levels II-1 (well-designed controlled trials without randomization), II-2 (well-designed cohort or case-control studies), and II-3 (multiple uncontrolled studies with dramatic results).

In this regard, TDFPS should employ a process by which the evidence behind funded practices and programs is continually assessed and interpreted. A process as such was outlined by TDFPS in its 2008 Strategic Plan for Child Abuse and Neglect Prevention Services. However, TDFPS proposes a guideline to evaluate the Level of Evidence that is the inverse of the broadly accepted USPTF. For instance, a Level I TDFPS practice would be a program with a strong foundation but lacking clinical or empirical evidence. This corresponds to Level III on the USPTF guideline. This could create confusion amongst grantees as well as funding agencies. Funding should be directed primarily towards evidence-based practices with an allotment of resources reserved for promising programs (evidence-informed) to be piloted, dependent upon the needs required of the local or regional population. Care must be taken with the use and evaluation of promising programs as these programs are more subjective and can be driven by popular theory and changing politics. For example, a meta-analysis of the evidence behind
previously popular juvenile delinquency programs such as “Scared Straight” found that the program had a “harmful effect” and was worse than doing “nothing at all.” Thoughtful evaluation of promising practices needs to occur as to not simply exclude reasonable but unproved strategies. This simply means that promising practices can be embraced as long as they have the appropriate oversight and measures in place, with clear success and failure pre-defined.

Current challenges faced by the PEI division of TDFPS includes 1) lack of evaluation process to determine service efficacy, 2) inadequate capture of federal matching funds, 3) insufficient provider capacity, and 4) a lack of a comprehensive approach to child abuse prevention. The programs and services that are offered are not targeted to many of the known risk factors associated with child abuse and neglect such as parents own child abuse experience, domestic violence, substance abuse, mental illness, poverty and teen pregnancy. In addition, under the current financial constraints, providers will often serve fewer families when evidence-based models are proposed.

States conventionally collect service related data with much less attention paid to process and outcomes. Many programs are evaluated utilizing outputs (the number of “clients served” or “sessions offered”) with less emphasis on efficacy and quality through outcomes (measurable client benefits). This critical change in thinking would require the use of uniform definitions of service, process, and outcomes across the various service providers, grantees and grantors. Traditional short-term measures have included client satisfaction (the parent), future substantiated cases of child maltreatment, and protective factors such as resiliency. Long-term outcome measures need to include tangible program goals that focus on the true client, the child. Funding and reimbursement should be geared toward the outcomes (not outputs) as well as to the quality and competency of the program. For evidence-based practice and the use of outcomes measures to be successful, a paradigm shift needs to occur among all stakeholders – clients, community-based agencies, providers, TDFPS, PEI, and legislators – to a culture that links and merges research with practice. There needs to be adequate infrastructural support including data and resource sharing, funding and training of providers, and fidelity to program models. Output measures such as number of clients served should be minimized and replaced by quality outcome
or “impact” measurement. Additionally, funding of prevention programs should be based on “performance measures of effectiveness” to ensure that successful programs continue to produce sustained, positive outcomes.

Home Visitation

About Home Visitation Programs
The home visitation (HV) model has become a well-recognized prevention and early intervention strategy. Home Visitation programs offer information, guidance, risk assessment, and parenting support interventions in the home for families with young children. Home visitation programs can be intensive and targeted to specific at-risk groups, or they can be universal and intended for any and all families who choose to participate. Different model curricula are geared towards different clients. These include: high-risk pregnant women, families with infants, low-income first-time mothers, overburdened families at risk of abuse and neglect, families lacking social supports and children with special health care needs. The two common threads in all of the different HV models is the importance of children’s early years, and the pivotal role that parents play in shaping children’s lives.

In a home visitation program, services are delivered by professionals (such as nurses or social workers) or trained community workers (often called paraprofessionals) in the home of the family. Programs are generally designed to improve some combination of pregnancy outcomes, maternal and child health, positive parenting practices, safe home environments, child’s cognitive development and school readiness. Additionally many models emphasize the family’s access to community services. All HV services are voluntary and based on an ongoing relationship between the visitor and the parent. Visits occur regularly, typically monthly, and last for generally 2-3 years. To ensure effectiveness, all HV services should be regularly monitored and assessed for effectiveness, model fidelity, impact, outcomes and return on investment. Each program model should use intervention strategies that are evidence-based to ensure programs efficacy so that they deliver intended results. It is also crucial that these programs retain the quality standards required to reach the original model’s outcomes during implementation at new sites, or fidelity to the model.
Evidence-Based vs. Promising Practice Home Visitation Programs

Home visitation programs also can be evidence-based or promising. As described, a program that is evidence-based uses the best empirically derived information to aid parents and children. To meet the Federal definition of “evidence-based,” a home visitation program must have at least one high-quality (or moderate-quality) impact study that demonstrates statistically favorable effects in at least two domains of maternal or child well-being, or the program must have at least two high- or moderate-quality impact studies using different samples with one or more favorable, statistically significant effects in the same domain. These positive outcomes must be maintained for at least a year after program enrollment, and the outcomes must be reported in a peer-reviewed journal. The Federal definition of “promising practices” (comparable to the evidence-informed practices or promising programs described earlier), on the other hand, includes programs that do not meet the evidenced-based criteria (or represent a significant modification to an EBP). The program must be grounded in relevant empirical work and have an articulated theory of change.15

Texas Home Visitation Programs and Evaluation Outcomes

Home visitation programs have shown a range of positive outcomes (see Appendix 2), including healthier pregnancy outcomes, improved child health and development, parenting practice development, child abuse and neglect reduction, enhanced parental self-sufficiency, early detection of developmental delays and health issues, and increased school readiness.16 Appendix 3 presents examples of home visitation programs with proven positive outcomes that are active in Texas.

Evidence Based Programs

The Nurse-Family Partnership (NFP):

The NFP is a HV model which utilizes registered nurses who are paired with low-income, first-time mothers.17 The primary goals of NFP are to improve pregnancy outcomes, child health and development, parenting practice development, and child abuse and neglect reduction. Enhanced parental self-sufficiency and early detection of developmental delays and health issues are also significant outcomes.17

15 Affordable Care Act Maternal, Infant, and Early Childhood Home Visiting Program; Supplemental Information Request for the Submission of the Updated State Plan for a State Home Visiting Program
development, family economic self-sufficiency, and stability and reduce the incidence of child abuse and neglect. Research on the NFP model has shown tremendous benefits being realized by the child, the family and the community. These include the following: 48% reduction in child abuse and neglect, 50% reduction in language delays at child age 21 months, 50% reduction in child arrests, 61% fewer arrests for the mother, 46% increase in father presence in the household, and 67% reduction in behavioral and intellectual problems for child age 6, among others.18

**Healthy Families America (HFA):**
The HFA HV model emphasizes the newborn period and initiates services either prenatally or at birth.19 The program is based upon 2 core principles of service delivery and has two main cornerstones: family assessment and family support via home visits. A standardized assessment tool is used to systematically identify families in need of services by assessing the presence of various factors associated with an increased risk for child abuse and neglect, or other poor childhood outcomes. The HFA model provides culturally competent services that focus on supporting parent(s), parent-child interaction, and child development. Research on HFA has shown that with model fidelity, the curriculum supports positive parent-child bonding and relationships, promotes optimal child health and development and enhances parental self-sufficiency. Additionally, a recent HFA-New York study reported lower rates of child abuse and neglect within the enrolled families.

**The Home-Based Instruction for Parents of Preschool Youngsters (HIPPY):**
The HIPPY HV model emphasizes parent involvement. Its main focus is as a school readiness program that helps low-literacy parents prepare their 3- to 5-year-old children for success in school and life. HIPPY has demonstrated the following outcomes: 93.5% of HIPPY children were reported as “average” or “above average” in classroom adaptability by their kindergarten teachers, 84.2% were reported as “ready for kindergarten,” 76% of HIPPY parents increased the

---


amount of time spent engaging their children in literacy activities at home, and 80.6% of HIPPY parents increased their level of involvement with their children’s school.20

**The Parents as Teachers Program (PAT):**
The PAT HV model aims to increase parental knowledge of early childhood development and improve parenting practices. The goals of the model are to provide early detection of developmental delays and health issues, prevent child abuse and neglect and increase a child’s school readiness.21 Programs results at age 3 have demonstrated children in the PAT group more likely to be fully immunized for their given age and less likely to be treated for injury in the previous year. Parents enrolled in the PAT curriculum scored significantly higher than comparison parents on four of six parent knowledge scales. These include the importance of physical stimuli in their child’s development, appropriate discipline and knowledge of child development. Children enrolled in the PAT curriculum have demonstrated higher levels of school readiness and continue to outperform their peers in first through fourth grades.

**Early Head Start-Home Visiting (EHS):**
The EHS program focuses on providing high quality, flexible and culturally competent child development and parent support services. EHS services include a weekly, 90-minute home visit and two group socialization activities per month for parents and children. EHS home visitors have knowledge and experience in: (a) child development and early childhood education, (b) principles of child health, safety, and nutrition, (c) adult learning principles, and (d) family dynamics.22 Analyses from a randomized control trial on EHS showed that by age 3, EHS-enrolled children had improvements in cognitive and language development, showed higher engagement with their parents in play activities, and sustained attention longer than controls. The study also showed that parents were more emotionally supportive, provided more learning

---

opportunities for their children, such as reading and speaking to them, and spanked their children less.\textsuperscript{23}

**Positive Parenting Program (PPP, or “Triple P”):**

The PPP is a tiered parenting and family support strategy that aims to prevent behavioral, emotional, and developmental problems in children by enhancing the knowledge, skills, and confidence of parents.\textsuperscript{24} There are 5 tiers in PPP with the basic tier being a public awareness campaign and the highest tier being targeted home visits directed towards specific child behaviors or conflicts identified by the parents. The Centers for Disease Control and Prevention and the University of South Carolina evaluated a statewide implementation of PPP and found that in a community with 100,000 children under 8 years of age, there were 688 fewer cases of child maltreatment than in the control counties.\textsuperscript{25} In addition, the study showed a 12% decrease in out-of-home placements, compared to a 44% increase in the control counties. Finally, the counties that received the program intervention had an 18% reduction in child maltreatment related injuries requiring medical attention, while there was a 20% increase in the control counties. A cost analysis reported the cost of the basic tier (Tier 1) was $1 per targeted child, and the highest tier (Tier 5) was less than $12 per targeted child.\textsuperscript{26}

**Promising Practices**

The AVANCE program, a promising practice in Texas, aims to help mothers see themselves as teachers and effective role models for their children through home visitation and coursework-driven parent-child intervention. The goal of AVANCE is to promote school readiness and parent engagement.\textsuperscript{27} The program spans 9-months and consists of monthly home visits, weekly 3-hour classes, and adult education or other services (e.g., ESL or GED courses, transportation

\begin{itemize}
  
\end{itemize}
services, food services, and support). Moreover, AVANCE’s model was evaluated through a random control trial demonstrating positive effects in a low-income, Latino sample in San Antonio. Specifically, this study found that mothers who participated in the program provided a more organized, stimulating, and responsive home environment (i.e., they provided more developmentally appropriate toys, interacted more positively with their children, initiated more social interactions with their children, used more consistent praise, spent more time teaching their children, spoke more with their children, used more developmentally appropriate speech with their children, and were more encouraging of their children’s verbalizations).28

**Texas Investment in Home Visitation**

In 2007, 2009 and again in 2011, the Texas Legislature made a significant investment in the Nurse-Family Partnership (NFP) HV program. Senator Shapiro authored SB 156 along with 16 Senate co-authors, which unanimously passed through both chambers during the Regular Session of the 80th Legislature. Representative Madden, the House Sponsor, led unanimous passage of the companion bill (HB424) with the help of 24 House co-authors. The legislation authorized and funded the Texas NFP (TNFP) home visitation program, which serves approximately 2,000 at-risk families across the state in 13 locations at $17.8 million. The RAND Corporation’s return-on-investment analysis yielded a $2.88 return for every $1.00 invested in low-risk families and $5.70 return for every dollar invested in high risk families29.

The TNFP home visitation program has already reported a wide range of benefits to many Texas communities. For instance, 90% of TNFP babies were born full-term, 87% of TNFP mothers initiated breastfeeding, and another 87% of children received all recommended immunizations by 24 months.30

**Texas Future Home Visitation: Meeting the Need**

While HV cannot claim to end child abuse, its potential benefits are tremendous. Home Visitation should be supported and expanded. The expansion of HV programs in Texas

---

would go a long way to realize the full cost/benefit of HV. There remains a great need in Texas for HV: There are approximately 240,000 Medicaid-eligible live births every year in Texas. Approximately 40% of those births are to first-time mothers. In Texas, the at-risk population for the pre-natal home visitation program is almost 100,000 first-time, low-income mothers per year. Based on data from other states’ implementation of HV programs, it can be expected that half of these mothers (50,000) will be eligible for services and only half of those identified will voluntarily participate in the program. Our goal in Texas should be to enroll 25,000 unique, low-income, first-time mothers in pre-natal HV programs every year. As noted earlier, we are currently serving only 2,025 families with NFP plus 600 additional families using the MIECHV funds. This number needs to grow with an expansion of NFP and a scale-up of other HV programs serving mothers prenatally, by a factor of ten. In addition, there are hundreds of thousands of at-risk families who would benefit from those home visiting programs that serve families after the child’s birth up to child age 6. Most other evidence-based programs only require parents to be low-income or have limited education to participate (see Table 1). At a minimum, the families in the highest risk category need served (e.g., those in extreme poverty). In 2011, approximately 225,599 families with children aged five and under lived in extreme poverty (<50%).\(^{31}\) If half of these families agreed to participate in a home visiting program, then approximately 112,799 families will benefit from services. Currently, slightly fewer than 11,500 children are served by the other evidence-based HV programs, and another 7,600 families are served by promising programs (using a variety of funding sources). Thus, Texas will need to increase services across the state by a factor of 6.

The Texas Health and Human Services Commission currently uses federal funding from the “Maternal, Infant and Early Childhood Visiting Program (MIECHV),” included in the Affordable Care Act, to provide home visitation services for almost 2,300 families (at present) in Texas. As part of the $17.8 million formula grant and $3.3 million competitive grant funding for 2012-14, four home visitation programs now serve families in 7 regions of Texas. Another home

---

The Texas Department of Family and Protective Services (DFPS) also funds five home visitation programs (three EBP and two promising) as part of their Prevention and Early Intervention (PEI) division.

### PEI Division of DFPS HV funding

<table>
<thead>
<tr>
<th>Program Name</th>
<th>Annual Contract for Home Visiting Portion*</th>
<th>Total Federal Funding</th>
<th>Total State Funding</th>
<th>Number of Families Served by Home Visiting in Past Year in TX Counties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents As Teachers</td>
<td>$597,318</td>
<td>$497,393</td>
<td>$99,925</td>
<td>427 families in Atascosa, Bandera, Crosby, Frio, Hale, Hockley, Karnes, Lubbock, Lynn, Real, Terry</td>
</tr>
<tr>
<td>Healthy Families</td>
<td>$409,497</td>
<td>$307,123</td>
<td>$102,374</td>
<td>219 families in Concho, Runnels, Tom Green</td>
</tr>
<tr>
<td>Triple P</td>
<td>$132,349</td>
<td>$99,262</td>
<td>$33,087</td>
<td>95 families in Tarrant</td>
</tr>
<tr>
<td>Nurturing Parenting Program</td>
<td>$389,458</td>
<td>$91,670</td>
<td>$297,788</td>
<td>241 families in Bexar, Concho, Crockett, Guadalupe, Runnels, Tom Green</td>
</tr>
<tr>
<td>Systemic Training for Effective Parenting (STEP)</td>
<td>$86,318</td>
<td>$86,318</td>
<td>$0</td>
<td>111 families in Bexar</td>
</tr>
<tr>
<td>TOTALS</td>
<td>$1,614,940</td>
<td>$1,081,766</td>
<td>$533,174</td>
<td>1266 families in 18</td>
</tr>
</tbody>
</table>
In addition, the Department of Health and Human Services provides $100,000 annually from State GR for one home visiting program (i.e., Healthy Start) as part of its Healthy Texas Babies Initiative. Taken together, the state spends a little over $6 million annually on home visiting programs:

<table>
<thead>
<tr>
<th>Annual State Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas Home Visiting Program</td>
</tr>
<tr>
<td>Nurse-Family Partnership</td>
</tr>
<tr>
<td>Parents As Teachers</td>
</tr>
<tr>
<td>Healthy Families</td>
</tr>
<tr>
<td>Positive Parenting Practices</td>
</tr>
<tr>
<td>Nurturing Parenting Program</td>
</tr>
<tr>
<td>Healthy Start</td>
</tr>
</tbody>
</table>

*This amount is $1 more than the total of the rows above due to rounding of values

The state provides funding for about 13% of the programs currently operating in Texas. As shown in the figure below, the majority of funding for home visiting programs in Texas is funded through the federal government (e.g., Federal Head Start Program, Title I, Title II, Children’s Bureau, Federal Healthy Start initiative, etc.). Private non-governmental organizations (e.g., United Way) and donors provide slightly more funding that the state.

Although the PEI division of DFPS is frequently cut, if they maintain the current $1.65 million in funding for home visitation programs another year (with the same Federal/State contribution), then:

**Total Government Spending on HV in Texas- $42,203,410**

MIECHV, $17.8 million formula, $3.3 million competitive
NFP (from SB 156), $6.6 TANF / $11.2 GR
PEI Division, $3.3 million
The task of implementing, monitoring and assessments should fall upon a recognized, statewide body overseeing the larger child abuse prevention strategy for the state. Texas has put in place an administrative infrastructure within the Health and Human Services Commission to support the implementation of the Nurse-Family Partnership in twelve locations across the State as well as the other four MIECHV-funded programs in 8 locations. The existing infrastructure could be extended to include other evidence-based home visitation programs.

Recommendations:

- Sustain current funding of home visiting to ensure that Texas meets the required Maintenance of Effort (MOE) and leverages the federal funds match (current funding to 13 Nurse-Family Partnership sites)
- Support the expansion of existing home visitation sites and additional sites
- State revenues must be invested in the most rigorously evaluated and proven, evidence-based child abuse and neglect prevention and school readiness programs (75% of state revenues in EBP)
- Allow up to 25% of state GR to fund “promising programs” to Incentivize innovation and entrepreneurship
- Ensure all home visiting programs enroll families voluntarily
- Ensure programs set clear standards and are accountable for their outcomes
- Implement programs with fidelity to the research model
Texas Statewide Blue Ribbon Task Force

- Continually evaluate programs for quality assurance and quality improvement

**Respite Care**

Families which are experiencing multiple challenges related to poverty, substance abuse, family violence, and other circumstances, have difficulty providing the safe and stable environments that children need in order to have a healthy path to adulthood. The greater the risk factors present in a family’s situation, the higher the risks for child abuse or neglect. Programs that focus services on reducing risk factors in families have shown positive outcomes for reducing child abuse and neglect by reducing family stress and strengthening parenting skills. According to data provided by the National KIDS COUNT Program, 27% of children in Texas are in households in which abuse and/or neglect are the norm.

The Relief Nursery is a nationally recognized, comprehensive family support program for parents of children up to six years of age who are experiencing extraordinary stress. Established in Oregon in 1976, the Relief Nursery program has consistently shown positive results in helping overwhelmed families decrease their stress and increase their parenting skills by providing services to families at high risk of involvement with the child welfare system. Services vary amongst the 11 Oregon Relief Nurseries, however all Nurseries provide therapeutic early childhood education in classroom settings, home visits, parent education classes and support groups, respite care, case management, and assistance accessing basic resources and other community services. The Oregon Commission on Children and Families contracted with NPC Research to conduct an evaluation of the 2007-2008 Relief Nursery Programs. The program showed improvement in the key outcomes identified as most important: improvement in family functioning; increased frequency of positive parent-child interactions; and reduction in the number of family risk factors. ([http://www.npcresearch.com/Files/Oregon_Relief_Nursery_Final_Report_0209.pdf](http://www.npcresearch.com/Files/Oregon_Relief_Nursery_Final_Report_0209.pdf))

In Austin, Texas, Strong Start (founded in 2008) was established to emulate The Relief Nursery. Like The Relief Nursery, Strong Start’s mission is to prevent the cycle of child abuse and/or neglect by early intervention that focuses upon building successful and resilient children. Strong Start seeks to provide therapeutic early childhood education in classroom settings, make visits to the home, offer parent education classes and support groups, case management, assistance to the
Texas Statewide Blue Ribbon Task Force

family in accessing basic resources and other community services, mental health evaluation and treatment, and support services such as a clothes closet, family meals, and transportation. Oregon’s program—upon which Austin’s program is modelled—demonstrated improvement in the key outcomes identified as most important:

- Improvement in family functioning;
- Increased frequency of positive parent-child interactions; and
- Reduction in the number of family risk factors.

Recommendation: Respite care (Relief Nursery) is a promising adjunct strategy for the prevention of CA/N. The low cost and community-based nature of the strategy are attractive as part of a larger state-wide plan.

Teen Pregnancy

Teen pregnancy poses numerous risks to both mother and child. Adolescent parenting can lead to lower education, poverty, depression, employment challenges, relationship or marital instability, and poor parenting ability. All these risk factors make the children of teen parents 3 to 5 times more likely to be abused. In the U.S., the birth rate is 34 per 1,000 teen girls who are 15-19 years of age and in Texas, the rate is 52 per 1,000 teen girls, according to the Centers for Disease Control and Prevention statistics as reported by UT Health Science Center. This means that 88 out of 1,000 Texas teens get pregnant every year, resulting in approximately 53,000 births per year. The cost of teen pregnancy in Texas is $1.2 billion dollars every year (www.thenationalcampaign.org/costs).

