REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT AND THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT

HEARING

BEFORE THE

SUBCOMMITTEE ON SELECT EDUCATION

OF THE

COMMITTEE ON EDUCATION AND LABOR HOUSE OF REPRESENTATIVES

ONE HUNDREDTH CONGRESS

FIRST SESSION

IELD IN WASHINGTON, DC, APRIL 29, 1987

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HEARING ON REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT AND THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT

WEDNESDAY, APRIL 29, 1987

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON SELECT EDUCATION,
COMMITTEE ON EDUCATION AND LABOR,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:20 a.m., in room 2261, Rayburn House Office Building, Hon. Major Owens (chairman of the subcommittee) presiding.

Members present: Representatives Owens, Biaggi, and Bartlett.

Staff present: Maria Cuprill, staff director; Lawrence Peters, legislative counsel; Pat Laird, legislative analyst; Yolanda Aviles, research assistant; Lisa Rogers, legislative analyst to Mr. Biaggi; David Esquith, legislative associate to Mr. Bartlett.

Mr. OWENS. The Subcommittee on Select Education of the Education and Labor Committee is now in session. I have a brief opening statement. I will enter my statement for the record and just read part of it.

This is the third and final hearing that we will be holding as a part of the reauthorization process for the Child Abuse Prevention and Treatment Act. Among the witnesses we heard from at our first hearing, which took place at New York's Founding Hospital, was the director of the hospital, a pediatrician and author, Dr. Vincent Fontana. His book, entitled, "Somewhere A Child Is Crying," was ground-breaking when it came out in the early seventies, and it still has important things to say to us today.

There is a chapter entitled, "Children's Rights: A New Crusade," and that chapter begins with a moving opening, and I quote: "Who, in our society, speaks for the children? Who speaks for them while they are still live? Not many people. Not very many people are in a position to. But even if they were, they would be talking into the wind. They can scarcely insist on upholding rights that do not even exist. Our cultural and legal traditions virtually deny the child's right to be heard or to have a spokesman. . . ."

The words are still true, despite some recent changes in our laws governing the court system. Very few of us do and can speak for children, but in this room today and at this hearing today there are many who do speak for children. There are people testifying

today who are among those who made the legislation that we are about to reauthorize possible.

Child abuse prevention legislation, family violence prevention legislation, sprang from the people. It was as a result of a need felt among the people. No political platforms and no Democratic or Republic think tanks came up with the legislation that we are reauthorizing. It was really a push from the people of a felt need, and it is that felt need which will guide us through the reauthorizing process and guarantee, despite opposition, that this act will be reauthorized.

I think Mr. Biaggi has an opening statement.

[The prepared statement of Hon. Major R. Owens follows:]

OPENING REMARKS OF CHAIRMAN MAJOR R. OWENS: CHAIRMAN OF THE HOUSE SELECT EDUCATION SUBCOMMITTEE, APRIL 29

THIS IS THE THIRD AND FINAL HEARING THAT WE WILL BE HOLDING AS PART OF THE RE-AUTHORIZATION PROCESS FOR THE "CHILD ABUSE PREVENTION AND TREATMENT ACT". AMONG THE WITNESSES WE HEARD FROM AT OUR FIRST HEARING WHICH TOOK PLACE AT NEW YORK'S FOUNDLING HOSPITAL WAS THE DIRECTOR OF THE HOSPITAL, PEDIATRICIAN AND AUTHOR, DR. VINCENT FONTANA. HIS BOOK, SOMEWHERE A CHILD IS CRYING, WAS GROUND-BREAKING WHEN IT CAME OUT IN THE EARLY SEVENTIES AND IT STILL HAS IMPORTANT THINGS TO SAY TO US TODAY. THERE IS A CHAPTER ENTITLED "CHILDREN'S RIGHT'S: A NEW CRUSADE" THAT BEGINS WITH A MOVING OPENING:

> "WHO, IN OUR SOCIETY, SPEAKS FOR THE CHILDREN ?
> WHO SPEAKS FOR THEM WHILE THEY ARE STILL LIVE ?
> NOT MANY PEOPLE. NOT VERY MANY PEOPLE ARE IN A
> POSITION TO. BUT EVEN IF THEY WERE, THEY WOULD
> BE TALKING INTO THE WIND. THEY CAN SCARCELY
> INSIST ON UPHOLDING RIGHTS THAT DO NOT EVEN EXIST.

OUR CULTURAL AND LEGAL TRADITIONS VIRTUALLY DENY THE CHILD'S RIGHT TO BE HEARD OR TO HAVE A SPOKESMAN.."

THE WORDS ARE STILL TRUE DESPITE SOME RECENT CHANGES IN OUR LAWS GOVERNING THE COURT SYSTEM. VERY FEW OF US DO AND CAN SPEAK FOR CHILDREN. IN THIS ROOM TODAY ARE SOME OF YOU WHO DO SPEAK FOR CHILDREN, AND WHOSE DEDICATED WORK ON THEIR BEHALF REMAINS THEIR STRENGTH IN THE FACE OF MINUSCULE GOVERNMENTAL INITIATIVES.