Recommendation: Teen pregnancy poses risks to the mother and the child. Texas should develop and oversee a comprehensive awareness and education program. The goal is to reduce teen pregnancy by building strong families, facilitating public dialogue, developing and implementing effective curricula, and ensuring access to contraception.
There is no greater influence in the life of a child than that of a parent. Parents serve as a child’s first teacher providing guidance, reassurance, and serving as a role model in a child’s life. Healthy parent-child relationships are fundamental to children’s brain development and their physical, emotional, social, behavioral, and intellectual capabilities. Positive parent-child relationships create the foundation for healthy child development including brain development, social skills, mental and physical health, and the ability to cope with major life events. Children who have positive nurturing relationships with their parents are more likely to develop into children, teens, and adults who are happy, healthy, and competent. Competent parenting has a positive impact on a child’s language development, readiness for school, academic achievement, and physical health. In addition, children who have a positive parental bond have a reduced risk of antisocial behavior and substance abuse problems.

On the other hand, children who lack positive relationships with their parents have poorer outcomes in life and are at greater risk of abuse and neglect. The lack of a warm positive relationship with parents, harsh discipline practices, inadequate supervision, marital conflict, and parental mental illness increase the risk that children will develop behavioral and emotional problems.

Given the benefits of positive parent-child relationships, the development of interventions that promote positive, caring, and consistent parenting practices has been cited as being critical to reduce the incidence of child maltreatment and behavioral disorders in children. The Centers for Disease Control and Prevention, “Promoting Safe, Stable and Nurturing Relationships: A Strategic Direction for Child Maltreatment Prevention” Accessed Oct 19, 2012. [link]


Texas Statewide Blue Ribbon Task Force

for Disease Control and Prevention has identified the promotion of Safe, Stable, and Nurturing Relationships (SSNR) between parents and children as their primary child abuse prevention strategy. Safe relationships protect children from physical or emotional harm; stable relationships provide children with regular routines and needed consistency to handle stressful experiences; and nurturing relationships ensure the parent responds to the needs of the child.

Despite a parent’s best intentions, many factors may prevent parents from forming the safe, stable, and nurturing relationships that children need to thrive. The composition of families and external social and economic stressors have left many well-intended parents stretched thin and struggling to meet the emotional and physical needs of their children. Single-family homes, dual income families, under employment and unemployment, health problems, and marital conflict all create extra strains on parents. Many parents report that it is more difficult to be a parent now than it used to be. People feel more isolated, and the world seems to be a more dangerous place.

Evidence-based parent education programs can have a positive impact on children and parents, and can reduce rates of CA/N. Parent education is designed to improve parenting skills and family communication, prevent child and family problems, and educate parents on child development and positive parenting practices with a goal of developing safe, stable, and nurturing parent-child relationships. Parents who attend evidence-based parent education classes have lower rates of depression and stress, and higher rates of confidence, appropriate use of discipline techniques, and knowledge of child development. Parent education also has a positive impact on the prevention of childhood social, emotional, and behavioral problems,

---

academic failure, truancy and school dropout, delinquency, substance abuse, anxiety disorders, and teenage parenthood.\(^{42}\)

Evidence-based parent education programs can also prevent child maltreatment. The Nurse-Family Partnership, SafeCare, The Incredible Years, Parent-Child Interaction Therapy, and the Positive Parenting Program (Triple P) are a few examples of evidence-based parent education programs that are designed to prevent child maltreatment.\(^{43}\) For example, the Nurse-Family Partnership (NFP, as noted above) is a home visitation program that equips registered nurses to visit homes and provide training and support to low-income new mothers. A 15-year follow-up study demonstrated that families who participated in NFP had a 48% reduction in child abuse and neglect.\(^{44}\) Triple P, a parent support program noted earlier, offers varying intensities of parental support to meet the various needs of parents. Communities that implement Triple P have lower rates of child maltreatment compared to communities that do not implement Triple P.\(^{45}\)

A positive parent-child relationship is fundamental to a child’s healthy development. Consequently, all families could benefit from parent education. No family is perfect and all parents can use support and guidance sometime during their child’s development. Evidence-based parent education programs have demonstrated a positive impact on parent-child relationships, the prevention of children’s social, emotional, and behavioral problems, and lower rates of child maltreatment at a community level. Given the critical importance of parenting, the changing composition of families, and the struggles families face, public policy should support parents and parent education to better the lives of children and families in our communities.

**Summary Points**

- Children that have positive nurturing relationships with their parents are more likely to develop into children, teens, and adults who are happy, healthy, and competent.


\(^{44}\) ZERO TO THREE. "A Better Start: Child Maltreatment Prevention as a Public Health Priority" (2010).

Texas Statewide Blue Ribbon Task Force

- Experts agree that interventions that promote positive, caring, and consistent parenting practices are critical to reduce the incidence of child maltreatment and behavioral disorders in children.
- Evidence-based parent education programs have demonstrated a positive impact on children, parents, and reduce rates of child maltreatment. Parents have lower rates of depression and stress, and higher rates of confidence and knowledge of child development. Children have lower rates of social, emotional, and behavioral problems.

**Recommendations:** Parenting support programs (such as Triple P and NFP) should continue to be explored and incorporated into a broad statewide CA/N prevention strategy.

*(with Nancy Correa, Children at Risk, Houston)*

**Child Sexual Abuse Prevention**

Prevention strategies for child sexual abuse differ significantly from those focused on child physical, emotional abuse and neglect. The consequences of child sexual abuse may manifest in adult victims in more prevalent and disturbing sequela than observed in the adult survivors of other types of child abuse. These emotional and behavioral outcomes often include: depression, borderline personality disorder, substance abuse, post-traumatic stress disorder (PTSD), eating disorders, and teen pregnancy. Treatment is essential for children victimized by sexual abuse and will help reduce the likelihood of the cycle of abuse perpetuating.

There has been very limited research on the effectiveness of child sexual abuse awareness or prevention programs. There is some preliminary data that suggest home visitation (such as NFP) could address some risk factors such as parental dysfunction, social isolation, maternal illness/alcoholism, maternal depression and child neglect which can provide opportunities for child sexual abuse to occur. Unlike physical child abuse, socioeconomic status is not a risk factor in child sexual abuse (Finkelhor, 1995) and the risk for child sexual abuse rises with age (US Department of Health & Human Service, 1998). Therefore, additional strategies are needed to combat child sexual abuse in a variety of populations.
Texas Statewide Blue Ribbon Task Force

The analyses of school-based child sexual abuse prevention education programs for children have often shown an increase in knowledge on protection strategies, at least in the short-term. However, some of these programs show negative effects in younger children, such as increased anxiety and feeling less in control. In older children, there appears to be more discomfort to normal touch than children who did not participate in these programs. (Taal & Edelaar, 1997) One encouraging long-term evaluation involved a survey of 825 female undergraduates, which found that those who had participated in a sexual abuse prevention program in their school years were less likely to have been sexually abused (Gibson & Leitenberg, 2000). In conclusion, more evaluation is needed to determine which type of child sexual abuse prevention education programs result in the most effective protection of children from sexual abuse. There are some recognized curricula that have been utilized across the country, but there is limited data regarding their impact on child sexual abuse.

“Stop It Now,” a national organization working to end child sexual abuse for the past 20 years, works to mobilize communities to action. They work to “create a culture of prevention,” which must include teaching adults to value protecting children above protecting themselves or the institutions they serve. This organization suggests that this can be accomplished by showing adults how to:

- Understand and overcome barriers to speaking up about potential abuse.
- Think about appropriate boundaries for adult interactions with children, so adults can more likely to respond when observing violated boundaries.
- Pre-plan a course of action.
- Demand high standards and expectations of organizations and institutions who work with children, in regards to their child protection policies, training, and leadership.

“Prevent Child Abuse America” also has an agenda that promotes “collective responsibility to prevent child sexual abuse through supporting children & families, strong legislation, research, training, and public education that addresses risk factors.” Respected experts in the field agree that child sexual abuse is currently being addressed almost exclusively through the criminal justice and child protection systems and this must be expanded to include partners that address child sexual abuse before it occurs.
“Darkness to Light” is a national organization whose mission is to empower adults to prevent child sexual abuse. Stewards of Children is a child sexual abuse prevention program, created by Darkness to Light, aimed at adults to take the responsibility to identify situations that present a risk for child sexual abuse (CSA), identify signs that CSA is occurring, and have the skills to intervene, thereby decreasing the incidents of CSA. The Stewards of Children prevention training is based on 7 steps to prevention:

- Step 1: Learn the Facts
- Step 2: Minimize Opportunity
- Step 3: Talk About It
- Step 4: Stay Alert
- Step 5: Make a Plan
- Step 6: Act on Suspicions
- Step 7: Get Involved

An independent multi-site controlled evaluation, supported by the Center for Disease Control and Prevention, found that child care providers showed an increase in prevention efforts after participating in the Stewards of Children training program.

“We Help Ourselves” (WHO is a national organization that is committed to empowering children and adolescents to help themselves stay safe and happy; to know what to do in a dangerous situation and to know who to tell. WHO is an educational program that helps children and teenagers learn how to avoid victimization, including child abuse and neglect, violent assault, kidnapping, peer pressure, domestic violence and emotional abuse.

The message of WHO is simple:

- KNOW – Recognize potentially dangerous situations; learn and practice personal safety rules help to avoid risk
- DO – Have a plan of action; think ahead about what to do in a scary, dangerous or uncomfortable situation
- TELL – Ask someone you trust for help; it’s important to tell someone about situations that are uncomfortable
WHO was developed by Mental Health America of Greater Dallas in 1981. It was designed to prevent the likelihood of child victimization, while building children's ability to analyze strange or dangerous situations in a critical way. WHO is a series of research-based curricula that are formed on sensitive, non-threatening content and methodology. WHO Training prepares school counselors, child advocates, nurses, teachers, case workers and volunteers to present WHO in classrooms settings for Kindergarten through the 12th Grade. The WHO Program has been adopted by public school systems, private schools, organizations and religious groups all over the country. Curriculum encourages learning through age-appropriate videos, discussion topics, situational problem solving and follow-up activities.

**Recommendations:** Texas currently does not have a statewide plan to evaluate and disseminate promising CSA prevention initiatives. The SBRTF feels strongly that a comprehensive plan to survey the needs of the state, evaluate potential promising practices, and oversee their implementation and impact is a critical component of a broad CA/N prevention effort.

**Child Sex Trafficking**

Child sex trafficking is a coordinated effort to identify, transport and enslave children for the sake of adult sexual activities. The U.S. Department of Justice estimates the average age of American children entering the commercial sex trade to be nine years old. Between the ages of 9 and 18, children are often controlled by a parent, boyfriend, family member, trusted family friend or a “pimp” (one who solicits individuals aka “Johns”, for sexual abuse of children). Commercial child sex trafficking (CCST) does not require the crossing of international borders, or national borders. CCST is defined by the actions of the child sexual abuse facilitator, not the distance traveled. The person trafficked is essentially rented to others for sexual purposes. This trafficking is facilitated by direct or indirect violence or threat of violence, or abuse of authority or dominant position, deception, or other forms of coercion. These victims are essentially captive of the person who controls their every move.

Some of these children have run away or are “throw-aways” from home or other places where they existed in vulnerable, neglectful and/or abusive environments. **Children who are**
Trafficked are usually running away from physical/sexual abuse, homelessness, poverty, educational failures of a combination these factors. The FBI sex trafficking Houston unit reports that most every sex trafficked child was previously a victim of child sexual abuse. 

**Trafficking is not a voluntarily move towards a life in the sex trade.** According to Polaris Project, 10% of calls to the National Human Trafficking Hotline involve cases where the child was actually trafficked by family or an intimate partner. The selling of children is often done for financial gains. When a father sells his child for sex to make a car payment, it is *familial sex trafficking and child abuse*. When a mother makes her child work long hours at the family business under duress instead of going to school, it is *familial labor trafficking and child abuse*. When a teenage boy convinces his girlfriend to sell sexual favors to feed his drug addiction, it is *intimate partner sex trafficking and teen dating violence*. And when these dynamics collide, it is very easy to see only one type of abuse and miss the others. Understanding all the unique factors associated with these different victimizations is critical to ending it.

The population of trafficked children does not have just one story. It is critical that the agencies that are designed to help children are aware of and informed by the individual victim’s experience because these victims are difficult to identify: They are physically and psychologically controlled by their abusers; trained to tell lies and false stories; technology and make-up helps to disguise their age; they are frequently isolated and have a deep-seated mistrust of authority figures, especially of service providers and law enforcement. More importantly, they frequently do not label themselves “victims”.

Local law enforcement, juvenile justice, mental health, medical providers, social services, school districts and child protective services are not trained to deal with the complex and varied services this population requires given their unique needs. These institutions and systems are designed to serve a different population base. This often creates an unintended dynamic in which caseworkers serve a very specific and limited role and cannot see the victim as an individual with multiple and complex needs. For this reason, forming coalitions developing and encouraging cross-department and cross-agency trainings and educating these personnel as to what services to access, where and who to contact when these complex cases arise, is critical.

With the exception of Letot Center in Dallas (which only serves child victims in Dallas County), there is a lack of emergency shelters and trained staff for emergency shelters in Texas.
Texas Statewide Blue Ribbon Task Force

Lifeworks in Austin and Freedom House in Houston do provide some emergency shelter for teens. In addition, there is a lack of funding to support adequate medical and dental services, safe and affordable transitional housing, life skills programs, or criminal justice remedies such as aggressive arrests and prosecution for pimps and Johns, as well as information and training for responders. Ultimately, our response to child sex trafficking is woefully inadequate and prevention efforts are almost non-existent. This is a dangerous combination.

There are no programs to prevent child sex trafficking currently offered in Texas schools. There are a few awareness programs offered in Houston schools through “Rescue & Restore”. This most vulnerable population requires information to protect themselves from this crime and the resources they need to escape.

There are two recognized child trafficking curricula; “Tell Your Friends” and “My Life, My Choice”. These Human Trafficking Awareness programs are for both potential victims and bystanders. “Tell Your Friends” is a 4 hour lesson plan designed for middle and high school girls (Washington, D.C.) “My Life, My Choice” is 10 (75 minute) sessions of a psycho-educational model for high-risk teenage girls (Boston). The later program has been evaluated for a change in attitudes and knowledge. Although these programs may be promising, the obvious shortcoming is that these programs are designed for girls, and therefore, there is a need for programs to be developed which are aimed specifically for boys and for prevention of child labor trafficking.

**Recommendations:** The state should develop a comprehensive plan for the identification and care of children who are victims of child sex trafficking. A comprehensive plan would include prevention and evaluation strategies.

### Bullying

Bullying is peer-on-peer violence and is a form of CA/N. Norwegian psychologist Dan Olweus pioneered the earliest definition of bullying to include aggressive or negative acts that were directed toward a student repeatedly over time by one or more students. Keys to his definition of
bullying were three criteria of: Intention, repetition, and an imbalance of power\textsuperscript{46}. It is estimated that bullying, nationally and internationally, affects 10\% of students\textsuperscript{47}. However, the definition of bullying excludes both trivial and serious acts of peer aggression. Prevention of peer violence in childhood and adolescence has traditionally focused on bullying prevention programs. When schools implement prevention programs, the intention is to prevent all acts of aggression, not just acts defined by repetition and an imbalance of power\textsuperscript{48}.

The prevention of peer violence needs to include bullying as well as peer victimization. Peer victimization includes physical assault, intimidation, emotional victimization, dating violence, peer sexual assault and internet harassment, as well as property crimes. In the Developmental Victimization Survey, 20\% of children ages 2-17 years reported being hit or attacked by a peer in the prior year with younger children experiencing similar levels of recurrent attacks and trauma symptoms as older children\textsuperscript{49}. Bullying, per se, actually peaked in children ages 6-9 years and dropped off in subsequent years\textsuperscript{50}. In 2008, almost 3000 youth ages 6-17 years were participants in the National Survey of Children’s Exposure to Violence (NatSCEV). The most common type of victimization reported by 20\% of the youth was physical assault. Property crimes, such as vandalism, theft, or robbery, were almost as common affecting almost 15\%. Sexual victimization, whether by sexual assault or harassment, affected as many as 6\% of the youth and was disproportionately seen in females and older adolescents ages 14-17 years. What is more concerning is that youth report that these types of victimization occur both on and off school grounds. The majority of bias attacks, peer emotional victimization, and non-sexual genital attacks (being hit or struck in the genitals) occur on school grounds. Physical assaults occur just

as often on and off school grounds. Overall, as many as 40% of all the assaults occur off school grounds. Prevention of bullying and other forms of peer victimization is a critical key to prevention of child abuse and neglect as violence experienced during the school age years and adolescence is associated with violence and criminality in adulthood. In a longitudinal study of the effects of bullying, Olweus reported that 55% of school bullies ages 13-15 years of age were convicted of one or more crimes between the ages of 16-24 years with more than a third being convicted of 3 crimes. In a larger systematic review and meta-analysis, bullying was a significant risk factor for later offending even after controlling for other childhood risk factors. Bullies were twice as likely as non-bullies to offend later in life. This research would suggest that peer violence or bullying prevention programs in the school should be seen as early crime and child abuse prevention.

Prevention programs for bullying and peer victimization are effective with evidence dating back to the 1980’s. The Olweus Bullying Prevention Program (OBPP) was designed to restructure the school environment fostering a sense of community among students and adults such that opportunities for bullying were reduced. Surveys administered as part of the introduction of the OBPP in the First Bergen Project in 1983-1984 demonstrated significant reductions in being bullied, bullying other students, numbers of bullies, and antisocial behavior; and increases in order and discipline in school as well as positive social relationships and attitudes. The OBPP has been implemented in multiple countries and in the United States (South Carolina, Washington, California and Pennsylvania). When implemented with fidelity to the model,
OBPP can demonstrate 25-50% reductions in school-based bullying behaviors. The Olweus Bullying Prevention Program (OBPP) meets the standards for evidence-based practice as it has been refined, replicated, implemented and evaluated multiple times internationally. It has also been endorsed by the American Academy of Pediatrics\textsuperscript{56}.\textsuperscript{11} As programs to reduce violence and bullying are implemented in our schools in the US, there is already a national trend demonstrating fewer physical assaults, sexual assaults, and peer/sibling victimizations. This is demonstrated in a comparison between National Crime Victimization Surveys completed in 2003 and 2008. Physical assault as reported by youth in the surveys dropped from approximately 53% to 50%, sexual victimization from 8% to 6.7%, and bullying from approximately 22% to 15%. While these changes appear small, they are statistically significant. As states and school districts implement programs to prevent bullying and peer violence there will be change in the school climate and hopefully in peer attitudes both on and off school grounds. Bullying and violence prevention programs should be a core school-based component to an effective statewide plan for child abuse prevention.

**Recommendation:** The state currently does not have a comprehensive state-wide plan for addressing bullying in our schools. The school and community-based bullying strategies and recent enacted anti-bullying legislation should be evaluated by the state for efficacy.

**Effects of Child Maltreatment on Mental Health Functioning**

Few associations in the mental health literature are as well established as the relationship between child abuse and neglect and adverse-psychological consequences among adults (e.g. Browne and Finkelhor 1986; Kendall-Tackett, Williams, and Finkelhor 1993; Polusny and Follette 1995; Kessler et al. 1997). Adults who report experiences of abuse and neglect as children, compared to those who do not, also report considerably higher rates of virtually every type of psychopathology including depression, anxiety, drug and alcohol disorders, personality disorders, and generalized distress. Adults who suffer sexual and physical abuse or severe neglect as young children are more likely to suffer from dysthymic symptoms and to act out and adult women are more likely to have more symptoms of alcohol problems than persons who

Texas Statewide Blue Ribbon Task Force

grew up in comparable environments but did not suffer from court substantiated cases of childhood abuse and neglect. (Horwitz, Widom, McLaughlin, White 2001).

Yet, a considerable body of research indicates that life experiences, including those that occur in childhood, do not occur in isolation from socio-economic, familial, and relational contexts (Pearlin 1989; Aneshensel 1992; Turner, Wheaton, and Lloyd 1995; Turner and Lloyd 1995). Childhood victimization is typically part of a matrix of environmental problems such as poverty, unemployment, parental alcohol and drug problems and inadequate family functioning (Straus and Gelles 1989; Widom and White 1997; Kruttschnitt, McLeod, and Dornfeld 1994).

Childhood victimization produces poor mental health outcomes among children. Poor early mental health could elevate the risk of self-anesthetizing behaviors in abusing substances, leading to poor school outcomes, juvenile delinquency, and adult incarceration among other outcomes. Child victimizations also increases the risk of experiencing subsequent life stressors such as getting fired from jobs, unemployment, and divorce, which in turn are strongly related to poor mental health among adults (Kessler et al. 1997; Kessler, Davis and Kendler 1998). The psychological consequences of abuse and neglect in childhood serve as stress proliferators that amplify the disadvantage of persons in stressful environments (cf. Pearlin 1989). The influence of these early childhood experiences varies depending on what happens to adults in subsequent stages of the life course. In particular, stressful life events that occur later in the life course influence how much effect childhood victimization will have on subsequent outcomes. When childhood victims of abuse or neglect do not experience more stressors than controls, they do not have worse mental health outcomes (alcohol problems, dysthymia, or antisocial personality disorder) as adults. Thus, not only do early childhood events affect later life experiences, but these later life experiences also affect how consequential these earlier events will be for subsequent mental health (Brown 1986; Elder 1998; Kagan 1998).

The impact of dire childhood experiences on later psychological outcomes is not simple and direct (Brown 1986; Elder 1998). Instead, the way early experiences affect later mental health varies in light of events that occur across the life course. The long-term mental health impacts of childhood victimization unfold within the context of a lifetime of stressors. Further, these effects
Texas Statewide Blue Ribbon Task Force

diverge considerably for men and women. These results indicate the importance of the structural
and temporal contexts of life experiences (Pearlin 1989; Turner et al. 1995; Turner and Lloyd

Decades of research has shown that most mental, emotional, and behavioral disorders have their
roots in childhood. Child maltreatment exacerbated by high risk environments results in
disorders that interfere with a person’s ability to accomplish normal developmental tasks, such as
developing healthy relationships, succeeding in school, and transitioning to the workforce.
These disorders also affect the lives of family members and society as a whole. The quantifiable
annual cost of these disorders is in the hundreds of billions of dollars. There currently is a
national shortage of qualified mental health professionals who can provide effective care to
children. In Texas, where approximately 1/3 of all hospitalized children have a mental health
diagnosis57, this scarcity is accentuated. The absence of qualified mental health providers for
children who have been victims of CA/N means that we can expect to increase the burden of
CA/N on future generations. Timely and effective mental health services to child victims of
CA/N would attenuate its impact.