THE WITNESSES, TODAY WILL ADDRESS SOME OF THE WIDE RANGING ISSUES CONNECTED BOTH WITH THE CHANGING NATURE OF CHILD ABUSE AND FAMILY VIOLENCE IN THIS COUNTRY, AS WELL AS WITH GOVERNMENT'S ROLE WITHIN THESE DEVELOPMENTS.

FIRST WE ARE GOING TO HEAR FROM A PANEL ON FAMILY VIOLENCE. AT OUR LAST HEARING WE LISTENED TO THE ADMINISTRATION'S PLANS FOR THE "FAMILY VIOLENCE PREVENTION AND SERVICES ACT", A PIECE OF LEGISLATION THAT FORMS PART OF THE "CHILD ABUSE PREVENTION AND TREATMENT ACT". AFTER CONSIDERABLE QUESTIONING IT WAS REVEALED THAT THE ADMINISTRATION DOES NOT SEEK RE-AUTHORIZATION OF THIS SMALL BUT VITALLY IMPORTANT PROGRAM. THEIR VIEW WAS THAT THE STATES WERE TO TAKE CARE OF SUCH ITEMS AS SHELTERS FOR BATTERED WOMEN, BUT THEY COULD NOT PROVIDE US WITH ANY DATA AS TO HOW THE STATES CAN MEET THESE NEEDS IN THE FACE OF INCREASING DEMANDS

PLACED ON THE STATES' SOCIAL SERVICES BLOCK GRANT MONEY. IN THE FACE OF OVER 200,000 WOMEN AND THEIR CHILDREN RECEIVING SHELTER AND OVER 300,000 BEING TURNED AWAY EACH YEAR, THE ADMINISTRATION CALMLY PROPOSES THAT THE PROGRAM BE TERMINATED. THE ADMINISTRATION OF COURSE RATHER THAN PROPOSING AN INCREASE IN THE SOCIAL SERVICE BLOCK GRANT, TITLE XX, KEEPS ITS CURRENT FUNDING LEVEL OF $2.7 BILLION THE SAME, LEAVING THE AMOUNT $1 BILLION LESS THAN ITS FY '81 FUNDING LEVEL IN INFLATION ADJUSTED DOLLARS.

ANOTHER COMPONENT PART OF THE "CHILD ABUSE PREVENTION AND TREATMENT ACT", THE "ADOPTION REFORM ACT OF 1978" MANDATED THE ADOPTION OPPORTUNITIES PROGRAM. OUR SECOND PANEL WILL REVIEW THE LEGISLATION AS IT HAS BEEN WORKING SO FAR AND ADDRESS THE IMPORTANT NEEDS THAT THE PROGRAM STILL NEEDS TO MEET. ADDITIONALLY, THIS PANEL WILL ADDRESS THE PROGRESS THAT HAS BEEN MADE IN THE LEGAL ARENA TO DEVELOP REFORMS IN THE AREA OF CHILD ABUSE AS WELL AS FOLLOW UP ON INITIATIVES TAKEN BY CONGRESS. ONE SUCH INITIATIVE WAS THE "CHILDREN'S JUSTICE AND ASSISTANCE ACT" ENACTED IN 1986 AND FOR WHICH WE ARE STILL AWAITING THE ISSUANCE OF REGULATIONS. AS WE SHALL SEE DEDICATED GROUPS AND INDIVIDUALS STAND READY TO MAKE THIS LEGISLATION WORK SO THAT THOSE WHO COMMIT ACTS OF CHILD ABUSE CAN BE SPEEDILY BROUGHT TO JUSTICE.

OUR THIRD AND FINAL PANEL, WILL FOCUS ON THE RAPID AND DISTURBING RISE IN THE INCIDENCE OF CHILD ABUSE

OVER THE PAST SEVERAL YEARS; 54.9 PERCENT BETWEEN 1981 AND 1985. WE WILL SEEK ANSWERS TO THE QUESTION AS TO WHETHER PRESENT FEDERAL EFFORTS ARE SUFFICIENT TO STEM THIS ENORMOUS TIDE OF MISERY AND SUFFERING, AND WHAT CAN AND SHOULD BE DONE TO IMPROVE EXISTING LEGISLATION. THIS PANEL WILL ALSO ADDRESS THE PLIGHT OF ABUSE AMONG OUR POPULATION OF HANDICAPPED CHILDREN. WE HAVE DISCOVERED THAT THIS GROUP STANDS AT INCREASED RISK FOR ABUSE AND NEGLECT, AND IT WILL BE OUR TASK TO SEE WHAT MEASURES ARE CAPABLE OF REMEDYING THIS SAD AND TRAGIC PROBLEM.

OUR HEARING WILL BE OPENED BY A CONTRIBUTION FROM CONGRESSMAN GEORGE MILLER, WHOSE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES RECENTLY COMPLETED A DISTURBING REPORT ON THE PROBLEM OF CHILD ABUSE ENTITLED ABUSED CHILDREN IN AMERICA: VICTIMS OF OFFICIAL NEGLECT. WE HAVE ALL BENEFITED FROM THIS MOST COMPREHENSIVE REVIEW OF EFFORTS TAKEN BY THE STATES TO STRUGGLE WITH THE PROBLEM OF CHILD ABUSE. I GREATLY APPRECIATE HIS ATTENDANCE HERE TODAY AND LOOK FORWARD TO HIS TESTIMONY BASED ON LONG EXPERIENCE WITH THE ISSUES TO BE ADDRESSED AT TODAY'S HEARING. MR. MILLER'S TESTIMONY WILL BE FOLLOWED BY THE PRESENTATION OF MR. EUGENE THOMAS, PRESIDENT OF THE AMERICAN BAR ASSOCIATION.

Mr. BIAGGI. Thank you, Mr. Chairman.

My interest in child abuse precedes my service in the Congress, which is a service of some 18 years. You mentioned Dr. Vincent Fontana. He has been a personal friend of mine for some 30 years, and in another career he made me mindful of the question of child abuse when child abuse was hardly a subject of discussion. It concerned a very few and attracted little or no attention. I guess it wasn't until the National Enquirer conducted a survey that resulted in the startling revelation that child abuse ranked third in general public concerns, that there was a universal awakening.

As far as this program is concerned, I have been associated with it since 1974 when I was an original cosponsor of that law. During the past several years this Nation has witnessed a new scandal in the ever-continuing tragedy of child abuse and neglect. Our Nation's foster care system has been rocked by charges of abuse and neglect—a system that is overloaded, a system unable to provide proper care and services to the millions of children within the system.

I find a sad and tragic irony in this situation. Most of the children placed in foster care, especially children with handicaps, children of drug abusers, and many others were placed in foster care because they were victims of abuse and neglect at home, yet they are subjected to the same treatment while under foster care. I find this to be an appalling situation, and I pledge to work to address this problem.

To this end, I have introduced legislation, H.R. 2038, to assist States in developing a high-quality foster care system. It is time we ensure that our Nation's children in foster care receive proper care and services.

There is only one other comment I wish to make at this time. Since the start of this decade, we have seen a 55 percent rise in the number of child abuse cases. At the same time, Federal funding has actually declined by $6 million in real dollars, and now the Administration is requesting that funding be stopped for vital components of this program. I don't think it is necessary for me to elaborate on this abominable situation. We should be getting more, not less.

We have the articulation from every quarter that condemns child abuse, but those in the position to do something about it and make the criticisms of the conditions that confront us, and do nothing about it, as a matter of fact are regressive in their attitude, is something that is detestable. We intend to work very hard to see that we get some more funding, but we can't do it alone, frankly. We need the universal, vigorous, unified support of those involved, the whole network of those involved in child abuse, as well as the American population that I believe would be sympathetic.

Now sympathetic is fine. Sympathy is great, but it is not sufficient. We need a very energetic and concerted effort to meet the problem that seems to be increasing and, unless we get more funding, will certainly not diminish. That is an understatement as an assessment. We, as a government, talk about child abuse and what we are doing about it; but, by the same token, we are neglectful in honestly addressing the problem.

I want to commend you, Mr. Chairman, for the hearings you have had and your initiative in this area. You know I pledge myself to you and to your predecessors in this undertaking, because this is not just a narrow, isolated issue of child abuse when you consider all of the consequences. You are building generations of abusers and victims. We know how it relates to abusing parents and what happens to them in society. So clearly this may be the last hearing, but we have our work cut out for us, and I know that you will lead us to successes.

Thank you.

Mr. OWENS. Thank you very much, Mr. Biaggi.

Our first scheduled witness is Congressman George Miller, who is the chairman of the Select Committee on Children and Families, the one committee that has an opportunity to view children and families in their entirety. We are pleased to have Mr. Miller here to testify. The committee recently authored a report entitled, "Abused Children In America: Victims of Official Neglect."

Thank you very much for agreeing to appear here, Congressman. We certainly welcome you.

STATEMENT OF HON. GEORGE MILLER, A MEMBER OF CONGRESS FROM THE STATE OF CALIFORNIA

Mr. MILLER. Thank you, Mr. Chairman, you and your colleagues, for your timely consideration of the reauthorization of the Child Abuse Prevention and Treatment Act, and for the long-time interest that Congressman Biaggi has had in this. When I first came on the committee, he was forcing this committee to take a look and to take an active role in not only the creation of this act but the ongoing oversight of the act, and I want to thank him for that.