Recommendation: The limited availability of qualified mental health professionals who can
provide care to children presents a profound future burden of limited economic production
and increased medical, mental health and law enforcement financial burden. The SBRTF
feels strongly that scarcity of mental health professionals available for children is a dire
need which needs to be prioritized.

Moving Forward

The first term of the Statewide Blue Ribbon Task Force (SBRTF) has been very productive. In
the 18 months since we were first appointed and met, we have had dozens of in-person meetings
and conference calls. We have taken written and verbal testimony from experts within the state
and from across the country. We have taken the charges before us with great seriousness and
pride. The report which we submit is an accurate and true account after extensive reflection,

57 Netherton, Van Horne, Helton and Greeley (manuscript under review)
discussion and judgment. With the 82\textsuperscript{nd} Legislative Session recently completed, it is now time to look forward and begin to map out the strategy to both realize the recommendations we put forth in this report, and to articulate a broader scope for the SBRTF. The crucial passage of SB 1154, which again creates the SBRTF for the next biennium, was the cornerstone and springboard of our moving forward.

The 82\textsuperscript{nd} Legislative Session was a time of profound reduction is state expenditures and resources impacting the vulnerable children in Texas. While the legislative budget reductions will impact all Texans, children, especially our poorest, most vulnerable children, will bear the largest burden. Careful planning for the future is imperative. Our Texas Spirit will find a way to not only cope with the new reality, but to thrive. With this goal in mind, the BRTF believes that some fundamental domains need to be addressed as we move forward.

"We have to make sure we don't lose sight of the important things… and children, public safety, quality of life… those issues are really important. We don't want to lose that in all of this debate."


**Prioritization of Resources**

As noted, the overall cuts to PEI child abuse prevention programs last biennium were approximately 44% of the total prevention dollars under PEI, with some programs being impacted more than others.\textsuperscript{58} The cuts range from 13% (Services to At-Risk Youth or STAR) to 74% cuts to competitively procured, evidence-based programs for at risk children.

The two largest prevention programs in PEI are STAR and Community Youth Development (CYD). The STAR program received a 13% reduction in funding. This is a reduction of over $5 million per year below the last biennium amount. This reduction will mean a decrease of over 800 children per month no longer receiving STAR services. The CYD program budget was cut by 32% for the biennium. This reduction will mean a decrease of over 2,000 children per month no longer being served. While these two programs suffered serious cuts, three other programs (Family Strengthening, Community Based Family Services and Tertiary Child Abuse Prevention Services) suffered the deepest cuts. These services to at risk children had 74% of their funding

\textsuperscript{58} Funding reduction data provided by Audrey Deckinga, DFPS Assistant Commissioner for Child Protective Services; Testimony to BRTF, July 5, 2011
Texas Statewide Blue Ribbon Task Force

cut. These combined cuts represent an additional 4,000 children per month not receiving these services.
These profound reductions in support will require that DPFS, and PEI in particular, prioritize the services it delivers. Currently, the strategy for prioritization of dollars and resources is opaque. The limited budget will force PEI to articulate how resource decisions are to be made. It remains unclear whether the current programs that are funded, aside from those home visiting programs and the few other showing efficacy, are all effective. Concrete metrics need to be developed and implemented to ensure that the limited dollars are spent is the most meaningful way. The PEI and DFPS leadership will be forced to decide how to best distribute these scant dollars. For example, should resources be directed to programs which have a limited preventative impact but touch a lot more families, or should the money be directed towards programs and services with a clearly more solid evidence base of effectiveness (Home Visitation, i.e. Nurse-Family Partnership) and positive return on investment? These will be important decisions for the leadership to make. Clearly, a haphazard distribution strategy will produce limited success.
As we enter into the 83rd Legislative session, prevention (PEI) once again is marginalized. In testimony to the SBRTF on July 23, 2012 it was outlined that PEI was number 12 out of 13 “Exceptional Items” listed for funding restoration by DFPS during the LAR exercise.59

Expanding the Task Force Domains

Our 18 months of work has exposed the SBRTF to a broad array of potential areas that are in need of deeper exploration in developing a comprehensive prevention strategy for the state. Our primary focus was to get a broad, vast and comprehensive understanding of the most vulnerable children and scope of services available in their communities. We received testimony from community providers and state officials who contributed to our understanding of the tremendous scope of domains which contribute to a Texas child being at risk of abuse and neglect. The SBRTF should methodically and thoughtfully explore some additional areas of focus. These potential areas would include:

Sexual Abuse:

While we initially focused on physical abuse, emotional abuse and neglect, we are quite aware that child sexual abuse remains a significant and most insidious pathology. Indeed, child sexual

59 Testimony by Cindy Brown (CFO, DFPS) on July 23, 2012
abuse consequences can be more damaging in scarring the psyche of the survivor than other forms of child abuse. There are some promising strategies that exist, both in the state and in other states, which are critical for the SBRTF to explore. Texas has taken national leadership in legislation and policy regarding human trafficking, or domestic minor sex trafficking, to which child sexual abuse is closely tied. Moreover, Texas has passed laws mandating child anti-victimization training be taught in public schools and in legislation mandating child care providers and new teaching professionals are training in recognizing, reporting and preventing child abuse. However, there is much more to do in this arena.

**Domestic Violence/Intimate Partner Violence:**
The co-existence of DV/IPV with child abuse and neglect is well known. A successful statewide strategy would need to include serious attention to this problem as this has been shown to be one of the most difficult problems to address. The creation of the new task force charged with addressing the link between DV/IPV and child abuse (SBS 434) is a major step forward, and the SBRTF should work closely with this entity in creating solutions.

**Bullying/Peer Violence:**
A physically abused child or adolescent does not care about the age of his or her abuser. Peer Violence is a major contributor to suicide and depression in teenage or young adulthood. The roots of teen peer on peer violence are found in youth violence and DV/IPV. The passage of SB 471 (82-R), bringing child abuse prevention training to the schools, is a potential vehicle for introducing, or expanding, bullying prevention strategies.

**Obesity and Food Insecurity:**
Over 17% of all Texas households will experience food insecurity during the year. The rate in Hispanic families can be as high as 26.8%. Food insecurity leads to both neglect (with poor school performance) and, paradoxically, obesity. Obesity is becoming a larger threat not just to the health of the child, but also to the health of the family. There are discussions in different communities as to the role the state has in dealing with a child who is developing, or has developed, health impacting obesity and whether there is a role for CPS. The SBRTF should proactively address this problem.

---

Safe Child Environments:
The passage of SB 993, clarifying the home placement policy for CPS, highlights the importance of children being maintained in a safe environment during a child abuse allegation investigation. Prior to an abuse allegation, a safe child environment is even more important. A crucial limitation to maternal school and workforce success is safe and effective childcare. One of the most efficacious and cost-effective child abuse prevention strategies is maternal education and employment. Some states have demonstrated success in families strengthening by providing child care support (i.e. tax credits or weekly child care stipends) for young mothers who are pursuing educational and employment goals. The SBRTF should evaluate potential pilot programs to support a safe childcare environment which would encourage increased maternal education or employment; a win-win.

Teen Pregnancy:
Texas has one of the highest rates of teen pregnancy in the USA, 16.8% higher than the national average. Teen pregnancy has been linked with decreased maternal school attendance and success. Maternal education is a strong protective factor in child abuse models. Teen pregnancy costs the United States over $10 billion per year. Teen pregnancy costs Texas over $1 billion per year. Bringing the teen pregnancy rate closer to the rate seen in a demographically similar state (California) would save both costs ($35 million alone in direct medical costs for 2008) and lower the risk of child abuse and neglect.

Implementation strategies:
Crucial to the success of any program is effective implementation. The growth of Dissemination and Implementation Science speaks to the fact that promising programs need to be thoughtfully rolled out across the state, if they are to be successfully brought to scale. Simply buying a program and farming it out is a wasteful strategy which increases the likelihood of failure. The thoughtful rollout of pilot programs in strategic locations within the state will go a long way in bolstering community support and ownership. A successful pilot to roll-out model to emulate for prevention investment is the Maternal, Infant, Early Childhood, Home Visitation Program (MIECHVP) implementation in Texas. Initially, a 2006 pilot program in Dallas serving 100

---

families utilizing the Nurse-Family Partnership curriculum was subsequently expanded via enabling legislation, SB156-80 (R), reaching 2,000 at-risk mothers, infants and their families by 2010. (See Previous Section “Home Visitation”). Due to the state General Revenue portion of funding (approximately $5.6 million per year), Texas was able to pull down an additional $11.8 million per year from MIECHVP serving approximately 4,250 families across the state of Texas in 2012.

During the 82nd Legislative session, Senator Carlos Uresti’s passage of SB1154 reinstated the SBRTF. The bill charges the SBRTF to “develop a strategy to reduce child abuse and neglect and improve child welfare”. This charge is quite similar to the initial charge of SB 2080 from the 81st Legislative session. As with the initial charge, the new charge is broad and ambitious. There can be neither quick, nor easy solutions to the state’s child abuse problems. Solutions must be as broad and ambitious as the charge itself. It will require years, and perhaps decades, to realize success. A cornerstone to the slow and steady improvements in the life of the children in the state is sustainability.

Sustainability will require innovation in how the state delivers, monitors and funds prevention its programs and initiatives. The different prevention structures within the state may require a novel infrastructure. A public-private partnership would allow the state to leverage the local engagement of community groups and stakeholders to extend state and federal resources. The more buy-in community groups have, the more sustainable the local efforts will be. A clearly defined public-private partnership will, in the long run, increase the likelihood of success of programs. Communities will rally around programs in which they feel a sense of ownership. The role of the state effort could be to emphasize capacity building and innovation and encourage local or regional resources for service delivery.

Support for the State’s prevention infrastructure needs to also attend to sustainability. As demonstrated by the 82nd Session, child abuse prevention resources and funding remain vulnerable to other budgetary forces. To generate a sustainable prevention plan, funding for prevention services needs to be more secure and less exposed to redirection. A concrete example of how the state can improve, in a meaningful way, its child abuse prevention efforts is to
administrate the Children’s Trust Fund dollars in following legal statute. As the Children’s Trust Fund is lawfully intended to be used to support primary child abuse prevention efforts, which it currently does not, these dollars should be redeployed in a manner which would form the seed of an ambitious, sustainable state strategy. The next SBRTF should be encouraged to redirect the Children’s Trust Fund dollars to the central mission of primary prevention. The Children’s Trust Fund dollars would have a more meaningful, sustainable impact, and would be in accordance with Texas statute, if used to seed promising, community-based prevention strategies. These strategies could use the Children’s Trust Fund dollars to draw down more local dollars, and even federal dollars. These strategies could be piloted in regions throughout the state, with successful strategies rewarded with greater state and federal support.

Currently, PEI is given little latitude in spending money it is allocated. This is an inefficient process, which results in funding of ineffective and outdated services. Experts in prevention, within DFPS/PEI, the SBRTF and community stakeholders in the state, should be afforded a larger role in how prevention services are actually allocated. A public-private partnership of experts in evidence-based, community centered, primary prevention who have the long-term view of outcomes on the horizon, would be a more efficient, cost-effective and responsive mechanism to allocate prevention resources. The pairing of experts in the field of prevention with the authority and capacity of the state of Texas could maximize the local and regional funding and philanthropy, as well as leveraging larger federal grant support, while keeping the expenses of the state in check. This public-private partnership could report directly to the legislature. This public-private partnership would have direct access to the resources utilized for prevention.

**Conclusion**

The SBRTF members recognize that the national and state recession creates fiscal constraints on the state of Texas. Despite these real and pressing forces, we must not become distracted from the most important charge of every state and every government: The protection of its most vulnerable citizens from harm. The decisions we make about how we allocate our resources reflects our priorities. There are obvious economic benefits to supporting families and
Texas Statewide Blue Ribbon Task Force

preventing abuse of our children, but our real motivation must not be financial, but moral. The prevention of child abuse is the right thing to do. Texas is, in many ways, at a crossroads.

_There is no moral precept that does not have something inconvenient about it._ Denis Diderot
Index of Appendices

Appendix 1: DFPS Prevention and Early Intervention (PEI) Division and Comparison
Appendix 2: Texas Home Visiting Program Outcomes, Return on Investment (ROI), and Levels of Evidence Supported
Appendix 3: Examples of Evidence-Based and Promising Programs Operating in Texas with Program Description
Appendix 4: Federal and State Funding for Child Abuse Prevention
Appendix 5: Texas Children’s Trust Fund Legislation
Appendix 6: Prevention Plans from Other States
Appendix 7: Child Abuse Prevention Program Pilot Revenue source: Birth Certificates
Appendix 8: Agendas from the 2012 Meetings of the Statewide Blue Ribbon Task Force
Appendix 9: Statewide Blue Ribbon Task Force Member Biographies
## Texas Statewide Blue Ribbon Task Force
### APPENDIX 1 - DFPS Prevention and Early Intervention (PEI) Division and Comparison

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR PROGRAM Services to At-Risk Youth Program</td>
<td>$40,814,988</td>
<td>$34,942,670</td>
<td>-14.4</td>
<td>$42,001,720</td>
<td>20.2</td>
<td>$42,001,721</td>
<td>0</td>
<td>$40,883,159</td>
<td>-2.6</td>
<td>$36.56</td>
<td>-11%</td>
</tr>
<tr>
<td>CYD PROGRAM Community Youth Development Program</td>
<td>15,111,901</td>
<td>13,105,282</td>
<td>-13.3</td>
<td>$15,795,196</td>
<td>20.5</td>
<td>$15,695,197</td>
<td>0</td>
<td>14,720,766</td>
<td>-6.2</td>
<td>$10.07</td>
<td>-32%</td>
</tr>
<tr>
<td>TEXAS FAMILIES PROGRAM Texas Families: Together and Safe Program</td>
<td>9,004,687</td>
<td>8,336,882</td>
<td>-7.4</td>
<td>$8,336,882</td>
<td>0</td>
<td>8,243,756</td>
<td>-1.1</td>
<td>7,563,578</td>
<td>-9%</td>
<td>$5.22</td>
<td>-31%</td>
</tr>
<tr>
<td>CHILD ABUSE PREVENTION GRANTS-Community Based Child Abuse Prevention-Fed. Grant</td>
<td>3,451,992</td>
<td>3,584,774</td>
<td>3.8</td>
<td>$3,584,774</td>
<td>0</td>
<td>3,591,698</td>
<td>.2</td>
<td>3,281,334</td>
<td>-9.5%</td>
<td>$3.28</td>
<td>0</td>
</tr>
<tr>
<td>OTHER AT-RISK PREVENTION PROGRAMS (Formerly program line items such as HFA, Family Outreach, PAT, other in-home visitation)</td>
<td>23,416,432</td>
<td>0</td>
<td>-100%</td>
<td>$9,360,564</td>
<td>+100</td>
<td>$13,911,733</td>
<td>48</td>
<td>17,521,606</td>
<td>26%</td>
<td>$4.58</td>
<td>-74%</td>
</tr>
<tr>
<td>AT-RISK PREVENTION PROGRAM SUPPORT At-Risk Prevention Services Program Support (PEI staff support plus Runaway and Youth Hotlines)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>$4,883,152</td>
<td>$3,711,208</td>
<td>-31.6</td>
<td>4,139,014</td>
<td>11.5%</td>
<td>$2.26</td>
<td>$61.995.401</td>
<td>-30%</td>
</tr>
<tr>
<td>TOTAL PREVENTION</td>
<td>$91.8</td>
<td>$60</td>
<td>-34.6</td>
<td>$83.9</td>
<td>+40%</td>
<td>$87,155,313</td>
<td>+3.9%</td>
<td>$88,109,457</td>
<td>7.2%</td>
<td>$61.995.401</td>
<td>-30%</td>
</tr>
</tbody>
</table>
# Texas Statewide Blue Ribbon Task Force

## Appendix 2. Texas Home Visiting Program Outcomes, Return on Investment (ROI), and Levels of Evidence Supported

<table>
<thead>
<tr>
<th>Texas Home Visiting Program</th>
<th>Examples of Program Outcomes</th>
<th>Annual Prgm Cost per Family</th>
<th>ROI</th>
<th>Levels of Evidence Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents as Teachers (PAT)</td>
<td>At age 3, children in PAT were more likely to be fully immunized and less likely to be treated for injury in prior year; PAT parents scored higher on 4 of 6 parent knowledge scales, including importance of physical stimuli in their child's development, appropriate discipline, and knowledge of child development. Children showed higher levels of school readiness and outperformed their peers in 1st - 4th grades</td>
<td>$2,650 (2011)</td>
<td>Long-term net return of $765 per person; $1.18 return per dollar</td>
<td>Yes</td>
</tr>
<tr>
<td>Nurse-Family Partnership (NFP)</td>
<td>Randomized Controlled trials (Elmira) - Follow-Up Child age 15 and 19: 48% reduced child abuse and neglect; 44% reduced maternal behavioral problems from use of alcohol/drugs; 69% fewer maternal arrests; 50% increase in maternal marriage; 54% fewer adolescent arrests and 81% fewer convictions; 63% fewer adolescent sexual partners; 40% fewer adolescent cigarettes smoked and 51% fewer days consuming alcohol</td>
<td>$4500 (national avg. $2914 - $6463)</td>
<td>Long-term net return of $13,181 per person; $2.37 return per dollar</td>
<td>Pacific Inst. for Research &amp; Eval-Net savings per child through age 3: $3,270; age 9: $8,036 54% ROI; RAND-$5.70 return per dollar for high-risk families (2005); $1.26 for low-risk (2003)</td>
</tr>
<tr>
<td>Home Instruction for Parents of Preschool Youngsters (HIPPY)</td>
<td>School Readiness - HIPPY children: 93.5% were “avg.” or “above avg.” in classroom adaptability, 91.4% avg. or above avg. in classroom behavior, 84.2% in TX were “ready for kindergarten” HIPPY Parent Involvement: 76.0% more time spent engaging children in literacy activities at home; 82.6% had more contact with school personnel; 80.6% more involved with child’s school</td>
<td>$1,200 to $2,000 (2011)</td>
<td>Long-term net return of $1,476 per person (2004); $1.80 return per dollar</td>
<td>Yes</td>
</tr>
<tr>
<td>Early Head Start (EHS)</td>
<td>EHS fathers more likely to be involved in child’s life; both EHS parents more emotionally supportive of child. Children (especially aged 0-3) show improved cognition and development; also display less problem behavior and more prosocial behavior</td>
<td>$7,600 (2009)</td>
<td>Long-term net loss of $8156; $0.22 benefit per dollar of cost**</td>
<td>Yes</td>
</tr>
<tr>
<td>Texas Home Visiting Program</td>
<td>Examples of Program Outcomes</td>
<td>Annual Prgm Cost per Family</td>
<td>WA State Institute for Public Policy</td>
<td>Other</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>-----------------------------</td>
<td>--------------------------------------</td>
<td>-------</td>
</tr>
<tr>
<td>Positive Parenting Program (PPP)</td>
<td>After enrollment in Triple P, reduced substantiated child abuse (25%), hospital/ER visits (35%), and out-of-home placements (33%); mothers reported less mental stress and better mental health overall; children displayed less problem behavior, and parents were better able to appropriately handle any problem behavior that occurred</td>
<td>Varies by level (5 levels). Range: $1-$12</td>
<td>Long-term net return of $722 per person; $6.06 return per dollar</td>
<td>PPP pays for itself by averting .5% of child conduct disorder; Children at Risk study (2012); total cost savings of $12,466,502; Rate of ROI: 8%</td>
</tr>
<tr>
<td>Healthy Families America (HFA)</td>
<td>From New York: Statistically significant differences showing HFNY participants vs. control, had fewer low-birth weight babies, were less likely to report neglecting their children, and reported committing fewer acts of severe physical abuse, minor physical aggression, and psychological aggression against their children (self-report)</td>
<td>$3,214 to $3,892 (2011)</td>
<td>Long-term net loss of $2011 after accounting for costs; $0.56 return per dollar</td>
<td>Women in NY saved gov’t avg of $628 compared to controls, net program cost of $4101, return of $15 for every dollar invested</td>
</tr>
<tr>
<td>AVANCE Parent Child Education Program</td>
<td>Randomized-Controlled trial showed one year after completing prgm, mothers provided more (a) organized, stimulating, and responsive home environment, (b) developmentally appropriate toys; Mother also (a) interacted more positively, (b) initiated more social interactions, (c) used more consistent praise, (d) spent more time teaching, (e) spoke more, and (f) used more developmentally appropriate speech with their child; Moms also were more encouraging of child's verbalizations</td>
<td>$888</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Texas Statewide Blue Ribbon Task Force

#### Nurturing Parenting Program

- **Examples of Program Outcomes:**
  - After 2 years in Nurturing Parenting, substantiated cases of child abuse and neglect decreased as well as reports of child maltreatment. Parents had increased empathy, better role-reversal abilities, more appropriate beliefs about harsh discipline, and more appropriate expectations of their child's development.

- **Avg. Annual Prgm Cost per Family:**
  - Avg. $800-$1,200 for 15 week prgm; $2,000 max

- **ROI:**
  - No* 3

- **Levels of Evidence Support:**
  - 31 DePelchin Children's Center also 25, 27, 28, 30

- **NREPP-SAMHSA Ratings**

#### Appendix 2(Cont.) Texas Home Visiting Program Outcomes, Return on Investment (ROI), and Levels of Evidence Supported

<table>
<thead>
<tr>
<th>Texas Home Visiting Program</th>
<th>Examples of Program Outcomes</th>
<th>Annual Prgm Cost per Famil</th>
<th>ROI</th>
<th>Federal - Defined EB HV Prgm</th>
<th>Levels of Evidence Support</th>
<th>Other Endorsements</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incredible Years</td>
<td>After 18 months in Incredible Years program, moms reported significant decreases in levels of stress and depression. Parents displayed more positive, supportive, competent, and consistent parenting, including using more positive discipline and using less harsh discipline. Contact with health and social services decreased after 18 months in program. Children displayed greater decreases in problem behavior at 18-month follow up and received fewer diagnoses of Conduct Disorder and Oppositional Defiant Disorder at 5-6 year follow-up</td>
<td>Avg. $2,579 - $2,868</td>
<td>Long-term net return of $408 per person for parent training; $1.20 return per dollar</td>
<td>No*</td>
<td>Exemplary</td>
<td>Proven</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>U of H EBP Score</td>
<td>CA Clearinghouse</td>
<td>OJJDP</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Does not meet the Federal definition of home-visiting because majority of services for all clients do not occur in the home

** NOTE: this is for all EHS - not just home-based component

#### Examples of References used in this Table


Texas Statewide Blue Ribbon Task Force


# Texas Statewide Blue Ribbon Task Force

## Appendix 3. Examples of Evidence-Based and Promising Programs Operating in Texas with Program Description

<table>
<thead>
<tr>
<th>Program</th>
<th>Offered States</th>
<th>Total TX Families Served in XX Counties</th>
<th>Enrollment Criteria</th>
<th>Age of Child Served</th>
<th>Program Goals</th>
<th>Service Intensity / Duration</th>
<th>Home Visitor Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents as Teachers (PAT)</td>
<td>50 (plus DC)</td>
<td>5308; Atascosa, Bandera, Bexar, Cherokee, Colorado/Fayette, Comal, Crosby, Dallas, Ector, Fort Bend, Frio, Gregg, Hale, Harris/Chambers, Hays/ Caldwell, Hockley, Hopkins, Karnes, Lubbock, Lynn, McLennan, Midland, Nueces, Potter/Hutchinson/Swisher, Real, Tarrant/Wise/Denton, Terry, Travis, Willacy/Hidalgo, Williamson, Young</td>
<td>Must be willing to engage in services for at least two years; sites determine other requirements</td>
<td>Prenatal to age 5</td>
<td>(1) Increase parent knowledge of early childhood development and improve parenting practices (2) Provide early detection of developmental delays and health issues (3) Prevent child abuse and neglect (4) Increase children's school readiness and school success</td>
<td>At least 10-12 home visits annually; higher-need families receive 20-24 visits for at least two years</td>
<td>High school diploma/GED, 2 years experience with young children or parents; complete PAT trainings; annual certification renewal</td>
</tr>
<tr>
<td>Nurse-Family Partnership (NFP)</td>
<td>42</td>
<td>2650; Bexar, Chambers/Hardin/Jefferson/Orange, Dallas/Tarrant, El Paso, Galveston/Harris/Fort Bend, Gregg, Hale/Hockley/Lamb/Terry/Lubbock/Crosby/Floyd/Garza/Lynn, Nueces, Potter, Travis/Williamson, Webb, Willacy/Hidalgo</td>
<td>First-time, low-income moms enrolled and willing to receive a home visit by end of 28th week of pregnancy</td>
<td>Prenatal to age 2</td>
<td>(1) Improve: (a) pregnancy outcomes, (b) child health / development, and (c) economic self-sufficiency of the family (2) Reduce domestic violence (3) Promote father involvement</td>
<td>About 64 home-visits for 60-75 minutes (weekly, every other week, then monthly)</td>
<td>Registered nurse with a BA (MA preferred); 3 Pre-Service core NFP education sessions; Annual education supplements</td>
</tr>
<tr>
<td>Home Instruction for Parents of Preschool Youngsters</td>
<td>22 (plus DC)</td>
<td>1496; Cherokee, Dallas, Ector, Gregg, Harris, Nueces, Potter, Willacy/Hidalgo</td>
<td>Parents with limited formal education with young children</td>
<td>Age 3 to age 5</td>
<td>(1) Help parents prepare children for success in school and all aspects of life (2) Empower parents to be child’s first teacher (3) Provide parents with skills, confidence, and tools needed to successfully teach their child in their home</td>
<td>30, 1-hour, weekly home visits in school year; parent group-meetings at least 6 times per year</td>
<td>Minimum of high school diploma/GED; receive ongoing training; live and work in community they serve</td>
</tr>
<tr>
<td>Early Head Start (EHS)</td>
<td>50 (plus DC and Puerto Rico)</td>
<td>1221; Bastrop/Lee, Bell/Coryell, Bexar, Bowie, Brazos, Dallas, Dawson, Garza, Grayson/Collin/Rockwall, Gregg, Harris, Liberty/Montgomery/NF Harris, Lubbock, McLennan, Nueces, Potter/Randall/Deaf Smith/Hutchinson/Gray, Shelby/Sabine/San Augustine/Jasper/Tyler/Newton/Angelina, Terry, Travis, Webb, Wichita</td>
<td>Low-income families with children ages birth-3</td>
<td>Prenatal to age 3</td>
<td>(1) Promote healthy prenatal outcomes for pregnant women (2) Enhance the development of young children (3) Promote healthy family functioning</td>
<td>Weekly, 90-minute, home visits for at least a year; 2 socialization events monthly</td>
<td>Must hold a Child Development Associate (CD) credential and be trained in early childhood development</td>
</tr>
<tr>
<td>Healthy Families America (HFA)</td>
<td>40 (plus DC and 5 US territories)</td>
<td>530; Concho, Dallas, Runnels, Tom Green, Travis</td>
<td>Low-income mothers; recruited prenatally or shortly after birth</td>
<td>Prenatal to age 5</td>
<td>(1) Build and sustain community partnerships to engage overburdened families (2) Strengthen parent-child relationship (3) Promote child health and development (4) Enhance overall family functioning by reducing risk and</td>
<td>Weekly home visits until child is as least 6-months-old; after, home visits occur less often until child is</td>
<td>No specific education requirements; recommended they have experience working with families who have multiple needs</td>
</tr>
</tbody>
</table>
## Appendix 3 Continued. Examples of Evidence-Based and Promising Programs Operating in Texas with Program Description

<table>
<thead>
<tr>
<th>Texas Home Visiting Program (PPP)</th>
<th>Offered in XX States</th>
<th>Total TX Families Served in XX Counties</th>
<th>Enrollment Criteria</th>
<th>Age of Child Served</th>
<th>Program Goals</th>
<th>Service Intensity / Duration</th>
<th>Home Visitor Credentials</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Positive Parenting Program (PPP)</strong></td>
<td>29</td>
<td>175 : Galveston, Tarrant (Plus Dallas location that does not currently offer HV and a pilot location about to begin in Houston)</td>
<td>Parents or caregivers of child aged birth to 9-16 (depending on location) who are at-risk for child maltreatment</td>
<td>Birth to age 16</td>
<td>(1) Promote (a) independence and health of families (b) developmental of non-violent, protective and nurturing environments (c) child development, growth, health and social competencies (2) Reduce incidence of child abuse, mental illness, behavioral problems, delinquency and homelessness (3) Enhance parent competence, resourcefulness and self-sufficiency</td>
<td>Varies depending on needs of family; home visits may consist of one consultation to more than 10 visits</td>
<td>Professional practitioners with a post-secondary degree in a field such as health, education, or social services; Accredited training courses for services</td>
</tr>
<tr>
<td><strong>AVANCE Parent Child Education Program</strong></td>
<td>3</td>
<td>5235: Bexar, Dallas, El Paso, Harris, McLennan, Travis, Willis/Starr/Hidalgo/Cameron</td>
<td>Low-income Hispanic families with children; age not specified</td>
<td>Not specified</td>
<td>Enhance child rearing skills of parents with young children so they are better able to foster optimal development of their children</td>
<td>Home visits occur monthly for nine months</td>
<td>BA in Education/related field; complete AVANCE training and obtain yearly updates</td>
</tr>
<tr>
<td><strong>Incredible Years</strong></td>
<td>At least 18</td>
<td>75 (used in HV format); Hays, Travis, Williamson</td>
<td>Parents, teachers, and children; prevention version for high-risk populations</td>
<td>Birth to age 12 (programs target ages 0-3 and 3-6).</td>
<td>(1) Promote emotional and social competence (2) Prevent, reduce, and treat behavior and emotional problems in young children; (3) Improve parent-child interactions, (4) Improve teacher classroom management skills and teacher-parent partnerships</td>
<td>One, 2-hour weekly visit; 8-20 sessions total depending on program; typically 14 visits for prevention</td>
<td>Master's level (or equivalent) clinicians and must become certified by program</td>
</tr>
<tr>
<td><strong>Nurturing Parenting Program</strong></td>
<td>50</td>
<td>656 (used in HV format); Bexar, Concho, Crockett, Guadalupe, Runnels, Tom Green, Travis</td>
<td>Families at-risk for abuse and neglect</td>
<td>Birth to age 18 (targets birth to age 5 group)</td>
<td>(1) Prevent recidivism of families receiving social services (2) Lower rate of teenage pregnancies (3) Reduce rate of juvenile delinquency and alcohol abuse (4) Stop intergenerational cycle of child abuse by teaching positive parenting behaviors</td>
<td>48-50 weekly home visits lasting 90 minutes, but frequency and length vary depending on need</td>
<td>Para- or professionals trained in fields such as social work, education, or psychology</td>
</tr>
</tbody>
</table>

*These are EB or Promising curriculums sometimes used in an HV setting*
Examples of References used in this Table


<table>
<thead>
<tr>
<th>Method of Financing</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Recovery &amp; Reinvestment Act (ARRA)</strong></td>
<td>Temporary economic stimulus funds</td>
</tr>
<tr>
<td>Adoption Incentive Payments</td>
<td>Social security funds based on keeping adoption numbers at certain levels (i.e. ensuring older children are adopted)</td>
</tr>
<tr>
<td>Guardianship Assistance</td>
<td>Payments to relatives who enter into permanency care assistance agreements with the state</td>
</tr>
<tr>
<td><strong>Title IV-B, Part 1, Child Welfare Services</strong></td>
<td>Preventive intervention and reunification services, workforce training and development; limited use on foster care; adoption assistance – 70K based + state population 21 and under x complement of state’s average per capita income and a 24% state match</td>
</tr>
<tr>
<td><strong>Title IV-B, Part 2, Promoting Safe &amp; Stable Families</strong></td>
<td>Prevention, family based safety services, family support and preservation – allocation based on food stamp usage</td>
</tr>
<tr>
<td><strong>Refugee &amp; Entrant Assistance</strong></td>
<td>Prevention services to families at risk or in crisis; portion of funds can be used for system improvement</td>
</tr>
<tr>
<td><strong>State Court Improvement Project</strong></td>
<td>System improvement of court &amp; child welfare systems</td>
</tr>
<tr>
<td>Child Abuse Prevention and Treatment Act, Title 1 (Child Abuse &amp; Neglect Services)</td>
<td>Improve CPS systems</td>
</tr>
<tr>
<td>Child Abuse Prevention &amp; Treatment Act, Title 2 (Community Based Child Abuse Prevention-CBCAP)</td>
<td>The only federal funding source dedicated to child abuse prevention activities; 70% based on state population and 30% based on leveraged funds</td>
</tr>
<tr>
<td><strong>TANF</strong></td>
<td>Assistance to children to keep them in their homes (must be eligible for TANF); job preparation, support of marriage; prevent out of wedlock pregnancies (no TANF eligibility required)</td>
</tr>
<tr>
<td>Title IV-E</td>
<td>States reimbursed for expenses for eligible children in care; placement &amp; administrative costs; staff and foster parent training</td>
</tr>
<tr>
<td><strong>Title IV-E Administrative Foster Care</strong></td>
<td>States reimbursed for administrative costs associated with foster care expenses</td>
</tr>
<tr>
<td><strong>Title IV-E Adoption Assistance</strong></td>
<td>States reimbursed for administrative costs associated with adoption services</td>
</tr>
<tr>
<td>Adoption Assistance</td>
<td>States reimbursed for services to adoptive parents for eligible special needs children, court costs, etc.</td>
</tr>
<tr>
<td>Independent Living</td>
<td>Capped entitlement funding that covers basic living skills, education and employment, preventive health etc.</td>
</tr>
<tr>
<td>Education &amp; Training Voucher</td>
<td>Expenses related to post-educational and vocational training</td>
</tr>
<tr>
<td>Social Security Block Grant</td>
<td>Funds prevention, protective, and permanency services (capped entitlement)</td>
</tr>
<tr>
<td><strong>Title XIX Medicaid</strong></td>
<td>Primarily based on inverse of state’s per capita income</td>
</tr>
</tbody>
</table>

**Highlighted** sources are temporary funding sources

<table>
<thead>
<tr>
<th>Method of Financing</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Revenue</td>
<td>-</td>
</tr>
<tr>
<td>General Revenue Dedicated (CTF)</td>
<td>Funds (a portion of marriage license fees and interest from the fund) dedicated to primary child abuse prevention activities</td>
</tr>
<tr>
<td>Interagency Contracts</td>
<td>Funds received from contracts between state agencies</td>
</tr>
<tr>
<td>Appropriated Receipts</td>
<td>Funds agencies receive for sale of documents, payments for certain services and local funds</td>
</tr>
</tbody>
</table>
### Method of Financing

<table>
<thead>
<tr>
<th>Method of Financing</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Support Collections</td>
<td>Collections from child support payments made for children in state custody</td>
</tr>
</tbody>
</table>

### State of Texas Children’s Protective Services Strategies

<table>
<thead>
<tr>
<th>STRATEGY/PROGRAM</th>
<th>PURPOSE/SERVICES PROVIDED</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Support Collections</td>
<td>System to receive/assign reports of abuse/neglect that includes statewide intake delivery staff, program support and training for staff, an automated intake system, capital expenses for intake automation, and allocated program support cost pool staff</td>
</tr>
<tr>
<td>Intake</td>
<td>Investigative units, Family Based Safety Services, Conservatorship, Foster Adoption Unit, Kinship, Legal, Other Direct Delivery expenses, Contributed CPS Direct Delivery, Allocated Program Support Cost Pool Staff</td>
</tr>
<tr>
<td>Direct Delivery</td>
<td>Preparation for Adult Living Staff, CPS Program Support, CPS Program Training, County/IAC Foster Care Administrative Staff, Discretionary Federal Projects, Allocated Program Support Cost Pool Staff</td>
</tr>
<tr>
<td>CPS Program Support</td>
<td>Expenses associated with providing day care services for children in foster care</td>
</tr>
<tr>
<td>TWC Foster Day Care Purchased Services</td>
<td>Expenses associated with providing day care services for children in relative care</td>
</tr>
<tr>
<td>TWC Relative Day Care Purchased Services</td>
<td>Expenses typically associated with providing day care services for children in substitute care but also for those kinship placements that need day care but don’t qualify for Relative Day Care</td>
</tr>
<tr>
<td>TWC Protective Day Care Purchased Services</td>
<td>Services, including recruitment and screening, that increase the likelihood of securing an adoptive placement for children that need special/-intensive services including those who are of a minority/mixed race background, sibling group, age 6 and up</td>
</tr>
<tr>
<td>Adoption Purchased Services</td>
<td>Services after consummation and for those families who are receiving an adoption subsidy</td>
</tr>
<tr>
<td>Adoption Subsidy &amp; Permanency Care Assistance (PCA) Payments</td>
<td>Includes adoption subsidies, non-recurring adoption payments, the healthcare benefit subsidy, PCA payments (recurring and non-recurring)</td>
</tr>
<tr>
<td>Relative Caregiver Monetary Assistance Payments</td>
<td>Payments for financial support and reimbursement for kinship placements</td>
</tr>
</tbody>
</table>

---

*Strategies Funded by Federal & State Child Welfare Expenditures*
### STRATEGY/PROGRAM

| Community Youth Development (CYD) | Juvenile delinquency programs including mentoring, youth employment preparation etc. |
| Texas Families Together and Safe (TFTS) | Programs designed to alleviate stress and promote parental competencies, allow children to remain in their own homes, and improve and enhance access to family support services. |
| Prevention Grants to Community Based Organizations (CBO) | Increase community awareness of prevention services, promote community collaboration around parental involvement and creation, implementation and evaluation of community based programs & activities that prevent child maltreatment |
| Other At-Risk Programs | This includes the Family Strengthening Services (increase protective factors in families), Youth Resiliency Services (increase protective factors in youth), Community Based At-Risk Family Services (targets families who were investigated by CPS but allegations were unsubstantiated), and the Statewide Youth Services Network (evidenced based juvenile delinquency prevention services youth ages 10-17) |
| Other At-Risk Program Support | This includes PEI program support cost pool staff program support and training and the Runaway & Youth Hotline. |

*This information is from the DFPS – Prevention & Early Intervention web page which can be accessed at: http://www.dfps.state.tx.us/prevention_and_early_intervention/about_prevention_and_early_intervention/programs.asp

---

**Child Abuse Prevention and Treatment Act, Title 2 – Community Based Child Abuse Prevention (CBCAP)**

The federal funding that a state can leverage is based on the following formula:

1) State’s Allowable Leveraged Amount (what the state puts up for leverage that is allowable)/Total Leveraged Funds Submitted by All States = State’s Portion of Leveraged Funds Claims

2) Portion of Leveraged Funds Claims x 30% of available leveraged funds = State’s Leveraged Fund Claim Share

**The key is to put up more for allowable leverage to achieve a greater leveraged fund claim**

The table below lists the average of Texas’ portion of leveraged fund claims from 2007-2011. Although the formula is not a direct relationship between what is leveraged and what is received, the only way to strategically increase the amount of your final leveraged claim is to increase what you offer up as leverage.

<p>| Portion of Leveraged Fund Claims 2007-2011 |</p>
<table>
<thead>
<tr>
<th>State</th>
<th>Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>VERMONT</td>
<td>0.17059</td>
</tr>
<tr>
<td>ILLINOIS</td>
<td>0.13206</td>
</tr>
<tr>
<td>NEBRASKA</td>
<td>0.07683</td>
</tr>
<tr>
<td>NEW YORK</td>
<td>0.06154</td>
</tr>
<tr>
<td>MARYLAND</td>
<td>0.05336</td>
</tr>
<tr>
<td>RHODE ISLAND</td>
<td>0.04877</td>
</tr>
<tr>
<td>MISSISSIPPI</td>
<td>0.04490</td>
</tr>
<tr>
<td>WYOMING</td>
<td>0.03818</td>
</tr>
</tbody>
</table>

* Much of the detailed information regarding CBCAP can be found at http://friendsnrc.org/
<table>
<thead>
<tr>
<th>State</th>
<th>Portion</th>
</tr>
</thead>
<tbody>
<tr>
<td>TENNESSEE</td>
<td>0.03709</td>
</tr>
<tr>
<td>VIRGINIA</td>
<td>0.02618</td>
</tr>
<tr>
<td>NEW MEXICO</td>
<td>0.02489</td>
</tr>
<tr>
<td>LOUISIANA</td>
<td>0.02480</td>
</tr>
<tr>
<td>SOUTH DAKOTA</td>
<td>0.02460</td>
</tr>
<tr>
<td>ALASKA</td>
<td>0.02357</td>
</tr>
<tr>
<td>PENNSYLVANIA</td>
<td>0.01952</td>
</tr>
<tr>
<td>NEVADA</td>
<td>0.01860</td>
</tr>
<tr>
<td>NORTH DAKOTA</td>
<td>0.01608</td>
</tr>
<tr>
<td>OREGON</td>
<td>0.01485</td>
</tr>
<tr>
<td>FLORIDA</td>
<td>0.01429</td>
</tr>
<tr>
<td>MICHIGAN</td>
<td>0.01321</td>
</tr>
<tr>
<td>NEW HAMPSHIRE</td>
<td>0.01181</td>
</tr>
<tr>
<td>CONNECTICUT</td>
<td>0.01045</td>
</tr>
<tr>
<td>WASHINGTON</td>
<td>0.00935</td>
</tr>
<tr>
<td>NEW JERSEY</td>
<td>0.00855</td>
</tr>
<tr>
<td>MASSACHUSETTS</td>
<td>0.00820</td>
</tr>
<tr>
<td>SOUTH CAROLINA</td>
<td>0.00722</td>
</tr>
<tr>
<td>MONTANA</td>
<td>0.00618</td>
</tr>
<tr>
<td>WISCONSIN</td>
<td>0.00533</td>
</tr>
<tr>
<td>INDIANA</td>
<td>0.00495</td>
</tr>
<tr>
<td>OHIO</td>
<td>0.00478</td>
</tr>
<tr>
<td>COLORADO</td>
<td>0.00463</td>
</tr>
<tr>
<td>CALIFORNIA</td>
<td>0.00459</td>
</tr>
<tr>
<td>MINNESOTA</td>
<td>0.00443</td>
</tr>
<tr>
<td>KANSAS</td>
<td>0.00422</td>
</tr>
<tr>
<td>IOWA</td>
<td>0.00376</td>
</tr>
<tr>
<td>WEST VIRGINIA</td>
<td>0.00346</td>
</tr>
<tr>
<td>GEORGIA</td>
<td>0.00322</td>
</tr>
<tr>
<td>UTAH</td>
<td>0.00258</td>
</tr>
<tr>
<td>TEXAS</td>
<td><strong>0.00152</strong></td>
</tr>
<tr>
<td>OKLAHOMA</td>
<td>0.00148</td>
</tr>
<tr>
<td>ARKANSAS</td>
<td>0.00139</td>
</tr>
<tr>
<td>IDAHO</td>
<td>0.00100</td>
</tr>
<tr>
<td>DELAWARE</td>
<td>0.00070</td>
</tr>
<tr>
<td>ALABAMA</td>
<td>0.00058</td>
</tr>
<tr>
<td>HAWAII</td>
<td>0.00050</td>
</tr>
<tr>
<td>KENTUCKY</td>
<td>0.00043</td>
</tr>
<tr>
<td>MAINE</td>
<td>0.00038</td>
</tr>
<tr>
<td>ARIZONA</td>
<td>0.00032</td>
</tr>
<tr>
<td>NORTH CAROLINA</td>
<td>0.00023</td>
</tr>
<tr>
<td>MISSOURI</td>
<td>0.00021</td>
</tr>
</tbody>
</table>
Leveraged Funds must be:

- From private, state or other non-federal sources
- Must be received during the prior Federal Fiscal Year and obligated or spent within that same time frame
- The funds that are used for leverage must be used for allowable activities (i.e. parenting classes, mentoring, home visitation, life skills, respite care, public awareness/education, youth life skills & training, etc.)
- Leveraged funds must be directed through and controlled by the CBCAP Lead agency (in Texas=DFPS)
- In-kind contributions cannot count as leveraged funds

Leveraged funds can include:

- Foundation grants or corporate grants & donations
- Individual donations
- State General Revenue & other statutory dedications
- Interest Income
- Conference registration fees
- Special events
- Blended & braided funding with other state agencies
- The 20% match states are required to put up

One particular strategy that states have used is developing a Memorandum of Understanding (MOU) between the CBCAP lead agency and a foundation, private or other state agency so that money can pass through the CBCAP lead, but still be used for whatever purpose the sending organization had. The activities/programs for which the money is used must of course fit the allowable activities under CBCAP requirements. One way to make this happen is to bring together the fiscal officers from the various state agencies, foundations and other potential private partners to examine the CBCAP criteria and consider what of their funds would qualify. A few suggestions on how to do this are listed below:

Developing Fiscal Partnerships to leverage additional federal dollars:

- Identify areas of commonality across agencies and private organizations
- Learn about policies and rules of each funding sources (limitations, caps, and how funds can be used)
- Develop a fiscal or interagency agreement or MOU
- Specify how partners will blend and braid funds and reflect the amount and use of these funds
- Determine how the fiscal management systems will ensure the integrity of separate funding streams and identify the requirements of tracking and reporting
FEDERAL AND STATE FUNDS EXPENDED FOR CHILDREN’S PROTECTIVE SERVICES AND PREVENTION ²
(all charts are average of expenditures from 2008-2011)³

² All base data comes from the DFPS Operating Budgets: http://www.dfps.state.tx.us/About/Financial_and_Budget_Information/
³ The data in these charts does not reflect every dollar that is spent for the administration of child welfare and prevention services. Costs related to central administration, regional administration and IT were not included due to a lack of information regarding the percentage of these costs allocated to CPS and PEI.
State & Federal Expenditures by Strategy

Federal Prevention Expenditures by Strategy

4 All base data comes from the DFPS Operating Budgets: http://www.dfps.state.tx.us/About/Financial_and_BudgetInformation/
Individual Strategy Expenditures by State & Federal Funding Sources

Services to At-Risk Youth (STAR) Expenditures by Source
One Voice Texas is a network of more than 100 public, private and non-profit organizations and individuals working together to ensure that the health and human services needs of all Texans are addressed in legislative, regulatory, funding and other public policy initiatives.
Statute:

Sec. 40.105. CHILD ABUSE AND NEGLECT PREVENTION TRUST FUND ACCOUNT. (a) The child abuse and neglect prevention trust fund account is an account in the general revenue fund. Money in the trust fund is dedicated to child abuse prevention programs.