According to a recent USA Today poli, our family is more important to us than anything else, outranking money, health, and career, but for many the demands of work, of poverty, of raising children singlehandedly, make the demands of parenting overwhelming. Too often, adults take out these pressures on children or on each other. Sadly, the emotional scars of abuse and neglect remain with the child long after any physical injuries have healed.

A nationwide survey by the Select Committee on Children, Youth and Families, which I Chair, confirms that the abuse of children in this Nation continues to rise but that the resources to prevent and treat abused children and their families barely holds steady. It needn't be that way. As our survey, "Abused Children In America: Victims Of Official Neglect," demonstrates, we have the tools to prevent that abuse.

Before highlighting those successful programs, let me take a minute to review our committee's findings. A complete listing of these findings is submitted for inclusion in the hearing record today.

According to our report, nearly 1.9 million children were reported as victims of abuse or neglect in 1985—a 55 percent increase from 1981. Child sexual abuse reports rose dramatically—80 percent between 1983 and 1985—but child neglect continued to comprise the majority of cases—58.5 percent of those in 1985. The National Committee for the Prevention of Child Abuse also reports

that in 1986, 29 percent more children died at the hands of their parents than in the previous year.

Unfortunately, as States reported to us, their ability to respond to abused children and families or those known to be at risk was seriously compromised by shrinking budgets. Despite a 55 percent increase in the reports of abuse, Federal, State and local resources to address the problem rose less than 2 percent overall. Resources either declined or failed to keep pace with the influx of reports in over half of the States.

A majority of the States reported that staff shortages, inadequate training, and high personnel turnover severely hampered their ability to provide needed services. With low pay and high caseloads, it is not surprising that the turnover rate among child protection staff is quite high and the morale strained, at best.

While child protection and child welfare services require coordination of many agencies, including social services, health, education and law enforcement, several States indicated that difficulty in coordinating these efforts continues to be a barrier to better services for children.

Despite these barriers, our report documents several prevention and early intervention efforts which have averted incidents of child abuse, improved family functioning and avoided costly treatment. Most States noted that they offer one or more promising efforts, whether crisis nurseries or respite care, parent education or in-home visitors for mothers at high risk of abusing children, or early screening for developmental disabilities.

Yesterday Dr. James Garbarino, president of the Erikson Institute for Advanced Study in Child Development in Chicago, told my committee that "programs of early relationship building, parent education, and home health visiting early in life predict reduced injuries due to assault in the early childhood period," but in most instances these are pilot programs or programs serving a fraction of those in need.

I am particularly distressed by our findings that at least 18 States do not fund respite care, and in at least 19 States crisis nurseries do not exist. These programs help prevent abuse by giving parents of handicapped or chronically ill children and other stressed parents a temporary break from the burden of caring for their children. As I have testified to this committee in the past, there is mounting evidence regarding the cost-effectiveness of both these approaches.

Our report also highlights many treatment programs which have reduced recidivism, enhanced parent-child interaction, and prevented unnecessary placement of children in foster care. Of note is a trend toward family preservation services, which have proven to be far less expensive and far less disruptive than removing a child from his or her own family and placing the child in foster care or an institutionalized setting.

A good example is Florida's intensive crisis counseling program, which prevented the removal of all but 5 of 196 children they served, and is expected to net the State over $619,000 in avoided placement costs. Due to the program's success, the average number of children in foster care has dropped by 1,500 over the past 5 years.

The "Children's Place" in Missouri is another exemplary treatment program which has eliminated significant development delays in maltreated children and has saved the State thousands of dollars per child in special education costs. Unfortunately, this program reached only 83 out of a possible 1,500 needy families due to the budget constraints.

This committee has an opportunity this year to carefully expand these proven, cost-effective prevention and treatment services. If left to the current administration, despite its rhetoric about the importance of the family, little systemic effort will be made in this direction.

This administration has requested zero funding to improve the handling, investigation and prosecution of child abuse cases as enacted by the Children's Justice Assistance Act of 1986. This administration has requested zero funding for the children's trust funds, one of the key innovations States have developed to support child abuse prevention activities, and it has refused to allocate any monies for fiscal year 1987 for these services, even though the funds were provided by Congress.

This administration has requested no funds for respite care or crisis nurseries demonstration programs enacted in 1986, and again this year the administration proposed to lump together the children's programs, including child abuse prevention, child welfare and other social services under a "generic appropriation" and slash the total by $100 million.

Mr. Chairman and members of the committee, I fully support reauthorizing the Child Abuse Prevention and Treatment Act and strengthening its emphasis on prevention activities and prevention research. I have made some recommendations that I hope the committee will take into account during the markup.

Closely related to the problems of child abuse and neglect is family violence. The Family Violence Prevention and Services Act, which I authored in 1984 to assist victims of spouse abuse, is needed as much today as during the 5 years it took to enact it. Each year as many as 6 million women are battered by their husbands, ex-husbands or boyfriends, and it is estimated that in half of the wife-abusing families, the children are abused as well.

Yet again the resources to support shelters and related services for family violence victims, adults and children alike, are scarce. Despite the best efforts by private organizations such as the local Junior Leagues, the YWCA's, family services and United Way that support these shelters, funds continue to be very limited and many communities still have no shelters at all. The National Coalition Against Domestic Violence reports that only 1,200 safe homes and shelters exist across the Nation.

My Sister's Place, the largest shelter program in Washington, DC, turns away seven out of every eight women—and the children that accompany those women—who seek refuge. In my own community, in Contra Costa County, Battered Women's Alternatives received 5,800 calls from women in need of crisis services in the first 3 months of 1987.

Many of these women and children have critical medical, housing and legal needs, as well as serious substance abuse and nutritional problems. In most instances, we are also talking about

women whose own resources are minimal or nonexistent and who need a chance to get back on their feet economically as well as emotionally. As a result, shelters must do more than just provide protection and a warm meal. They must provide counseling, housing and employment referral services, legal advice, child care and other services for children. Otherwise, most of these women and their children will be forced to go back into the abusive situation.

I am proud to say that family violence organizations in California's San Francisco Bay area have developed pioneering prevention and early intervention services. In June, the Battered Women's Alternatives will have trained emergency room personnel in five Bay area hospitals to identify and treat spouse abuse. In addition, Battered Women's Alternatives is undertaking an exciting project for high school students which will include a video on preventing violence in their teen dating relationships. Battered Women's Alternatives also has 1 of 10 men's treatment groups in the country. About 75 percent of the men graduating from their program remain nonviolent one year after therapy.

The administration's response to family violence is just as neglectful as its response to child abuse. As in previous years, it has again requested zero funding for fiscal year 1988 for the Family Violence Prevention and Services Act, to assist battered women and their children, and it continues to delay the release of funds to States in fiscal year 1987.

If we really want to reduce family violence and child abuse in this country, then reauthorization of both the Child Abuse Prevention and Treatment Act and the Family Violence Prevention and Services Act is essential. I urge my colleagues to join me in making sure that these crucial bills are adequately funded and appropriately implemented.

I again thank you, Mr. Chairman, and members of the committee for the opportunity to address the subcommittee.

[The prepared statement of Hon. George Miller follows:]

THE HONORABLE GEORGE MILLER, CHAIRMAN
SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES
TESTIMONY BEFORE THE SUBCOMMITTEE ON SELECT EDUCATION

APRIL 29, 1987

CHAIRMAN OWENS AND MEMBERS OF THE SUBCOMMITTEE, I APPRECIATE THIS OPPORTUNITY TO TESTIFY REGARDING THE REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT AND THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT.

ACCORDING TO A RECENT USA TODAY POLL, OUR FAMILY IS MORE IMPORTANT TO US THAN ANYTHING ELSE -- OUTRANKING MONEY, HEALTH AND CAREER.

BUT FOR MANY, THE DEMANDS OF WORK, OF POVERTY, AND OF RAISING CHILDREN SINGLE-HANDEDLY MAKE THE DEMANDS OF PARENTING OVERWHELMING. TOO OFTEN, ADULTS TAKE OUT THESE PRESSURES ON CHILDREN OR ON EACH OTHER. SADLY, THE EMOTIONAL SCARS OF ABUSE AND NEGLECT REMAIN WITH A CHILD LONG AFTER ANY PHYSICAL INJURIES HAVE HEALED.

A NATIONWIDE SURVEY BY THE SELECT COMMITTEE ON CHILDREN, YOUTH AND FAMILIES, WHICH I CHAIR, CONFIRMS THAT ABUSE OF CHILDREN IN THIS NATION CONTINUES TO RISE, BUT THAT THE RESOURCES TO PREVENT AND TREAT ABUSED CHILDREN AND THEIR FAMILIES ARE BARELY HOLDING STEADY.

IT NEEDN'T BE THAT WAY. AS OUR SURVEY, "ABUSED CHILDREN IN AMERICA: VICTIMS OF OFFICIAL NEGLECT," DEMONSTRATES, WE HAVE THE TOOLS TO PREVENT AND TREAT ABUSE.

BEFORE HIGHLIGHTING THOSE SUCCESSFUL PROGRAMS, LET ME TAKE A MINUTE TO REVIEW OUR COMMITTEE'S FINDINGS. A COMPLETE LISTING OF THESE FINDINGS ARE SUBMITTED FOR INCLUSION IN THE HEARING RECORD.

ACCORDING TO OUR REPORT,

- NEARLY 1.9 MILLION CHILDREN WERE REPORTED AS VICTIMS OF ABUSE AND/OR NEGLECT IN 1985 -- A 55% INCREASE SINCE 1981.

- CHILD SEXUAL ABUSE REPORTS ROSE DRAMATICALLY -- 80% BETWEEN 1983-85.

- BUT CHILD NEGLECT CONTINUED TO COMPRISE THE MAJORITY OF CASES -- 58.5% IN 1985.