(b) The department may transfer money contained in the trust fund to the operating fund at any time. However, during a fiscal year the department may not transfer more than the amount appropriated for the operating fund for that fiscal year. Money transferred to the operating fund that was originally deposited to the credit of the trust fund under Section 118.022, Local Government Code, may be used only for child abuse and neglect primary prevention programs.

(c) Interest earned on the trust fund shall be credited to the trust fund.

(d) The trust fund is exempt from the application of Section 403.095, Government Code.

(e) All marriage license fees and other fees collected for and deposited in the trust fund and interest earned on the trust fund balance shall be appropriated each biennium only to the operating fund for primary child abuse prevention programs.


Amended by:

Acts 2007, 80th Leg., R.S., Ch. 632, Sec. 4, eff. June 15, 2007.

Acts 2007, 80th Leg., R.S., Ch. 632, Sec. 4, eff. September 1, 2010.

There are two accounts with the Texas Comptroller of Public Accounts for the CTF. The first account, which is GR Account 5085 receives funds from the marriage license fee and also interest earned on the account. Funds from GR Account 5085 can be transferred into the GR Account 5084, which is the Child Abuse Prevention Operating Account. It is from this account that DFPS accesses appropriated funds. Funds transferred from the Trust Account 5085 to the Operating Account 5084 cannot exceed the amount appropriated by the legislature. The Department can use up to the amount appropriated by the legislature. The funds that are used are a mix of interest and fees from marriage licenses. Per the Comptroller Manual of Accounts, the CTF accounts can only be used for child abuse prevention.

Legislative Appropriations of the Children’s Trust Fund:

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>7,663,848</td>
<td>7,663,848</td>
<td>5,685,702</td>
<td>5,685,701</td>
</tr>
</tbody>
</table>
CTF Expenditures and Budget Amounts in the DFPS Operational Budget:

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Fiscal Year</th>
<th>2010 (EXP)</th>
<th>2011 (EXP)</th>
<th>2012 (BUDGETED)</th>
</tr>
</thead>
<tbody>
<tr>
<td>STAR Program</td>
<td></td>
<td>$7,189,792</td>
<td>$7,663,848</td>
<td>$4,835,702</td>
</tr>
<tr>
<td>STAR Services</td>
<td></td>
<td>$6,005,004</td>
<td>$6,868,917</td>
<td>$3,178,409</td>
</tr>
<tr>
<td>Universal</td>
<td></td>
<td>$1,184,392</td>
<td>$794,931</td>
<td>$1,657,293</td>
</tr>
<tr>
<td>CYD</td>
<td></td>
<td>$0</td>
<td>0</td>
<td>$750,000</td>
</tr>
<tr>
<td>Other At-Risk</td>
<td></td>
<td>$474,056</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Family Strengthening</td>
<td></td>
<td>$474,056</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Program Support for At-Risk Prevention Services</td>
<td></td>
<td>$0</td>
<td>0</td>
<td>$100,000</td>
</tr>
<tr>
<td>PEI Program Support and Training</td>
<td></td>
<td>-</td>
<td>-</td>
<td>$100,000</td>
</tr>
</tbody>
</table>
Appendix 6: State Reports

Kansas Children’s Trust Fund:

In 1980, Kansas was the first state to establish a special fund, The Kansas Children’s Trust Fund, dedicated to the prevention of child abuse and neglect. Children’s Trust Fund dollars provide funding for community-based prevention programs to implement a range of strategies that assist families and individuals in preventing child abuse and neglect.

The 1999 Legislative session created the Kansas Children's Cabinet to oversee the expenditures from the Master Tobacco Settlement. Ninety-five percent of the state's portion of the Master Tobacco Settlement was dedicated to improving the health and well-being of children and youth in the state.

The Kansas Children's Cabinet has been directed by the statute to undertake these four overarching responsibilities:

1. Advising the Governor and the legislature regarding the uses of the moneys credited to the Children's Initiatives Fund;
2. Evaluating programs which utilize Children's Initiatives Fund moneys;
3. Assisting the Governor in developing and implementing a coordinated, comprehensive delivery system to serve children and families of Kansas;
4. Supporting the prevention of child abuse and neglect through the Children's Trust Fund.

The Children’s Trust Fund became the responsibility of the Children’s Cabinet. A focus of the Cabinet is on Early Childhood and Early Childhood Comprehensive Systems Plan. The Cabinet oversees grants for: Smart Start Kansas, Community-Based Child Abuse Prevention (CBCAP), and the Early Childhood Block Grant.

The Children’s Trust Fund receives a percent of marriage license fees and the federally funded Community-Based Child Abuse Prevention (CBCAP) grant program through Title II of the Child Abuse Prevention and Treatment Act (CAPTA). Children’s Trust Fund license plates and limited edition prints generate further income for prevention activities. The Children’s Trust Fund and local communities partner to raise funds that support child abuse and neglect prevention programs.
**Kansas Strengthening Families Plan**

Kansas Strengthening Families Plan began when a team of Kansans competed for a spot in the PREVENT Institute (Preventing Violence Through Education, Networking and Technical Assistance). This institute is a training program, funded by the CDC’s National Center for Injury and Prevention and Control, that seeks to teach prevention skills to professionals working in governmental and non-profit settings.

The KCCTF and the PREVENT Team initiated an extensive planning process to bring together stakeholders from the Child and Family Services Review, the Community-Based Child Abuse Prevention (CBCAP) network, state agencies, parents, and all other interested parties.
Kansas Strengthening Families Plan Proposed
Revisions, Sept 2010

Goal #1 – Kansas families will have access to tangible goods and services to help them cope with stress, particularly in times of crisis or intensified need. (Concrete Supports)

Objective 1.1: Children will have health needs met.
- Strategy 1.1.1 Provide universal health insurance for all children birth to five.
- Strategy 1.1.2 Increase access to health care providers and dental services.
- Strategy 1.1.3 Increase support for a continuum of early screenings for fetal alcohol and drug exposure, obesity, pre-K, early dental, social-emotional, developmental, and universal KEMPE assessments.
- Strategy 1.1.4 Increase immunization rates for all children.

Objective 1.2: Families will have access to quality child care while parents work or attend school.
- Strategy 1.2.1 Increase the availability of child care options, especially for infants and toddlers.
- Strategy 1.2.2 Increase the quality of child care by increasing licensing regulations.
- Strategy 1.2.3 Improve accessibility of education and training for child care providers.

Objective 1.3: Families will receive economic supports to meet their needs.
- Strategy 1.3.1 Provide adequate funding for quality early child care.
- Strategy 1.3.2 Increase economic stability by increasing participation in family support programs.
- Strategy 1.3.3 Increase state minimum wage.
- Strategy 1.3.4 Improve transportation support.

Objective 1.4: Families will receive services in their communities to support stable, healthy living environments.
- Strategy 1.4.1 Increase the number of shelters that are family-friendly.
- Strategy 1.4.2 Increase awareness of respite care for families.
- Strategy 1.4.3 Develop partnership with businesses to provide support to families.
- Strategy 1.4.4 Increase availability of drug and alcohol inpatient facilities that accept families.

Goal #2 – Parents in Kansas have adaptive skills to accept, solve, and manage problems. (Family Functioning/ Resiliency)

Objective 2.1: Children will live in safe and stable environments.
- Strategy 2.1.1 Identify and treat parent/caregiver physical and mental health needs in order to allow them to care for their dependent children.
- Strategy 2.1.2 Provide services to meet the needs of all caregivers, including mothers, fathers, grandparents raising grandchildren, kinship and foster parents.
- Strategy 2.1.3 Increase community partnerships to support families, including partnerships with homeless shelters, faith-based organizations, libraries, etc.
- Strategy 2.1.4 Expand prevention services and incorporate prevention into existing child- and family-serving programs.
Statewide Blue Ribbon Task Force Final Report

- **Strategy 2.1.4** Increase home safety by providing families with information on basic safety issues.
- **Strategy 2.1.5** Increase availability of affordable housing.

Goal #3 – Parents in Kansas are responsive to their children’s needs. (Nurturing and Attachment/Social-Emotional Development)

**Objective 3.1:** Children will have social and emotional needs met.
- **Strategy 3.1.1** Promote breastfeeding.
- **Strategy 3.1.2** Provide parent education on developmental milestones.
- **Strategy 3.1.3** Increase training provided in institutions of higher education about infant/toddler mental health.
- **Strategy 3.1.4** Implement an early childhood mental health endorsement in Kansas.
- **Strategy 3.1.5** Assure screening for all young children and their families utilizing tools as determined appropriate by professional peers.

Goal #4 – Kansas families have a strong network of others in the community to rely on for emotional support. (Social Connections)

**Objective 4.1:** Families will gain skills to build and maintain naturally occurring support systems.
- **Strategy 4.1.1** Support family, friend and neighbor care.
- **Strategy 4.1.2** Increase opportunities for parent-child activities.
- **Strategy 4.1.3** Increase opportunities, build capacity within communities, and promote and support families in gaining skills to develop healthy, naturally-occurring supports.
- **Strategy 4.1.4** Develop opportunities for virtual social networking for parents using online tools such as Facebook and Twitter.

Goal #5 – Kansas parents understand normal child development and utilize effective child management techniques. (Knowledge of Parenting and Child Development)

**Objective 5.1:** Parents will have the skills and knowledge they need to nurture healthy child development.
- **Strategy 5.1.1** Increase health literacy to parents and caregivers.
- **Strategy 5.1.2** Implement universal screening for home visitation.
- **Strategy 5.1.3** Increase economic security for families by developing financial literacy skills.
- **Strategy 5.1.4** Implement life skills education in the school system.
- **Strategy 5.1.5** Increase effectiveness and quality of referrals that connect families with services.

**Key Infrastructure Elements of the Kansas Strengthening Families Plan**

**Element 1:** Prevention programs in Kansas utilize evidence-based practices.
- Provide more funding for parent education programs.
- Increase funding to support EBP and improve training regarding EBP and evaluation.
- Provide diverse Evidence-Based Practices.
Statewide Blue Ribbon Task Force Final Report

- Evaluate Strengthening Families efforts at the agency, community, and state levels.
- Encourage development of evaluation capacity and identify consistent indicators that are used statewide.

**Element 2:** Prevention programs in Kansas will advocate for changes in policies that work to support families.
- Increase collaboration and communication across systems and empower communities to advocate for needs of families.
- Review regulations and advocate for statute changes that respect privacy and ensure safety.
- Consider revision of Kansas Sentencing Guidelines related to drug offenses.
- Advocate for expanded universal training for mandatory child abuse and neglect (CA/N) reporters.
- Engage parents across all socioeconomic levels.

**Element 3:** Coordinate public awareness messages and improve public perception of parenting education and support services.
- Increase public education and awareness of infant/toddler mental health.
- Promote key parenting messages that are consistent, delivered in multiple ways, are universal to families, and are culturally sensitive.

**Element 4:** Promote parent leadership and ownership within parent education programs.

**Element 5:** Culturally appropriate services are available to families statewide.

**Protective Factors**

The Kansas Strengthening Families Plan uses the Center for the Study on Social Policy’s (CSSP) model of protective factors to help strengthen families (http://www.cssp.org/reform/strengthening-families).

The Strengthening Families Plan developed out of the realization that there has been little substantiated success in reducing child maltreatment in the 40 years since maltreatment was first recognized. The CSSP decided to take a new approach to child maltreatment, using early childhood programs to build protective factors for families.

The Strengthening Families approach differs from the current approach to child maltreatment in a number of ways:
- It is based in the early childhood education system.
- There is a focus on building protection for children within their homes and communities, rather than focusing solely on identifying risks.
- Rather than removing children from their homes, the Plan works to overcome or mitigate manageable individual causes of child neglect and abuse—parental isolation, lack of knowledge about child development, and mental, physical or financial crisis in the family.

Protective factors are attributes that work as a buffer for families. These factors help parents at risk for abuse to find resources and supports to help them cope more effectively. When protective factors are present, child abuse is less likely to occur.

Protective factors include:
- Parental Resilience
- Social Connections
- Knowledge of Parenting and Child Development
- Concrete Support in Times of Need
Social and Emotional Competence of Children

The Strengthening Families Plan works to increase protective factors by focusing on strengths and resiliency rather than on risks and deficits. Protective factors reduce vulnerability to becoming a victim or perpetrator. Below is the list of protective factors, examples of what these factors look like, and specific actions that can be taken to increase these factors.

**Parental Resilience**
- Positive parental psychology
- Forming caring relationships
- Trusting staff, disclosing problems, asking for help

**Building Parental Resilience**
- Set aside space for parents
- Train staff to have relationships with parents
- Work with family support workers and mental health consultants
- Train staff to watch for problems and offer help

**Social Connections**
- Can help reduce isolation
- Help build “social capital”
- Develop community norms against violence
- Friends can provide tangible and emotional support

**Building Social Connections**
- Classes and workshops
- Help parents make connections
- Outreach for fathers, grandparents, and other extended family members

**Knowledge of Parenting and Child Development**
- Understanding normal child development
- Non-violent help with problem behaviors such as biting or hitting
- Modeling non-violent, positive parenting techniques
- Providing additional support for parents with children who have special needs

**Building Knowledge of Parenting and Child Development**
- Daily interactions with parents
- Providing parent education classes
- Allowing observation space for parents

**Concrete Support in Times of Need**
- Supports that assist in connecting families with materials or services in times of need
- Connect families to resources
- Provide families with food, clothing
- Help families connect with services

**Building Concrete Support**
- Linking parents with specific contacts in organizations and agencies
- Immediate crisis response from staff and assistance in connecting with the appropriate resources

**Social and Emotional Competence of Children**
- Behavior problems put children at a greater risk for abuse
- Early childhood programs help children develop socially and emotionally
Statewide Blue Ribbon Task Force Final Report

- Less likely to act out at home
- Learn how to verbally express their problems
- Children who have experienced violence need a safe environment

Building Social & Emotional Competence of Children
- Teach social and emotional skills
- Staff respond quickly when there is a concern
Statewide Blue Ribbon Task Force Final Report

NJ Task Force Child Abuse and Neglect
Division of Prevention and Community Partnerships

History:
1983  Governor’s Task Force on CA/N was created by Executive Order
Goal: Make recommendations to improve the state’s response to child
maltreatment and to educate communities and professionals on prevention and
treatment of child abuse

1996  Legislature established the NJ Task Force on CA/N
Goal: Expanded initial mandate and Task Force now authorized to study and
develop recommendations regarding the most effective means of improving the
quality and scope of child protective services
Membership: 24 member Task Force including Commissioners (or designees) of
DCF, Human Services, Education, Community Affairs, Corrections, Health and
Senior Services, Attorney General, Chief Justice of Supreme Court, Public
Defender and Superintendent of State Police as well as a county prosecutor, 2
members of Senate and General Assembly, and 13 public members appointed by
the Governor.

2007  Statute expanded again to include the development of recommendations to
improve quality and scope of child protective and preventative services to include
a review of practices and policies utilized by Division of Child Protection and
Permanency and Division of Family and Community Partnerships in Department
of Children and Families.

Current Task Force is co-chaired by the Commissioner of Department of Children and
Families and by a child abuse physician (Dr. Martin Finkel). The Task Force includes
cabinet level officers as outlined above and the public members include representatives
from multiple agencies such as the statewide parent advocacy network, NJ children’s
alliance, foster and adoptive family services, CASA, Catholic Charities, etc.

The Task Force has developed several projects including:
• Finding Words – child-friendly forensic interviewing protocol
• Multidisciplinary Team Training
• Professional Conferences and Skill Building (multifaceted statewide conference)
• Educator’s Training
• Development of the Standards for Prevention Programs: Building Success
  Through Family Support
• Child Abuse Prevention 101 Training
• 2010-2013 New Jersey Child Abuse and Neglect Prevention Plan – A Roadmap to
  Child and Family Well-Being
New Jersey Child Abuse & Neglect Prevention Plan 2010-2013
A Roadmap to Child and Family Well-being January 2010

The NJ Child Abuse and Neglect Prevention Plan (NJ Prevention Plan) “outlines the planned prevention and family strengthening efforts of the Department of Children and Families”. This plan is the latest update to the state’s formal plan for prevention and is the product of the collaboration between the NJTFCAN (Task Force) and DCF’s DPCP (Division of Prevention and Community Partnerships). The main emphasis of DPCP has been on primary and secondary prevention. DPCP has 4 main prevention priorities:

- **Early Childhood Services** for pregnant women, parents and young children up to age 5 years
- **School-Linked Services** for school-aged children, teenagers and their families
- **Family Support Services** for any family in need of neighborhood center-based services
- **Domestic Violence Services** for adults and families impacted by intimate partner violence

In 2008, NJTFCAN and DCF completed a statewide survey on prevention of child abuse and neglect targeting families, government workers and non-profit/grassroots organizations. The results provided valuable input for the recommendations in the document.

The 2010-2012 Statewide Plan encourages private and public agencies to engage families by integrating Protective Factors (1-5) into the community and family services as well as assets which can strengthen families (6-8 from Child Welfare Information Gateway). These factors include:

1. Parental Resilience
2. Social Connections (providing family support)
3. Knowledge of Parenting and Child Development
4. Concrete Support in Times of Need (financial supports)
5. Healthy Social and Emotional Development of Children
6. Nurturing and Attachment
7. Effective Problem Solving and Communication Skills
8. Healthy (Marriages) Relationships

The Statewide Plan also outlines principles that focus on families, practice and resources. The plan is then divided into the 4 main prevention priorities. Each section (see below) includes a nice overview, objective and strategies section with statistics and references.

**Early Childhood Services: Pregnancy to Age 5**

1. Evidence Based Home Visitation (EBHV) – Pregnancy to Age 3
   a. Expanded from 19 to 35 sites. This DCF funded program includes Healthy Families – TANF Initiative for Parents (TIP), Nurse Family
Partnership, and Parents as Teachers. TIP is now in all counties and 13 counties have more than 1 EBHV model

b. EXPECTED OUTCOMES: Document includes expected outcomes such as improved perinatal outcomes (prenatal care, use of WIC, postpartum care), participating parents able to identify resources, participating infants have improved outcomes for low birth weight and prematurity, infants are breastfed for 4 weeks, reduction in unplanned subsequent pregnancies, etc.

c. Short and Long Term Recommendations are included.

2. Strengthening Families through Early Care & Education – Infancy to Kindergarten
   a. Operates in 180 child care centers in NJ. Each of the 21 counties in NJ has a minimum of 8 participating child care centers.
   b. EXPECTED OUTCOMES: Document includes expected outcomes such as child care staff have phone trees, car pools, baby-sitting coops, play groups; parent classes and home materials, etc.
   c. Short and Long Term Recommendations are included

**School Age Youth** (all programs also have outcomes listed as well as short and long-term recommendations)

1. **School Based Youth Services Programs (SBYSP)** are located in elementary, middle and high schools offering a blend of services to help students stay in school, graduate and obtain skills. Each site has a liaison board comprised of school personnel, youth, community representatives and parents. 2 major components include the **Adolescent Pregnancy Prevention Initiative (APPI)** and **Family Friendly Centers (FFC)**. APPI uses education, counseling and health services to reduce the birth rate. Students can self refer or be referred by peers, family members, guidance counselors or resource families. FFC provided services such as tutoring, counseling and cultural enrichment to enhance after school programs (elementary and middle schools).