THE NATIONAL COMMITTEE FOR THE PREVENTION OF CHILD ABUSE ALSO REPORTS THAT IN 1986, 29% MORE CHILDREN DIED AT THE HANDS OF THEIR PARENTS THAN IN THE PREVIOUS YEAR.

BARRIERS TO HELPING MALTREATED CHILDREN

UNFORTUNATELY, AS STATES REPORTED TO US, THEIR ABILITY TO RESPOND TO ABUSED CHILDREN AND FAMILIES OR THOSE KNOWN TO BE AT RISK WERE SERIOUSLY COMPROMISED BY SHRINKING BUDGETS. DESPITE A 55% INCREASE IN REPORTS OF ABUSE, FEDERAL, STATE AND LOCAL RESOURCES TO ADDRESS THE PROBLEM ROSE LESS THAN 2% OVERALL. RESOURCES EITHER DECLINED OR FAILED TO KEEP PACE WITH THE INFLUX OF REPORTS, IN OVER HALF OF THE STATES.

A MAJORITY OF STATES REPORTED THAT STAFF SHORTAGES, INADEQUATE TRAINING, AND HIGH PERSONNEL TURNOVER SEVERELY HAMPERED THEIR ABILITY TO PROVIDE NEEDED SERVICES. WITH LOW PAY AND HIGH CASELOADS, IT IS NOT SURPRISING THAT THE TURNOVER RATE AMONG CHILD PROTECTION STAFF IS QUITE HIGH AND THE MORALE STRAINED, AT BEST.

WHILE CHILD PROTECTION AND CHILD WELFARE SERVICES REQUIRE THE COORDINATION OF MANY AGENCIES, INCLUDING SOCIAL SERVICES, HEALTH, EDUCATION, AND LAW ENFORCEMENT, SEVERAL STATES INDICATED THAT DIFFICULTY IN COORDINATING THESE EFFORTS CONTINUES TO BE A BARRIER TO BETTER SERVICES FOR CHILDREN.

SUCCESSFUL PREVENTION EFFORTS

DESPITE THESE BARRIERS, OUR REPORT DOCUMENTS SEVERAL PREVENTION AND EARLY INTERVENTION EFFORTS WHICH HAVE AVERTED INCIDENTS OF CHILD ABUSE, IMPROVED FAMILY FUNCTIONING AND AVOIDED COSTLY TREATMENT.

MOST STATES NOTED THAT THEY OFFER ONE OR MORE PROMISING EFFORTS, WHETHER CRISIS NURSERIES OR RESPITE CARE, PARENT EDUCATION OR IN-HOME VISITORS FOR MOTHERS AT HIGH RISK OF ABUSING THEIR CHILDREN, OR EARLY SCREENING FOR DEVELOPMENTAL DISABILITIES.

JUST YESTERDAY, DR. JAMES GARBARINO, PRESIDENT OF THE ERIKSON INSTITUTE FOR ADVANCED STUDY IN CHILD DEVELOPMENT IN CHICAGO, TOLD MY COMMITTEE THAT "PROGRAMS OF EARLY RELATIONSHIP BUILDING, PARENT EDUCATION, AND HOME HEALTH VISITING EARLY IN LIFE PREDICT REDUCED INJURIES DUE TO ASSAULT IN THE EARLY CHILDHOOD PERIOD."

BUT IN MOST INSTANCES, THESE ARE PILOT PROGRAMS, OR PROGRAMS SERVING A FRACTION OF THOSE IN NEED. I AM PARTICULARLY DISTRESSED BY OUR FINDING THAT AT LEAST 18 STATES DO NOT FUND RESPITE CARE AND THAT IN AT LEAST 19 STATES, CRISIS NURSERIES DO NOT EXIST. THESE PROGRAMS HELP PREVENT ABUSE BY GIVING PARENTS OF HANDICAPPED OR CHRONICALLY ILL CHILDREN AND OTHER STRESSED PARENTS A TEMPORARY BREAK FROM THE BURDEN OF CARING FOR THEIR CHILDREN. AS I HAVE TESTIFIED TO THIS COMMITTEE IN THE PAST, THERE IS MOUNTING EVIDENCE REGARDING THE COST-EFFECTIVENESS OF BOTH OF THESE APPROACHES.

SUCCESSFUL TREATMENT EFFORTS

OUR REPORT ALSO HIGHLIGHTS MANY TREATMENT PROGRAMS WHICH HAVE REDUCED RECIDIVISM, ENHANCED PARENT-CHILD INTERACTION, AND PREVENTED UNNECESSARY PLACEMENT OF CHILDREN IN FOSTER CARE.

OF NOTE IS A TREND TOWARD FAMILY PRESERVATION SERVICES, WHICH HAVE PROVEN TO BE FAR LESS EXPENSIVE AND FAR LESS DISRUPTIVE THAN REMOVING A CHILD FROM HIS OR HER FAMILY AND PLACING THAT CHILD IN FOSTER CARE OR AN INSTITUTIONALIZED SETTING.