2. **Parent Linking Programs (PLP)** provide childcare near or in the high school for youth parents. Other services from this program includes teaching youth to delay a second pregnancy and parenting skills focusing on reducing abuse and neglect as well as helping teen mothers and fathers graduate from high school.

3. **Prevention of Juvenile Delinquency Programs (PJD)** provides healthy alternatives for youth in trouble with the law (in conjunction with the Stationhouse Adjustment regulations of NJ Department of Law and Public Safety).

4. **The Family Empowerment Program (FEP)** is collaboration with Division of Addiction Services and provides intensive prevention and treatment for adolescents whose families have a history of serious addictions.

5. **NJ Child Assault Prevention (NJ CAP)** is a primary and secondary program that provides CAP and “No More Bullies, No More Victims” programs to schools and communities. CAP programs include a 3 fold approach: staff in-service, parent workshops, and individual classroom presentations for children and teens.

6. **Outreach to At-Risk Youth** is designed to prevent crime/juvenile delinquency and deter gang involvement. It targets youth 13-18 years of age but can extend to 21. The programs are located in communities with demonstrated high crime and gang
violence and provides enhanced recreation, vocational, educational, outreach or supportive services.

7. **2nd Floor Youth Helpline** provides confidential telephone assistance to address social and health needs of NJ’s youth. Telephone services have been provided 24 hours a day since September 2008.


9. **Memorandum of Agreement (MOA) and Education Practice Manual** is being developed between DCF and DOE to address school enrollment and stability, school readiness, provision of supports to prevent and reduce student drop-out rates and behavioral concerns, needs of children with disabilities including compliance with special education procedures, and ongoing communication and information sharing between DCF and school districts.

10. **NJ Afterschool Network (NJAN)** is a 3 year grant and supports a statewide network of funding with matched funds from NJ DOE, Human Services and Children and Families to build public awareness and support, offer guidance to parents and advocates.

**Parents and Families** (again includes overview, objectives and strategies at the beginning as well as outcomes, short and long term recommendations)

1. **Family Success Centers (FSC)** – neighborhood-based gathering places where residents can find family support, information, and services whose purpose is to enrich the lives of children by making families and neighborhoods stronger. These services may relate to employment, parent education, parent-child activities, life skills, housing and access to health care.

2. **Differential Response (DR)** – community-based case management and service delivery initiated by a call to the child abuse hotline for families whose needs do not rise to the level of an investigation. DR Parents and Families gain access to formal and informal supports.

3. **Technical Assistance and Training (for the centers)** – to build capacity of centers, oversee continuous quality improvement, ensure parent leadership development, promote partnership between organizations

4. **1-800-THE-KIDS** is a helpline for pregnant women, parents and families, which also operates 24 hours a day.

**Domestic Violence** (again includes overview, objectives and strategies at the beginning as well as outcomes, short and long term recommendations)

1. **Domestic Violence Core Services** – emergency response 24 hour hotline and 24 hour emergency shelter entry; information and referral; counseling; financial, legal, housing and general advocacy; children’s services; and community education. DCF funds a network of at least 1 core service in every county.

2. **Peace: A Learned Solution (PALS)** – is a research-based intensive therapeutic program model using creative arts therapies including art, dance and drama therapies for children ages 4-12 who are exposed to DV. Case management and
counseling are provided to non-offending parents. One PALS program uses “Parenting Journey” a 12-week course that is offered in English and Spanish.

3. **DCF/DV Program Collaboration on Co-Occurrence of Domestic Violence/Child Abuse** – address the co-occurrence of DV and CA and brings the DCF case practice model to life when working with families experiencing DV. DCF adopted a DV case practice protocol and the statewide DV Liaison Program which features domestic violence experts co-located in DYFS offices.

4. **Other Strategies:** Promotion of mutually respectful behavior and challenging gender stereotypes and community silence which will result in positive messages about relationships and a community that speaks out against violence. A key strategy will be to engage non-violent men as leaders and role models.

**Resources and Partnership**

1. County Welfare Agencies
2. Community-Based Child Abuse Prevention (CBCAP)
3. Primary health care providers (for health care services to children)
4. New Jersey Children’s Trust Fund (CTF)
Standards for Prevention Programs: Building Success through Family Support
(These are included as an appendix to the current plan as well as a stand alone document)

The task force created a Prevention Programs Working Group interested in advocating for the support expansion of some prevention programs. The working group reviewed literature on effective prevention programs for multiple fields including child welfare, public health, juvenile Justice, substance abuse, and mental health. Rather than taking model programs, the group organized information under 3 headings: conceptual standards, practice standards, and administrative standards. As the group looked at specific programs, it became apparent that it would be an overwhelming task to review each type of program across multiple factors nor did it have the resources to conduct a thorough analysis. The group focused on identifying factors that appear to be present in prevention programs that were considered to be effective according to research or analytical studies reviewed.

The standards working group chose to use the Family Support Approach citing a book by researchers Carl Dunst and colleagues: Enabling and Empowering Families: Principles and Guidelines for Practice.

- Extending the definition of intervention to be more ecologically oriented and comprehensive
- Moving beyond the child as the focus of the intervention to the family as a whole system
- Promoting growth-producing behavior – positive behaviors and outcomes – rather than only treating problems or preventing negative outcomes
- Focusing on family-identified needs and aspirations rather than professionally identified, defined, and labeled needs
- Placing major emphasis on strengthening the family’s social network and utilizing the network as the primary source of support
- Perceiving the family has a social unit embedded within other formal and informal social units in networks

The standards working group report that applications of the standards are endless including:

- Requiring the grantees seek state funding from a variety agencies that adhere to the standards
- Applying language from the standards in mission statements and written materials for state agencies in their programs
- Building the standards into evaluation and review processes for state agencies in the programs administer
- Integrating the standards in the policy development had seen committee levels
The standards working group as part of the New Jersey Task Force recommended the following standards for effective prevention programs based on the principles and premises of Family Support Practice.

### Principles of Family Support Practice

1. Staff and families work together in relationships based on equality and respect.
2. Staff enhance families’ capacity to support the growth and development of all family members—adults, youth, and children.
3. Families are resources to their own members, to other families, to programs, and to communities.
4. Programs affirm and strengthen families’ cultural, racial, and linguistic identities and enhance their ability to function in a multicultural society.
5. Programs are embedded in their communities and contribute to the community-building process.
6. Programs advocate with families for services and systems that are fair, responsive, and accountable to the families served.
7. Practitioners work with families to mobilize formal and informal resources to support family development.
8. Programs are flexible and continually responsive to emerging family and community issues.
9. Principles of family support are modeled in all program activities, including planning, governance, and administration.

### Premises of Family Support

1. Primary responsibility for the development and well-being of children lies within the family, and all segments of society must support families as they rear their children.
2. Assuring the well-being of all families is the cornerstone of a healthy society, and requires universal access to support programs and services.
3. Children and families exist as part of an ecological system.
4. Child-rearing patterns are influenced by parents’ understandings of child development and of their children’s unique characteristics, personal sense of competence, and cultural and community traditions and mores.
5. Enabling families to build on their own strengths and capacities promotes the healthy development of children.
6. The developmental processes that make up parenthood and family life create needs that are unique at each stage in the life span.
7. Families are empowered when they have access to information and other resources and take action to improve the well-being of children, families, and communities.
A. Conceptual Standards:

1. **Family Centered**: Family focused or centered does not have to mean that the program targets the whole family but rather involves the parents and family members at some level. The goal is to avoid child only or parent only approaches. This is supported by family support premise #3.

2. **Community-Based**: The community can be defined as a neighborhood, municipality, or region. Ideally, the program needs to be where the participants live, work, or attend school. 
This is supported by family support principle #5.

3. **Culturally Sensitive and Culturally Competent**: Cultural sensitivity is an awareness and tolerance for diversity cultural competence goes on to be a knowledge about the culture is used to assist participants in programs. This is supported by family support principle #4.

4. **Early Start**: The recommends it is imperative the progress begin working with parents at the time of the birth of their first child (referencing a meta-review by MacLeod and Nelson 2000). Pregnancy is highlighted as an effective time to learn infantile their care, parenting, and to decrease drug use for substance abusing parents. 
This is supported by family support premise #4.

5. **Developmentally Appropriate**: It is crucial for the participants to understand stages of development tasks. This is applicable to both the ages and stages the child goes through physically, emotionally, socially, and intellectually, as well as the stages of parenting as parenting is a developmental process. This is supported by family support premise #6.
Statewide Blue Ribbon Task Force Final Report

6. **Participants as Partners with Staff**: Partnering with parents is the critical difference between prevention programs and treatment programs. This can allow the participants to "drive" the service rather than the provider or professional prescribing the services.
   This is supported by family support principle #1.

7. **Empowerment and Strength-Based Approaches**: Programs should empower participants by identifying and building on capabilities and competencies. Programs should build on the positive functioning of the parents and family rather than seeing the family as “broken” or “needing to be fixed”. This concept is also known as *"asset building"*. This is supported by family support premise #5.

B. **Practice Standards**

1. **Flexible and Responsive**: Programs should tailor practices to the needs of the participants. An example would be to provide an evening meal in child care for nighttime parenting education class.
   This is supported by family support principle #8.

2. **Partnership Approaches**: The first kind of partnership is seen in conceptual standards in the participants is a partner and helps to structure the program. The second type of partnership refers to how the program interacts with other agencies to maximize coordination of services incorporation. Effective programs do not operate in isolation and are integrated into the continuum of services.
   This is supported by family support principle #6.

3. **Links with Informal and Formal Supports**: Formal supports are linkages with other social services or institutions. Informal supports are linkages tip ears, extended family members, volunteers, paraprofessionals, groups, and informal organizations.
   This is supported by family support principle #7.

4. **Universally Available and Voluntary**: Prevention programs should be offered to the brought community, not just to persons or families with "problems". There is a higher likelihood of success when working with families of mixed in comes instead of targeting low socioeconomic status families. "Programs for poor families tend to become poor programs" (MacLeod and Nelson 2000).
   This is supported by family support premise #2.

5. **Comprehensive and Integrated**: Supportive programs are needed for all new parents starting prenatally and continuing until the child enters school to include healthcare; an educational system that prepares the child for successful adulthood; human relationship developmental skills training for school-age children; education for parents and services to help them safely raise and nurture their children; supportive housing policies and community development efforts; economic opportunities to provide above-poverty standards of living; access to parenting information and parenting skill development. The list goes on with her the services needed to integrate prevention programs and chronic operative strategy.
   This is supported by family support premise #7.
6. **Easily Accessible:** Services should be offered in a non-threatening environment with a "public face" that is acceptable to all and without stigma. This is supported by family support premise #7.

7. **Long Term and Adequate Intensity:** The message needs to be integrated through multiple sources such as public media, school, business, and places of worship. Successful programs need a long-term, persevering approach. This is supported by family support principle #8.

C. **Administrative Standards**

1. **Sound Program Structure, Design, and Practices:** The components in approaches should be reviewed as to whether or not they reflect some standards for being Family centered, committee based, and culturally competent as well as addressing the target population and using approaches their development appropriate. The program should also treat participants as collaborators and partners and used a strength-based approach. This is supported by family support principle #9.

2. **Committed, Caring Staff:** Kumpfer and Alvarado (1998) note that there are nine staff characteristics and skills for program effectiveness: warmth, genuineness, and empathy; communication skills in presenting and listening; openness and willingness to share; sensitivity to family and group processes; dedication to, care for, and concern about families; flexibility; humor; credibility; and personal experience with children as a parent or childcare provider. Adequate staff training is essential. This is supported by family support principle #1.

3. **Data Collection and Documentation:** Data should be gathered at intake (source of referral; family structure; major strengths; presenting problem; etc.), service summary (units of service over each week or month and number of families receiving services); descriptive data (length of time of service, level of family’s participation, percentage of goals achieved, reason for termination of service). This is supported by family support principle #9.

4. **Measures Outcomes and Conducts Evaluation:** The should include quantitative and qualitative data to determine if the program is achieving anticipated outcomes. Funding should be provided only to programs that show evidence of effectiveness. Evaluation tools should address program relevance, client relevance, research relevance, normative relevance, staph relevance, and fiscal relevance. This is supported by family support principle #9.

5. **Adequate Funding and Long Range Plan:** Elements of effective programs include financial accountability in addressing the need for adequate funding. This is supported by family support principle #6.

6. **Participants and Community as Collaborators:** Administrative practices need to provide for participants and committee participation which could include many forms such as community focus groups, participants surveys, follow up questionnaires, and advisory groups. This is supported by family support principle #9.
North Carolina Task Force Charge

> Include different levels of intervention, including universal, selective, and indicated programs that target children, families, and communities that are based on empirical research (to the greatest extent possible).

> Establish indicators and a timetable to measure our state’s progress in implementing the statewide plan towards reducing child maltreatment.

> Identify a state agency or agencies that have preventing child maltreatment as one of their principal responsibilities, along with a set of recommendations on the resources needed to carry out this responsibility.

> Focus governmental and nongovernmental organizations on programs and systems of care that will reduce the incidence of child maltreatment.

> Identify ways to maximize existing funding or retool existing programs to prevent child maltreatment.

> Examine gaps in existing programs or resources needed to prevent child maltreatment along with identifying possible funding sources.

> Identify additional measures and establish mechanisms for collecting data to more accurately assess and monitor the incidence of child maltreatment and effectiveness of prevention efforts.

North Carolina Task Force Prevention Principles

> Promote the healthy development of the parent/child relationship through community and institutional support of parenting.

> Consist of normative, universal efforts to promote healthy parenting among all North Carolina families, as well as more targeted efforts directed towards higher risk families.

> Target the developmental stages of pregnancy and the first years of a child’s life as the foundation of our commitment to prevention.

> Add services at different developmental stages to support the healthy formation of the parent/child relationship.

> Match family needs with an appropriate level of support.

> Integrate prevention and support services across public and private agencies.

> Enhance the role of community institutions and informal supports in helping families raise children.
Statewide Blue Ribbon Task Force Final Report

> Use family support principles in program planning, implementation, and governance.

> Be linguistically and culturally accessible and responsive.

> Incorporate strong theory-based and empirically-based strategies into program planning and implementation.

> Evaluate programmatic efforts and ensure that training, quality assurance, and technical assistance resources are available. While

> Ensure that sufficient resources are available to successfully implement prevention strategies and programs.

North Carolina Task Force Structure

Other North Carolina Task Force Areas of Focus

* Monitoring the Problem of Child Maltreatment

* Social Norms and Policies that Promote Effective Parenting and Community Responsibility for Child Well-Being

* Evidence-Based and Promising Programs to Prevent Child Maltreatment

* Systems Changes to Strengthen Families and Prevent Child Maltreatment

* Funding
Leadership Structure
Two-tiered state level leadership: Child Maltreatment Prevention Legislative Oversight Council and Child Maltreatment Prevention Leadership Team

Child Maltreatment Prevention Legislative Oversight Council (NC Division of Public Health): state and local agencies, oversight

Child Maltreatment Prevention Leadership Team (public and private agencies): actual work of prevention (surveillance, evidence based/best practices, other work)

Monitoring the Problem
Multiple sources of data to track

Occurrences
*Central registry (DCS)
*Child Fatality data
*Emergency department discharge data
*Medicaid data

Consequences
*Youth Risk Behavior Surveillance System
*Criminal Justice
*NC Department of Public Instruction
*Child Exit Interview

Risk Factors
*Birth certificates
*Pregnancy risk assessment monitoring system (PRAMS)
*Behavioral Risk Factor Surveillance System (BFRSS)
*Criminal justice data
*Child Health Assessment and Monitoring Program Survey (CHAMP)
*Census

Promote Effective Parenting and Community Responsibility for Child Well-Being
Strategy 1-Child Abuse Prevention Public Awareness Campaigns: reframing prevention messages, strategic framing, social marketing
Strategy 2-Comprehensive Grassroots Violence Prevention Efforts: what is violence?, violence permeates American life, Engaging Communities in the prevention of violence

Evidence-Based/Promising Programs in Prevention

Major Service Models:
*Home-based services/home visitation (various programs and models)
*Parent education and parent training (various programs and services)
*Mutual support/social support (Circle of parents, Parents anonymous, Parent to Parent)
Statewide Blue Ribbon Task Force Final Report

*Respite care (various models)
*Early Childhood Initiatives (Head Start etc.)
*Primary Health Care Initiatives (Triple P, Healthy steps, etc.)
*Child Sexual Abuse Prevention (School based, STOP IT NOW!, etc.)
*Family Resource Centers

**Systems Changes**

**Strengthening Families:**
Focus on Pregnancy and the Early Years of Childhood (medical homes, coordination)
Home visiting services (coordination and state-wide vision)
Maternal and Child Health Services (maternal care coordination, identification of risks)
Early Intervention Services (developmental services/agencies, identification of risks)
Primary Health Care Providers (medical homes, developmental services, coordinated case-management)
Early Childhood Mental Health Services and Practices (coordination of comprehensive mental health plan)

Early Childhood Education (improving training for childcare workers and teachers)

**Build Services Developmentally According to Family Need**
Parent Support Services (coordination of public and private support services)
Services through the Public Schools (counselors, after-school programs)
Services through Social Services Providers (multiple response)

**Reducing Risk Factors**
Unwanted or Closely Spaced Pregnancies (family planning, education)
Preventing Adolescent Pregnancy (family planning and education)
Substance Abuse (increased services for teens and pregnant moms)
Postpartum and Maternal Depression (improved screening)
Domestic Violence (work with public and private agencies, pilot programs)
Children with Disabilities (strengthen screening and early intervention services)
Unavailable/Inadequate Childcare (improve access and support for at risk families)
Natural Disasters
Military Communities
Incarcerated Parents

**Funding Sources**
NC Children’s Trust Fund (state)
Safe and Drug Free Schools and Community Programs (“No Child Left Behind”)
NC DHHS (Division of Social Services, Division of Public Health, Division of Mental Health, Developmental Disabilities and Substance Abuse)
NC Partnership for Children
NC Governor’s Crime Commission
NC Department of Juvenile Justice and Delinquency
Specific Task Force Recommendations (cut-and-paste)

- The NC General Assembly should establish a standing Child Maltreatment Prevention Legislative Oversight Council that has diverse membership representation and strong leadership from state and local agencies and community providers. (priority)
- The NC Division of Public Health’s Injury and Violence Prevention Branch should work with a Technical Advisory Committee to develop a North Carolina data collection system for monitoring child maltreatment prevention. (priority)
- PCA North Carolina, in partnership with the NC Division of Public Health, should take the lead in developing a public education and marketing campaign aimed at encouraging community members to support parents by promoting positive parenting behaviors and increasing public support for programs and resources aimed at strengthening positive family interaction. (priority)
- PCA North Carolina, in collaboration with the NC Division of Public Health, the NC Division of Social Services, the NC Coalition Against Domestic Violence, the NC Domestic Violence Commission, the NC Partnership for Children, the NC Department of Public Instruction, and the NC Department of Juvenile Justice and Delinquency Prevention, should work with and support ongoing grassroots efforts to establish community norms that support families and healthy child development, and reduce social acceptance of violence as an appropriate response to interpersonal conflict. (priority)
- Public and private funders should place priority on funding evidence-based and promising child maltreatment prevention and family strengthening programs. When those programs are not available for a specific population, public and private funders should give funding priority to those programs that are theory-based and incorporate elements identified in the research literature as critical elements of effective programs. (priority)
- PCA North Carolina should work with the NC Division of Medical Assistance, the NC Division of Public Health, and Community Care of North Carolina to implement the Nurse Family Partnership Program in two to three additional sites in North Carolina. (priority)
- PCA North Carolina and the NC Division of Public Health should work with the Education Begins at Home Alliance to develop a model of home visitation for families at high risk of maltreatment based on the most current research of perinatal and early childhood home visitation programs, and from an assessment of the current resources and infrastructure for home visiting programs in North Carolina.
- The Child Maltreatment Prevention Leadership Team should work to pilot or replicate promising child maltreatment prevention programs, such as Parent-Child Interaction Therapy, the Strengthening Families Program, and the Chicago Child-Parent Center, and to evaluate their effectiveness with a North Carolina population.
- The Child Maltreatment Prevention Leadership Team should work to ensure community-based family resource centers offer or link to evidence-based and promising prevention programs; require use of social support and parent education programs that have been evaluated and show evidence/promise in
preventing maltreatment; re-target funding for school-based child sexual abuse prevention programs to promising models; and develop an evaluation process for family support and child maltreatment prevention programs using a shared set of research-based intermediate indicators for child maltreatment, nurturing parent-child interaction, and healthy child development.

- The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and other agencies and private providers providing oversight or treatment for children who have experienced abuse or neglect to encourage the use evidence-based models identified by the Kaufmann Best Practice Initiative, Substance Abuse Mental Health Services Administration, and the Centers of Excellence.

- The Child Maltreatment Prevention Leadership Team should work closely with the Early Childhood Comprehensive System Initiative in the development of an integrated and comprehensive early childhood system that promotes the health and well-being of young children birth through age five. Specifically, stakeholders from both initiatives should identify common outcomes and common areas of focus, and integrate efforts whenever possible to maximize resources and prevent duplication.

- The NC Division of Medical Assistance, the NC Division of Public Health’s Women’s and Children’s Health Section, PCA North Carolina, and other appropriate partners should work with the Education Begins at Home Alliance to ensure a coordinated and effective system of prenatal and early childhood home visitation programs across North Carolina, which are voluntary and appropriately match services to families’ risks and needs.

- The NC Division of Public Health and the NC Division of Medical Assistance should strengthen the Maternity Care Coordination and Child Service Coordination programs with regard to child maltreatment prevention by requesting that prevention is included as a major goal of the programs, strengthening intervention models, and increasing training on the issue.

- The NC Division of Public Health and the NC Division of Medical Assistance should support the Children’s Developmental Services Agencies in ensuring families who are maltreating and who are at high risk of maltreating their children continue to be served.

- The NC Division of Medical Assistance – Office of Research, Demonstrations, and Rural Health Development and the NC Division of Public Health should work together to explore ways to enhance the role of primary care providers in child maltreatment prevention through the NC Medical Home Initiative and the Assuring Better Child Health and Development Project.

- The Child Maltreatment Prevention Leadership Team and the Early Childhood Comprehensive System Initiative should work together in identifying the needs of families and other caregivers in promoting young children’s social/emotional health, identifying effective strategies to meet these needs, and enhancing the capacity of multiple provider systems to coordinate and deliver services to those caregivers and children.
The NC Division of Child Development, the NC Department of Public Instruction, and the NC Partnership for Children should work with the Early Childhood Professional Development Institute to develop a plan for increasing the training of childcare providers to better understand and to assist parents in understanding stages of child development and age appropriate child behavior, and to promote infant/child mental health and social/emotional development.

PCA North Carolina should work with family support organizations to increase the availability of respite care, parent support groups, and parent support strategies, and to ensure that families in need of support are able to access services within their communities.

The NC Department of Health and Human Services should ensure that a strengthening parenting component is included across state programs that serve families, including culturally appropriate programmatic strategies that will support and strengthen parent-child relationships, especially during pregnancy and the first two years of the child’s life.

The North Carolina State Board of Education and the NC Department of Public Instruction should identify strategies to increase support for children at risk of maltreatment and their families to ensure that children are able to fulfill their academic potential in traditional schools, alternative schools, or other educational settings.

The NC Division of Social Services, the NC Association of County Directors of Social Services, and the Children’s Services Advisory Committee, in conjunction with community providers, should explore ways to strengthen universal/selective child maltreatment prevention efforts by expanding prevention services through the Multiple Response System for all children and developing family strengthening/child maltreatment prevention strategies for the Work First population.

The NC Division of Public Health and the NC Division of Medical Assistance should pursue a more rapid rollout of the federal Medicaid family planning waiver.

The NC General Assembly should appropriate additional stable funding to the NC Division of Public Health to expand the Teen Pregnancy Prevention Initiative and revise G.S. 115C-81 (e3-8) to ensure that students are receiving medically accurate information and that schools are using evidence-based approaches to prevent unwanted pregnancies and the transmission of STD/HIV.

The NC Division of Public Health should assess the potential costs and benefits to the state of providing some level of service to all pregnant adolescents and adolescent parents by reviewing evaluation data from programs serving these populations across the country.

The Child Maltreatment Prevention Leadership Team should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other substance abuse treatment organizations to increase the number of substance abuse treatment programs with a particular focus on gender specific programs for pregnant women and women with children, and increase outreach to identify women in need of these services. (priority)

The NC Division of Public Health should work with the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, the NC
Division of Social Services, the NC Division of Medical Assistance, professional associations, and appropriate health professional training schools to jointly develop a strategy to assess the prevalence of maternal and postpartum depression for North Carolina women, and examine the issues regarding screening for, access to, and availability of services for this condition. (priority)

- The Child Maltreatment Prevention Leadership Team should work with the NC Coalition Against Domestic Violence and other domestic violence advocates, PCA North Carolina, the NC Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and the NC Division of Public Health’s Injury and Violence Prevention Branch to identify and pilot evidence-based or primary prevention strategies for domestic violence and child maltreatment.

- The NC Office of Education Services should work with PCA North Carolina to strengthen early intervention services with regard to parent-child interaction and child maltreatment prevention for families of children with special needs enrolled in their services.

- The Child Maltreatment Prevention Leadership Team should work with the Early Childhood Comprehensive System Initiative, the NC Partnership for Children, the NC Division of Child Development, and other appropriate organizations to identify strategies to increase the availability of affordable, quality childcare and request that the NC General Assembly increase funding for childcare subsidies to county departments of social services offices to ensure that 1% of additional families needing childcare subsidies are served each year until at least 50% of eligible families are being served.

- The Child Maltreatment Prevention Leadership Team should work with the State Emergency Management Team and other NC disaster response professionals and rapid response professionals to increase awareness of increased risk for child maltreatment in young children, particularly inflicted traumatic brain injury, occurring immediately after and up to six months following a natural disaster, and to ensure that appropriate parent support services are in place for those families at highest risk.

- The Child Maltreatment Prevention Leadership Team should work with state and local nonprofit organizations to increase the capacity of local communities to identify and implement research-based strategies focused on the primary prevention of child maltreatment among military families and communities.

- The Child Maltreatment Prevention Leadership Team should work with the NC Department of Corrections to examine whether incarcerated parents have a higher risk of future child maltreatment, and if so, develop recommendations to address this issue.

- The NC Department of Public Instruction should ensure that funds from the NC Children’s Trust Fund are used to support a full-time administrator for the NC Children’s Trust Fund whose responsibilities are solely dedicated to child maltreatment prevention efforts.

- The NC General Assembly should make necessary funds available to implement the recommendations of the Task Force on Child Abuse Prevention through the implementation of an additional fee on birth certificates, marriage licenses, and
divorce decrees, or through a check-off on income taxes for the NC Children’s Trust Fund, and to appropriate funds to replicate specific programs identified as evidence-based or promising in preventing child maltreatment or strengthening families. (priority)

- The Child Maltreatment Prevention Leadership Team should work to increase funds available to implement the recommendations of Task Force on Child Abuse Prevention with a specific focus on the support of evidence-based and promising child maltreatment prevention programs.
Florida State

Florida’s State Plan for the Prevention of Child Abuse, Abandonment, and Neglect
July 2005 through June 2010

Florida’s Plan was developed by The Florida Inter program Task Force. There are two primary outcomes Florida seeks to achieve:
1. By June 30, 2010, the child maltreatment rate will be reduced from the fiscal year 2003-2004 statewide rate of 32.3 to 15.0 per 1,000 children.
2. By June, 30, 2010 the re-abuse rate within six months of initial abuse will be reduced from the 2003 statewide rate of 8.8% to 4.0%.

Florida plans to achieve these outcomes by building interventions around four goals:
1. All families and communities ensure that children are safe and nurtured and live in stable environments that promote well-being.
2. State, local, and community resources comprise a collaborative, responsive, family-centered service delivery system that promotes the well-being and safety of children, families and communities.
3. The prevention continuum has the capacity to ensure the needs of children and families will be addressed competently, collaboratively, and effectively.
4. The prevention continuum’s accountability system ensures the evidence-based effectiveness of planning and resource utilization.

Florida’s programs are defined within the Primary, Secondary and Tertiary prevention definitions.
- Within each prevention discipline there are identified categories in which programs are aimed to address and the funding source. For example in Primary Prevention a category is Child Abuse Prevention Awareness, this will come from the Department of Health, one program is Safe Sleep Education and funding will be state revenue.

The Task Force recommended an implementation plan be developed by a statewide multidisciplinary work group in consultation with local planners. The plan will include timelines, outline communication strategies and will evaluate statewide and local planning and prevention efforts.

The Task Force recommended which departments should work together to achieve particular objectives. For example the Department of Law Enforcement and Department of Health shall work together in developing ways to inform and instruct appropriate local law enforcement personnel in the detection of child abuse, abandonment, and neglect and in the proper action that should be taken in a suspected case of child abuse, abandonment, or neglect.

The Task Force utilized the University of South Florida to create a workbook to guide local communities (Florida is broken into Districts where Texas is divided into Regions) on how to identify, plan and implement their own priorities.

Governor’s Office of Adoption and Child Protection
On 12 June 2007, Governor Charlie Crist signed into law a bill creating the Office of Adoption and Child Protection. The office was created with the Executive Office of the Governor for the purpose of establishing a comprehensive statewide approach for the prevention of child abuse, abandonment and neglect; promotion of adoption; and support of adoptive families. The office has a dedicated staff of four.

In October 2007, the Office established a Child Abuse Prevention and Permanency Advisory Council. This council is how Florida is coordinating and integrating prevention efforts from among 15 state-level entities. They created Planning Teams based on Circuits/Districts throughout the state. The planning teams worked from a turn-key prepared format to assure consistency in action steps and final product.

The Florida Advisory Council was concerned with cooperative planning efforts at the state level so they created two state level planning teams: Education Cooperative Planning Team and Law Enforcement Cooperative Planning Team.

- Both of the above prevention planning efforts are supported through State offices and State funding. At this time Texas’ Task Force to Reduce Child Abuse and Neglect is not.
The Washington Council for the Prevention of Child Abuse and Neglect (WCPCAN), which later changed its name to the Council for Children and Families Washington (CCF), started in 1982. Shortly thereafter, a 15-member council formed to address child abuse prevention. Members of this council included concerned citizen members, representatives from the Department of Health (DOH), the Department of Social and Health Services (DSHS), the superintendent of schools, and four legislators (two from the State Senate/two from the House; two Democrats/two Republicans). They utilized the six protective factors established in the prevention literature for children: a) nurturing and bonding, b) non-punitive discipline and guidance, c) a responsive social network, d) parental knowledge of child development, e) parent/caretaker stress management, and f) parent/caretaker effective communication skills. Thus, the council supported such programs as:

- Home visiting
- Parent education classes
- Parent support and mentoring programs
- Parent training programs, and
- Crisis nurseries

CCF awarded competitive grant money to organizations providing these services. These selected programs all demonstrated a focus on the Federal Strengthening Families model and the protective factors for child abuse, and they provided quality services for relatively low cost. CCF also required an evaluation of the programs; in 2005-2006 (the last outcome report was made public), many of the outcomes comprised participant reports on their own learning improvement, although at least some of the surveys utilized are well-established and standardized measures (e.g., parent child interaction dysfunction scale). In some programs, observational data also were collected, such as videotaped sessions between parents and children. The exact method used to code these interactions is unknown, but it appears that CCF dictated the type of data to collect. Moreover, data collection frequently occurred prior to program implementation, again at the midpoint, and after program completion (although some programs only completed pre- and post-tests). Ultimately, the programs funded by CCF appeared to have positive results overall. Among programs whose outcome was to link parents with social supports, the majority of participants reported being connected to more supports and/or reported that the quality of those connections improved. Programs that focused on helping parents develop the attitudes and skills necessary to nurture and bond with their young children demonstrated more nurturing and attachment behaviors among the parents served both through self-

---

63 Plan for the Washington Early Learning System (December 2009)
64 Washington State Home Visiting Needs Assessment Narrative (January 2011)
65 Transition plan for the Council for Children & Families to the Department of Early Learning (January 2012)
66 Washington State Early Learning Plan (September 2010)
67 Thrive by Five Washington, found August 18, 2012 at http://thrivebyfivewa.org
68 Community-Based Funded Programs Outcomes Report, WCPCAN (2006)
69 Senate Bill 5830: Home Visiting Collaboration and Consolidation (2007)
report and home visitor observation. Similarly, the majority of parents participating in programs where learning and applying positive discipline and guidance techniques was the focus, showed an increase in skills and comfort in using those skills. Nevertheless, sample sizes were small and specific measurements unclear, thus making it difficult to assess the generalizability of these findings and programs.  

Home visitation programs garnered the most support in the state. In 2007, State Senate Bill 5830 directed CCF to collaborate with other agencies to consolidate home visiting services for children and families. The Department of Social and Health Services (DSHS), the Department of Health (DOH), the Department of Early Learning (DEL), and the Family Policy Council (FPC) joined the Council to develop a statewide plan for home visiting that identified opportunities for increasing collaboration and included short and long term objectives. The state did not implement the workgroup’s initial plan due to budget constraints, but the state did award $3 million to home visiting programs, assigned CCF as the administrator of the Children’s Trust of Washington, and charged CCF with the responsibility of testing these programs. Moreover, in 2010, the Home Visiting Services Account (HVSA) was established, which matches public and private money to fund, support and evaluate evidence-based, research-based, and promising home visiting programs for some vulnerable families with young children.

The Washington State Department of Early Learning (DEL) formed in 2009 and was the nation’s first cabinet-level early learning agency. This agency represents a partnership between DEL, Thrive by Five Washington (a private, non-profit organization), and the Office of the Superintendent of Public Instruction. Washington is the only state to have these specific groups all formally committed to working together for families and children from birth to the 3rd grade. In 2010, DEL completed the Washington Early Learning Plan (ELP). The ELP is a collaborative and comprehensive strategic 10-year roadmap for building an early childhood system across the state that improves outcomes in school and in life for children. The organizations in the DEL partnership sponsored this effort, but the plan was developed in close collaboration with the Department of Health, the Department of Social and Health Services, and state and local stakeholders.

As of July 1, 2012, CCF was renamed “Strengthening Families Washington” and nested under DEL. The enabling legislation HB 1965, signed by Governor Gregoire, was part of the Governor’s and Legislature’s effort to reduce boards and commissions and streamline the government. The bill also provides the opportunity for exploration of how the state can reduce adverse childhood experiences (ACEs).

Funding Sources – an overall goal in Washington has been to diversify program resources

1. Children’s Trust Fund – multiple methods source this fund, including proceeds from residents who purchase Keep Kids Safe specialty license plates and Heirloom Birth Certificates. Grants (e.g., Burlington Northern Foundation Grant) and private donations still comprise a large portion of this fund.

---

70 Community-Based Funded Programs Outcomes Report, WCPCAN (2006)
71 Transition plan for the Council for Children & Families to the Department of Early Learning (January 2012)
72 Children's Trust Foundation History, found August 20, 2012 at http://www.childrenstrust.org/ourhistory.html
2. Private Donations
   a. CCF and DEL obtained funding from corporate sponsors. For example, the W.K. Kellogg Foundation helped Washington design and establish early learning plans and programs that advance racial equity. Bill Gates Senior also donated foundation dollars into a special account that is managed by Thrive by Five. These organizations also co-sponsored various marketing campaigns (e.g., specialty license plates and birth certificates that contribute to the Children’s Trust Fund; public awareness campaign for child abuse prevention month).

3. Federal Funding
   a. Federal CBCAP funds (Community Based Child Abuse Prevention; Title IIB of the Child Abuse Prevention and Treatment Act – CAPTA)
      i. CCF (i.e., WCPCAN) previously managed this money. CCF fought many battles to keep the CBCAP and Children’s Trust Fund revenue together, which is ideal because both funding streams can be used for the same goal (e.g., home visiting).
   b. The federal Health Resources and Services Administration awarded the Department of Health (DOH) a five year early childhood comprehensive systems (ECCS) grant in 2003. DOH used the ECCS grant to develop and support Kids Matter, a statewide partnership and strategic framework to build Washington’s early childhood system, which also included implementation of home visiting programs.
   c. Washington State received a Project LAUNCH (Linking Actions for Unmet Needs in Children’s Health) grant from the federal Substance Abuse and Mental Health Services Administration in 2008. Home visiting is one of five key strategies of Project LAUNCH.

4. State Legislative Appropriations
   a. The state legislature awarded CCF with $3 million in 2007.
   b. As part of HB 1965, the 2012 supplemental operating budget included $250,000 to develop a public-private initiative to promote innovative new approaches to prevention and mitigation of ACEs. The Department of Social and Health Services leads this effort.

5. The Home Visiting Services Account (HVSA) has become a national model for leveraging public (state and federal) and private funds to support voluntary home visiting programs and has helped Washington state invest 10 times more than it did in home visiting two years ago. As of July 1, 2012, the HVSA awarded nearly $4 million in grants to 31 evidence-based, research-based and promising home

---

73 Washington Leads, found August 18, 2012 at http://thrivebyfivewa.org/about/waleads/
74 Personal Correspondence with Chris Jamieson, who was formerly with CCF and is now the program administrator of Strengthening Families Washington (August 17, 2012)
75 Updated Strategic Plan for WCPCAN (Spring, 2006)
76 Personal Correspondence with Chris Jamieson, who was formerly with CCF and is now the program administrator of Strengthening Families Washington (August 17, 2012)
77 Plan for the Washington Early Learning System (December 2009)
78 Personal Correspondence with Chris Jamieson, who was formerly with CCF and is now the program administrator of Strengthening Families Washington (August 17, 2012)
79 House Bill 1965: Adverse Childhood Experiences (2011)
visiting programs serving about 1,000 families in 13 Washington counties. The DEL oversees the account, and Thrive by Five administers it.  

6. Partnerships

   a. Thrive by Five raises private funds to match public support for the HVSA account, and they won a $60 million Race to the Top – Early Learning Challenge grant.
   b. CCF (i.e., WCPCAN) had partnerships with a variety of other entities, such as the Blue Ribbon Collaborative (e.g., Child Abuse Prevention Month), the BUILD Initiative, Kids Matter & Head Start State Collaboration Office Joint Advisory Council, Kids Matter Early Childhood Comprehensive Systems Collaborative, Speak Up When You’re Down’ Post-Partum Depression Awareness Campaign, Leadership Advisory Group, Prevention Pays Coalition, Shaken Baby Syndrome Prevention Partnership, Strengthening Families through Early Care & Education Washington Collaboration, and Strengthening Relationships WA - Healthy Marriage Initiative.

7. Volunteer Support – volunteers provide support to the various agencies; for example, WCPCAN estimated approximately $75,130 worth of funding from volunteers in 05-06.

Lessons from Washington State

- Obtaining Federal Revenue - according to Chris Jamieson, Washington received $30-40 million from successfully drawing down Federal money. The state was awarded these competitive funds because Washington had a good system in place, including a foundation, vision, and a specific plan for how to use the money. Washington also looks to current policies to fund future programs. For instance, they are applying for money from the Federal Health Care Reform initiative to fund their ACEs’ program (Prevention and Mitigation of Adverse Childhood Experiences) because these adverse experiences are associated with various adult health risks.

- A portfolio approach to home visiting can be beneficial. In Washington, all the HV programs are managed in one place, and the specific HV program offered depends on what a particular community needs. For example, if a community is primarily Spanish speaking, then PAT might be most desirable. In communities

---

80 Thrive by Five Washington, found August 18, 2012 at http://thrivebyfivewa.org
81 Thrive by Five Washington, found August 18, 2012 at http://thrivebyfivewa.org
82 Personal Correspondence with Chris Jamieson, who was formerly with CCF and is now the program administrator of Strengthening Families Washington (August 17, 2012)
83 Washington Leads, found August 18, 2012 at http://thrivebyfivewa.org/about/waleads/
84 Updated Strategic Plan for WCPCAN (Spring, 2006)
85 Updated Strategic Plan for WCPCAN (Spring, 2006)
86 Personal Correspondence with Chris Jamieson, who was formerly with CCF and is now the program administrator of Strengthening Families Washington (August 17, 2012)
where teen pregnancy is particularly high, programs with a prenatal element might be better (e.g., NFP).

- Establish partnerships with as many organizations as possible.
- Develop strong relationships with legislators and the governor.

**Future Directions in Washington State**

- Most of the money garnered by DEL (and previously CCF) funds evidence-based programs, but DEL also uses some money to fund innovative and promising programs. For instance, Washington is interested in establishing a community-level approach to address the needs of children and families.\(^{87}\)

- As part of the 10-year early learning plan, an annual report assesses progress from the previous years and outlines strategies for the next year. In 2012, for example, Washington plans to implement a voluntary, universal pre-kindergarten program, ensure developmental screening of children from birth to third grade, and expand its home visiting program.\(^{88}\)

---

\(^{87}\) Personal Correspondence with Chris Jamieson, who was formerly with CCF and is now the program administrator of *Strengthening Families Washington* (August 17, 2012)

\(^{88}\) Early Learning Partnership 2012 Priority Strategies (2012)
Appendix 7

Child Abuse Prevention Program Pilot Revenue source: Birth Certificates

To generate the required revenue to implement a pilot prevention program to reduce child abuse and neglect in Texas, a $5 fee increase for birth certificates would cover the $4 million biennium fiscal note. Below is a breakdown of the numbers:

As recorded on the Texas Department of State Health Statistics website, this chart reports the births in Texas for years 1998-2010:

<table>
<thead>
<tr>
<th>Year</th>
<th>Births in Texas</th>
<th>% Increase from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>342,199</td>
<td>N/A</td>
</tr>
<tr>
<td>1999</td>
<td>349,157</td>
<td>2%</td>
</tr>
<tr>
<td>2000</td>
<td>363,325</td>
<td>4%</td>
</tr>
<tr>
<td>2001</td>
<td>365,092</td>
<td>0.5%</td>
</tr>
<tr>
<td>2002</td>
<td>372,369</td>
<td>2%</td>
</tr>
<tr>
<td>2003</td>
<td>381,239</td>
<td>2.4%</td>
</tr>
<tr>
<td>2004</td>
<td>381,441</td>
<td>0.05%</td>
</tr>
<tr>
<td>2005</td>
<td>385,537</td>
<td>1.1%</td>
</tr>
<tr>
<td>2006</td>
<td>399,309</td>
<td>3.4%</td>
</tr>
<tr>
<td>2007</td>
<td>407,453</td>
<td>2%</td>
</tr>
<tr>
<td>2008</td>
<td>405,242</td>
<td>-0.5%</td>
</tr>
<tr>
<td>2009</td>
<td>401,599</td>
<td>-0.9%</td>
</tr>
<tr>
<td>2010</td>
<td>386,118</td>
<td>-4%</td>
</tr>
</tbody>
</table>

Texas birth rates showed an average increase of 1.98% per year from 1998 through 2007. From 2008 to 2010, birth rates decreased, slowing the birth rates to an average increase of 1% per year. Using a projected 1% growth rate, the projected births for 2011-2017 are as follows:

<table>
<thead>
<tr>
<th>Year</th>
<th>Births in Texas</th>
<th>% Increase from previous year</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>389,979</td>
<td>1%</td>
</tr>
<tr>
<td>2012</td>
<td>393,878</td>
<td>1%</td>
</tr>
<tr>
<td>2013</td>
<td>397,816</td>
<td>1%</td>
</tr>
<tr>
<td>2014</td>
<td>401,794</td>
<td>1%</td>
</tr>
<tr>
<td>2015</td>
<td>405,991</td>
<td>1%</td>
</tr>
<tr>
<td>2016</td>
<td>410,050</td>
<td>1%</td>
</tr>
<tr>
<td>2017</td>
<td>414,150</td>
<td>1%</td>
</tr>
</tbody>
</table>
The 2016 and 2017 anticipated revenue based on the $5 birth certificate fee increase more than covers the fiscal note:

\[
\begin{align*}
403,064 \times \$5 &= 2,015,320 \\
411,126 \times \$5 &= 2,055,630 + \\
&\quad 4,070,950 \\
410,050 \times \$5 &= 2,050,250 \\
414,150 \times \$5 &= 2,070,750 + \\
&\quad 4,121,000
\end{align*}
\]