A GOOD EXAMPLE IS FLORIDA'S INTENSIVE CRISIS COUNSELING PROGRAMS (ICCP), WHICH PREVENTED THE REMOVAL OF ALL BUT 5 OF THE 196 CHILDREN THEY SERVED AND IS EXPECTED TO NET THE STATE OVER $619,000 PER ICCP IN AVOIDED PLACEMENT COSTS. DUE TO THE PROGRAM'S SUCCESS, THE AVERAGE NUMBER OF CHILDREN IN FOSTER CARE HAS DROPPED BY 1,500 OVER THE PAST FIVE YEARS.

THE "CHILDREN'S PLACE" IN MISSOURI IS ANOTHER EXEMPLARY TREATMENT PROGRAM WHICH HAS ELIMINATED SIGNIFICANT DEVELOPMENTAL DELAYS IN MALTREATED CHILDREN AND SAVED THE STATE THOUSANDS OF DOLLARS PER CHILD IN SPECIAL EDUCATION COSTS. UNFORTUNATELY, THIS PROGRAM REACHED ONLY 83 OUT OF A POSSIBLE 1,500 NEEDY FAMILIES DUE TO BUDGET CONSTRAINTS.

THIS COMMITTEE HAS AN OPPORTUNITY THIS YEAR TO CAREFULLY EXPAND THESE PROVEN COST-EFFECTIVE PREVENTION AND TREATMENT SERVICES.

IF LEFT TO THE CURRENT ADMINISTRATION, DESPITE ITS RHETORIC ABOUT THE IMPORTANCE OF THE FAMILY, LITTLE SYSTEMATIC EFFORT WILL BE MADE IN THIS DIRECTION.

THIS ADMINISTRATION HAS REQUESTED ZERO FUNDING TO IMPROVE THE HANDLING, INVESTIGATION AND PROSECUTION OF CHILD ABUSE CASES AS ENACTED BY THE CHILDREN'S JUSTICE ASSISTANCE ACT IN 1986.

THIS ADMINISTRATION HAS REQUESTED ZERO FUNDING FOR CHILDREN'S TRUST FUNDS, ONE OF THE KEY INNOVATIONS STATES HAVE DEVELOPED TO SUPPORT CHILD ABUSE PREVENTION ACTIVITIES. AND, IT HAS REFUSED TO ALLOCATE ANY MONEY FOR FY87 FOR THESE SERVICES, EVEN THOUGH FUNDS WERE APPROPRIATED BY CONGRESS.

THIS ADMINISTRATION HAS REQUESTED NO FUNDS FOR RESPITE CARE AND CRISIS NURSERY DEMONSTRATION PROGRAMS ENACTED IN 1986.

AND AGAIN THIS YEAR, THE ADMINISTRATION PROPOSED TO LUMP TOGETHER CHILDREN'S PROGRAMS, INCLUDING CHILD ABUSE PREVENTION AND CHILD WELFARE, AND OTHER SOCIAL SERVICES UNDER A "GENERIC APPROPRIATION" AND SLASH THE TOTAL BY $100 MILLION.

MR. CHAIRMAN, I FULLY SUPPORT REAUTHORIZING THE CHILD ABUSE PREVENTION AND TREATMENT ACT AND STRENGTHENING ITS EMPHASIS ON PREVENTION ACTIVITIES AND PREVENTION RESEARCH.

IN PARTICULAR, I WOULD LIKE TO RECOMMEND THE FOLLOWING:

1) STRONG SUPPORT FOR COST-EFFECTIVE PREVENTION EFFORTS, SUCH AS EARLY SCREENING AND INTERVENTION SERVICES, PARENT EDUCATION, HOME VISITOR PROGRAMS AND RESPITE AND CRISIS NURSERY PROGRAMS.

2) STRONG SUPPORT FOR COST-EFFECTIVE TREATMENT EFFORTS, SUCH AS FAMILY PRESERVATION SERVICES.

3) BETTER TRAINING PROGRAMS FOR CHILD PROTECTIVE PERSONNEL.

4) INCENTIVES TO IMPROVE INTERAGENCY COORDINATION SO THAT ABUSED AND NEGLECTED CHILDREN RECEIVE ALL OF THE NECESSARY SERVICES.

5) BETTER DATA COLLECTION ON AT-RISK POPULATIONS, INCLUDING HANDICAPPED CHILDREN; SYSTEMATIC INFORMATION COLLECTION ABOUT LAW ENFORCEMENT RESPONSES TO CASES OF ABUSE; AND EVALUATIONS OF PREVENTION AND TREATMENT EFFORTS.