Madeline McClure 4/29/05 Updated 12/1/12
Statewide Blue Ribbon Task Force Meeting Agenda

Tuesday March 20\textsuperscript{th}, 2012
Richmond Room, 4\textsuperscript{th} Floor
Westin Galleria
Houston, TX

9 AM  Introductions: Senator Uresti will briefly speak about his vision for the SBRTF and the state

915 AM  Katherine Barillas (OneVoice, Houston): Researcher on child abuse prevention policy;
\hspace{1cm} a) will provide an overview of prevention services in the state and the 2009 U of H report
\hspace{1cm} b) provide overview of prevention recommendations being developed by other statewide research/advocacy organizations

1000 AM  Randall Alexander (University of Florida): will present a perspective of statewide prevention efforts in Florida

1030 AM  Sandra Alexander (CDC): will present her perspective on the national efforts on the reframing of child abuse prevention

1100 AM  General Discussion about next steps

1230  Conference Closing Luncheon: Dr. Greeley and Senator Uresti will make some closing comments to the conference participants

Of Note: Dr. Greeley and Senator Uresti will have a forum discussion as part of the Conference Luncheon on Monday 19\textsuperscript{th}. Dr. Greeley will make some introductory remarks and then “interview” Senator Uresti about child abuse prevention and public policy. They will also take questions from the audience.
Statewide Blue Ribbon Task Force Meeting Agenda
Monday April 15th, 2012
Austin, TX

1. Welcome and Introductions                                           9:00 am

2. Overview of the new Juvenile Justice Dept. prevention division, PEI   Lauren Rose, TCFC 9:15
3. National Guidelines and trends of CTF                                Theresa Rafael, National Alliance on Children’s Trust fund 10:00

4. Q & A                                                                All 10:45


6. Lunch 12-12:45 pm

7. Plans for Child Abuse Prevention/ PEI division                       Howard Baldwin (or Audrey and David Whiteside) 12:45-2pm

8. BRTF Closed Discussion                                               2:00-3:00pm
   Goals
   Timeline
Statewide Blue Ribbon Task Force Meeting Agenda
Friday, May 11, 2012
Meadows Foundation Executive Suites
2904 Floyd Street, Floyd 1 Conference Room
Dallas, TX 75204
214-442-1672

9:00 am Introductions and Welcome
Chris Greeley, MD, FAAP

9:15 am Overview of Today’s Goals and Presenter Guidelines
Chris Greeley, MD, FAAP

9:20 am Susan Hoff, Sr. VP of Community Impact
United Way of Metropolitan Dallas

9:40 am Jessica Trudeau, Executive Director
Child Abuse Prevention Center

10:00 am Dr. Wayne Carson, LCSW, PhD, CEO
ACH Child and Family Services

10:20 am Cindy Patrick, Senior Program Officer and
Adrianna Cueller Rojos, Senior Program Officer
Meadows Foundation, Zero to Five Funders Collaborative
Danny Henley, Program Manager
Zero to Five Funders Collaborative

10:40 am George Holden, PhD., Professor & Director of Undergraduate Studies
Dept. of Psychology, SMU

11:00 am Sylvia Orozco-Joseph, National Director
WHO program, Mental Health America Dallas

11:20 am Lydia Connor, LMSW, Volunteer Coordinator
Darkness to Light, Collin County Children’s Advocacy Center

11:45 am Lunch

12:40 pm Diane Mayfield, M. Ed., CMC, Life Coach, Relationship Coach and Group Facilitator
Statewide Blue Ribbon Task Force Final Report

Ft. Worth Child Abuse Prevention Strategic Planner

1:00 pm Martha Stowe, Executive Director
Vickery Meadows Learning Center; formerly E.D. of the Dallas County
Injury Prevention Center

Home Visitation Program Presentations

1:20 pm Laura Misuk, Regional Program Developer OK & TX
Alison Collazo, RN BSN, Nurse Supervisor, YWCA Dallas
Nurse-Family Partnership

1:40 pm Keshia Bruno
Home Instruction for Parents of Preschool Youngsters (HIPPY)

2:00 pm Terry Ford, Early Head Start -INVITED

2:20 pm Elayne Shiver, Parents as Teachers-INVITED

3:00-4:00 Closed Session: Debrief on discussion.
Plan and schedule next hearing. If needed, schedule conference call time
to further debrief on today’s presentations.
Statewide Blue Ribbon Task Force Final Report

Statewide Blue Ribbon Task Force
Meeting Agenda
Monday, June 18 2012
St. Peter – St. Joseph Children’s Home
919 Mission Road
San Antonio, TX 78210
210-533-1203

9:00 am Chris Greeley, MD, FAAP; Chair Statewide BRTF
Welcome, Introductions & Presenter Guidelines

9:15 am James Castro, LPC, LMFT; CEO, St. PJ’s Children’s Home
Statewide Blue Ribbon Task Force “Overarching” Goal

9:30 am Press Conference with San Antonio Media

10:00 am Kathleen Fletcher, P.h. D., M.P.H., President/CEO
Voices for Children, Bexar County BRTF Ex. member
Video presentation promoting child abuse prevention.

10:25 am Kim Abernethy, President/CEO
Child Safe, Bexar County BRTF Ex. member
Child sexual abuse prevention and strategies.

10:50 am Darryl Bryd, CEO, SA 2020 & Toni-Marie Van Buren, Senior Vice President, Partners for Community Change, United Way of San Antonio & Bexar County
SA 2020 Lead Partner on Family Well Being
How Family Well Being and Community Safety fit into San Antonio Mayor Julian Castro’s Community Initiative.

11:20 am Break

11:30 am Jessica Dixon Weaver, Professor, SMU
Child welfare and collaborations.

12:00 pm Lunch

1:00 pm Madeline McClure, Vice Chair Statewide BRTF
Review, summarize and prioritize information learned from presenters at May meeting.
Statewide Blue Ribbon Task Force Final Report

2:00 pm  Chris Greeley, MD, FAAP, Chair Statewide BRTF
Review, discuss and prioritize items from the Statewide Blue Ribbon Task
Force August 2011 Final Report for further strategic actions.

3:00 pm  Chris Greeley, MD, FAAP, Chair Statewide BRTF
Discussion on tasks and timelines.

4:00 pm  Adjourn
Statewide Blue Ribbon Task Force Final Report

Statewide Blue Ribbon Task Force
Meeting Agenda
Monday, July 23rd 2012
Texas Medical Association
401 West 15th Street
Austin, Texas 78701 (512) 370-1300

9:00 am Welcome, Introductions & Presenter Guidelines
Chris Greeley, MD, FAAP

9:15 am Cindy Brown, CFO, DFPS
To discuss funding & LAR process; how prevention efforts will be reflected in the budgeting process.

9:45 am David Whiteside, PhD, Director of Purchased Services
To discuss prevention programs (PEI); where the division currently stands and the future of the programs and grants.

10:45 am Audrey Deckinga, CPS Assistant Commissioner & Jane Burstain, CPS Senior Policy Analyst
To discuss CPS policy recommendations for next legislative session; how DFPS is approaching the upcoming session and budgeting cuts; the philosophy of prevention within the DFPS.

11:15 am Break

11:30 am Colleen McCall, CPS Director & Donna Wood, CPS Community Affairs
To discuss the work of the Domestic Violence Task Force; how the BRFT and the DVTF can work together.

12:15 pm Working Lunch

12:30 pm Tina Amberboy, Executive Director, Children's Commission
To discuss the work of the Children’s Commission and how the BRTF can collaborate

1:15 pm Kathryn Kramer, Office of Early Childhood Coordination, and Sherri Hammack, Texas Council on Children and Families
To provide an update on the Texas Council of Children and Families.

2:00 pm Chris Greeley, Chair State BRTF
Discussion on tasks and timelines.

4:00 pm Adjourn
Statewide Blue Ribbon Task Force Final Report

Statewide Blue Ribbon Task Force
Meeting Agenda
Monday, August 20th 2012
Texas Medical Association
401 West 15th Street
Austin, Texas 78701 (512) 370-1300

9:00 am Welcome, Introductions & Presenter Guidelines
Chris Greeley, MD, FAAP

9:15 am Kyle Janek
To discuss HHSC

9:45 am Barrie Rosenbluth of Safe Place
To discuss Teen Dating Violence

10:45 am Susan Tortolero, PhD, UT School of Public Health
To discuss teen pregnancy, the impact on the teen and her family as well as the outcome for the infant

11:15 am Break

11:30 am Jackie Macha of Strong Start
To discuss Respite Care

12:15 pm Working Lunch

12:30 pm Nancy Correa, MPH, Children At Risk Center for Parenting and Family Well-Being
To discuss the benefit of parenting programs and the Triple P program

1:15 pm Mary Riggs,
To provide an overview of Texas state home visitation strategy

2:00 pm BRTF Members Discussion of Other State Plans
Chris—NC
James—FLA
Nancy—NJ
Annette—Wisc
Madeline—Wash
Janetta—Kansas
Mary—Iowa

4:00 pm Adjourn
Statewide Blue Ribbon Task Force Final Report

Statewide Blue Ribbon Task Force
Meeting Agenda
Monday, September 17th, 2012
Texas Medical Association
401 West 15th Street
Austin, Texas 78701 (512) 370-1300

9:00 am Welcome, Introductions & Presenter Guidelines
Chris Greeley, MD, FAAP

9:15 am BRTF Members Discussion of Other State Plans
Chris—NC
James—FLA
Nancy—NJ
Annette—Wisc
Madeline—Wash
Janetta—Kansas
Mary—Iowa

10:00 am Discussion with Representative Dawnna Dukes

11:15 am Break

11:30 am Kelly White (Executive Director of Austin Children’s Shelter)

12:15 pm Working Lunch (Discuss Final Recommendations and Format)

1:00 pm Surabhi Kukki (Director of Prevention at TCFV)

1:45 pm Morgan Curtis (Director of Prevention Programs at TAASA)

2:30 pm Writing assignments and timelines

4:00 pm Adjourn
APPENDIX 9

Statewide Blue Ribbon Task Force Members Biographies

Annette Burrhus-Clay

Annette Burrhus-Clay is the Executive Director for the Texas Association Against Sexual Assault (TAASA) in Austin. She has worked for 30 years in the crime victim services field. Her areas of expertise include sexual violence, sexual harassment, and stalking. Clay is a member of several state and national advisory boards dedicated to interpersonal violence. She is a licensed law enforcement instructor in the state of Texas and continues to provide training and technical assistance as her schedule allows.

James S. Castro, LPC, LMFT

In 14 short years James has gone from graduating with his Master’s degree in Marriage & Family Therapy from St. Mary’s University to a leader in our community promoting children’s and family’s well-being. Currently he is the Executive Director of St. Peter-St. Joseph Children's Home (St. PJ’s) here in San Antonio. St. PJ’s cares for abused and neglected children, 138 at any given time, ranging in age from infancy to 17 years old. James was recognized by Governor Rick Perry for his work by appointing him in October 2009 to the Texas State Task Force to Reduce Child Abuse & Neglect.

Before joining St. PJ’s Castro was the Director of Children’s Operations at the Center for Health Care Services (CHCS). He joined CHCS in 1999. While there he transformed the children’s division into a community partner and leader in assisting children with mental health needs. As a member of the Texas State Children’s Directors Consortium he was instrumental in bringing innovative programs to Bexar County through CHCS. He volunteered for Catholic Television of San Antonio for six years as a host of one of their longest running programs, Catholicism Live. He currently holds licenses as a Licensed Professional Counselor and a Licensed Marriage & Family Therapist.

Christopher Spencer Greeley, MD, Chair
Christopher Spencer Greeley, received his undergraduate degree from Hobart College in Geneva New York where he majored in Biology and Religious Studies. He received his medical degree from the University of Virginia in 1992 and completed his internship and residency in pediatrics at Vanderbilt University. He spent three years in private pediatric practice in Franklin Tennessee before returning to Vanderbilt University in the Division of General Pediatrics in 1998. He is board certified in General Pediatrics as well as Child Abuse Pediatrics, and is a member of the American Medical Association (AMA), the American Academy of Pediatrics (AAP) and the Academic Pediatric Association (APA). He is a member of the AAP Section on Child Abuse and Neglect and Section on International Child Health. His main clinical interests are in International Child Health, Child Abuse and Neglect, and vulnerable populations.

Dr. Greeley was the 2006 Ray E Helfer Award winner. The Ray E Helfer Award is an annual award jointly presented by The American Academy of Pediatrics and The National Alliance of Children’s Trust and Prevention Funds “to a distinguished pediatrician for his or her contribution to the prevention of child abuse and neglect.” Dr. Greeley is Associate Professor of Pediatrics in the Center For Clinical Research and Evidence-Based Medicine in the Department of Pediatrics at the University of Texas Health Science Center at Houston. He spends most of his clinical time working in the Pediatric Emergency Center and inpatient ward, and training residents and medical students. He has won the Pediatrics Departmental teaching award in 2008, 2009 and 2010. He was awarded the 2011-2012 Dean’ Teaching Award for the University of Texas Health Science Center at Houston School of Medicine. He lectures locally, regionally, nationally and internationally on various topics regarding child maltreatment, vulnerable populations and the evidence-based medicine. He is the current Chair of Board of Directors for the national organization Prevent Child Abuse America (2009 to present). He was the past chair for the Research committee as well as the chair of the ad hoc Committee on Healthy Families America.

In 2010 Dr. Greeley was awarded a very competitive K23 Mentored Training grant from the NIH (NICHD). He was one of 9 nationally funded recipients in Child Abuse and
Neglect Research. He has received support from the Houston Endowment ($100,000 for 2011, $300,000 for 2012-2014) to develop and implement a comprehensive parent support center and program in Houston.

Dr. Greeley has published on various areas of child abuse. He is Associate Editor for the Journal of Applied Research on Children and is on the editorial board for The Quarterly Update, a prominent child abuse publication. He has written book chapters on Child Abuse Prevention as well as Mimics of Abusive Head Trauma. He is also a contributing editor for the AAP publication, Grand Rounds, representing the Section on Child Abuse and Neglect. He is an external reviewer for Pediatrics, The Journal of Pediatrics, Academic Pediatrics, Acta Pædiatrica, Child Abuse and Neglect, Pediatric Emergency Care, Trauma, Violence, & Abuse, European Journal of Paediatric Neurology, and Frontiers in Child and Neurodevelopmental Psychiatry.

He is married to a pediatrician and they have triplet sons.

**Nancy S. Harper, MD FAAP**

Nancy Sanders Harper is the Medical Director for the CARE (Child Abuse Resource & Evaluation) Team at Driscoll Children’s Hospital in Corpus Christi, TX. Dr. Harper is Board Certified in General Pediatrics and Child Abuse Pediatrics. She graduated from Dartmouth Medical School in 1995, and completed her pediatric residency in 1998 at Naval Medical Center Portsmouth in Virginia.

After graduation, Dr. Harper served as a staff pediatrician and Child Abuse Consultant for Naval Medical Center Portsmouth, and then moved overseas to US Naval Hospital Okinawa in Japan where she continued as a Child Abuse Consultant and chair of the medical staff. In 2004, Dr. Harper resigned from the US Navy and entered into fellowship training in Forensic Pediatrics at Brown University in RI, graduating in January 2007. Dr. Harper has served on the Committee on Pediatric Centers of Excellence (79th Legislature) tasked with the development of guidelines for designating regional centers of excellence for child abuse in Texas.
Statewide Blue Ribbon Task Force Final Report

Dr. Harper is a consultant on the medical advisory committee for Superior Health Plan for foster care. She is the current Co-Chair for the Texas Pediatric Society Committee on Child Abuse and Neglect. Dr. Harper was appointed by Governor Perry to the state-wide Blue Ribbon Task Force to Reduce Child Abuse and Neglect (81st Legislature SB 2080). The Task Force of nine people has been legislatively charged with addressing child abuse prevention and the promotion of child well-being for the state of Texas.

Madeline McClure, LCSW, Vice Chair

Madeline McClure, LCSW is the founder and Executive Director of TexProtects, The Texas Association for the Protection of Children. Madeline Chairs the Texas Home Visiting Consortium (HVC); Chairs of The Nurse Family Partnership Statewide Advisory Board and serves as a Collaborative Council Member on the Supreme Court Permanent Judicial Commission on Children and Youth (Children’s Commission). She is Lieutenant Governor David Dewhurst’s appointee to the current Blue Ribbon Task Force (BRTF) on Child Abuse Prevention and Child Welfare (SB 1154-82(R) and the Texas Speaker of the House Appointee to the previous BRTF enabled by SB 2080 (81-R). After earning her Economics degree from Rutgers University, followed by a 9-yr. career in finance as V.P. of SG Warburg in Manhattan, Madeline switched careers after earning her MSSW and her clinical license, practicing over 5 years providing therapy to child abuse victims.

Madeline now focuses on making systemic change by helping thousands of children via legislative advocacy in child protection issues. She founded TexProtects, which conducts research and provides blueprints for legislation and facilitates passage of dozens of Texas policy priorities and child protection funding. In this role of TexProtects E.D., she Chairs the Child Protection Roundtable, a collaborative of statewide child abuse researchers, private providers, medical staff, legal counsel, public policy groups and other stakeholders that work towards unanimous legislative and funding priorities for the benefit of children at risk of maltreatment and those victimized by child maltreatment. She has received 10 awards for her advocacy service to the children of Texas.
Pamela A. Russell, LCSW, LPC
Pamela A. Russell has over 38 years of experience as a licensed Clinical Social Worker, Licensed Professional Counselor, LPC Supervisor and Certified Anger Resolution Therapist. She holds a Bachelor of Science in Marriage and Family Relationships from Oklahoma State University and a Master of Science in Social Work from the University of Texas at Arlington. She is a member of the American Association of Christian Counselors.

Mary Tipps
Mary Tipps is the executive director of Texans for Lawsuit Reform. She manages the day-to-day operations of this statewide advocacy organization with over 18,000 members. She represents and is a spokesman for TLR at the capitol and in communities across the state of Texas. Her previous employment was in the field of marketing, which took her from Mexico to north Texas.

Mary is a graduate of the University of Texas at Austin with a Bachelor of Arts degree in Latin American studies. She was appointed by Governor Bush to the Colonia resource committee of the Texas department of housing and community affairs. She is a resident of Austin. She is an active community volunteer. At the Austin children’s shelter, she was awarded volunteer of the year in 2003 and 2008 and has served on the board of directors since 2007. Mary also serves on the board of directors of dress for success and is a member of the settlement home for girls. She is a member of the Women’s Fund of Central Texas and chaired the fund’s 2012 and 2013 grants committee.

Janetta Michaels, MPA
Janetta Michaels received a Bachelor of Social Work from the University of North Texas, and a Masters of Public Administration from the University of Texas at Dallas. Janetta has been with the Children's Advocacy Center of Collin County since 1994, and is the Senior VP of Operations and a Forensic Interviewer. In this capacity, Janetta is directly
Statewide Blue Ribbon Task Force Final Report

responsible for program development and implementation, staff development, coordination of client services, coordination of volunteer services and forensic interviewing.

Janetta has served on numerous committees including Senator Shapiro’s Blue Ribbon Legislation Committee that designed and passed “Ashley’s Laws”, an aggressive package of sex offender laws, the Collin County Council on Family Violence, Target Kids In Court Foster Care Forum, Children's Advocacy Center of Collin County Training Institute, and the Collin County Child Fatality Review Team. Janetta conducts training in the areas of forensic interviewing and developing a multi-disciplinary team.

Adriana Maddox, JD

Adriana Benavides Maddox graduated from St Mary's University School of Law with a JD/MBA in 1999. She began her legal practice prosecuting family violence and white collar crime cases at the Webb County District Attorney's Office in Laredo, Texas, her hometown. Since 2004, she has been in private practice. Adriana's practice is primarily focused on civil litigation with an emphasis in family law, probate law, and oil and gas law.

Adriana is an active advocate for Casa de Misericordia Woman's Shelter where she works as a pro bono attorney and fundraiser. She also serves on the Board of the Children's Advocacy Center of Laredo-Webb County, where she works to ensure the safety of children and families who have fallen victim to abuse. Adriana also currently serves as the secretary for the International Good Neighbor Council, working to maintain strong ties with Mexico.

Adriana has received awards and recognition from the Laredo Police Department and the Webb County Domestic Violence Coalition for victim advocacy. She was also named Hero of Hope by the Laredo Morning Times in February 2011. She is a member of the Society of Martha Washington.
Statewide Blue Ribbon Task Force Final Report

Chair Acknowledgements

Each of the members of the Statewide Blue Ribbon Task Force has been dedicated to the well-being of the children in Texas. We spent our time and sweat to present a meaningful step forward for the state to improve the lives of its children and families. Our work could not have occurred without the active support by a number of people.

We are grateful for the support of Senator Carlos Uresti and his staff, in particular Jason Hassay and Micah Rodriguez. The Senator and his staff have provided the SBRTF with technical and administrative support which was crucial for our function and success. In addition, the SBRTF is grateful for Debbie Haluzan and the UT Systems for administrative support and keeping minutes. This represents a tremendous effort by Ms. Haluzan and we are greatly indebted.

Much of the data utilized by the SBRTF during our meetings and within this report was facilitated by both Dr. Katherine Barillas and the staff of TexProtects. Having accurate and timely data are fundamental to a meaningful prevention strategy. Dr. Barillas was a fount of knowledge and tremendous counsel on pitfalls and potential strategies. The state is very lucky to have such skill within its borders.

The SBRTF is also grateful for the hospitality it was shown by the Texas Medical Association for allowing us the use their conference facility for our meetings. The facility was a great benefit to the task force. Additionally, the SBRTF is grateful to the Department of Family and Protective Services for continued engagement over the past 12 months. We are in particular grateful for the many discussions with Audrey Deckinga, David Whiteside, Ph.D, Kelli Cleveland and Donna Norris Wood. They served as excellent resources during this process.

Christopher Spencer Greeley, MD
Chair, Statewide Blue Ribbon Task Force
Associate Professor of Pediatrics
University of Texas Health Science Center at Houston