FAMILY VIOLENCE PREVENTION AND SERVICES ACT

CLOSELY RELATED TO THE PROBLEM OF CHILD ABUSE AND NEGLECT IS FAMILY VIOLENCE. THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT, WHICH I AUTHORED IN 1984 TO ASSIST VICTIMS OF SPOUSE ABUSE, IS NEEDED AS MUCH TODAY AS DURING THE FIVE YEARS IT TOOK TO ENACT IT. EACH YEAR, AS MANY AS SIX MILLION WOMEN ARE BATTERED BY THEIR HUSBANDS, EX-HUSBANDS OR BOYFRIENDS. AND IT IS ESTIMATED THAT IN HALF OF WIFE-ABUSING FAMILIES, THE CHILDREN ARE ABUSED AS WELL.

YET, THE RESOURCES TO SUPPORT SHELTERS AND RELATED SERVICES FOR FAMILY VIOLENCE VICTIMS -- ADULTS AND CHILDREN ALIKE -- ARE SCARCE.

DESPITE THE BEST EFFORTS OF PRIVATE ORGANIZATIONS -- SUCH AS LOCAL JUNIOR LEAGUES, YWCAS, FAMILY SERVICES AND UNITED WAYS -- THAT SUPPORT THESE SHELTERS, FUNDS CONTINUE TO BE VERY LIMITED AND MANY COMMUNITIES STILL HAVE NO SHELTERS AT ALL. THE NATIONAL COALITION AGAINST DOMESTIC VIOLENCE REPORTS THAT ONLY 1200 SAFE HOMES AND SHELTERS EXIST ACROSS THE NATION.

MY SISTER'S PLACE, THE LARGEST SHELTER PROGRAM IN WASHINGTON, DC TURNS AWAY 7 OUT OF EVERY 8 WOMEN (AND HER CHILDREN) WHO SEEK REFUGE. IN MY OWN COMMUNITY, CONTRA COSTA COUNTY, BATTERED WOMEN'S ALTERNATIVES (BWA) RECEIVED 5,800 CALLS FROM WOMEN IN NEED OF CRISIS SERVICES IN THE FIRST THREE MONTHS OF 1987 ALONE.

MANY OF THESE WOMEN AND CHILDREN HAVE CRITICAL MEDICAL, HOUSING AND LEGAL NEEDS, AS WELL AS SERIOUS SUBSTANCE ABUSE AND NUTRITIONAL PROBLEMS. IN MOST INSTANCES, WE ARE ALSO TALKING ABOUT WOMEN WHOSE OWN RESOURCES ARE MINIMAL OR NONEXISTENT AND WHO NEED A CHANCE TO GET BACK ON THEIR FEET ECONOMICALLY AS WELL AS EMOTIONALLY. AS A RESULT, SHELTERS MUST DO MORE THAN JUST PROVIDE PROTECTION AND A WARM MEAL. THEY MUST PROVIDE COUNSELING, HOUSING AND EMPLOYMENT REFERRAL SERVICES, LEGAL ADVICE, CHILD CARE AND OTHER SERVICES FOR CHILDREN. OTHERWISE, MOST OF THESE WOMEN AND THEIR CHILDREN WILL BE FORCED TO GO BACK TO AN ABUSIVE SITUATION.

I AM PROUD TO SAY THAT FAMILY VIOLENCE ORGANIZATIONS IN CALIFORNIA'S BAY AREA HAVE DEVELOPED PIONEERING PREVENTION AND EARLY INTERVENTION SERVICES. BY JUNE, BWA WILL HAVE TRAINED EMERGENCY ROOM PERSONNEL IN FIVE AREA HOSPITALS TO IDENTIFY AND TREAT SPOUSE ABUSE. IN ADDITION, BWA IS UNDERTAKING AN EXCITING PROJECT FOR HIGH SCHOOL STUDENTS WHICH WILL INCLUDE A VIDEO ON PREVENTING VIOLENCE IN TEEN DATING RELATIONSHIPS. BWA ALSO HAS ONE OF TEN MEN'S TREATMENT GROUPS IN THE COUNTRY. ABOUT 75% OF THE MEN GRADUATING FROM THEIR PROGRAM REMAIN NONVIOLENT ONE YEAR AFTER THERAPY.

THE ADMINISTRATION'S RESPONSE TO FAMILY VIOLENCE IS JUST AS NEGLIGENT AS ITS RESPONSE TO CHILD ABUSE. AS IN PREVIOUS YEARS, IT HAS AGAIN REQUESTED ZERO FUNDING IN FY88 FOR THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT TO ASSIST BATTERED WOMEN AND THEIR CHILDREN. AND IT CONTINUES TO DELAY THE RELEASE OF FUNDS TO THE STATES FOR FY87.

IF WE REALLY WANT TO REDUCE FAMILY VIOLENCE AND CHILD ABUSE IN THIS COUNTRY, THEN REAUTHORIZATION OF BOTH THE CHILD ABUSE PREVENTION AND TREATMENT ACT AND THE FAMILY VIOLENCE PREVENTION AND SERVICES ACT IS ESSENTIAL. I URGE MY COLLEAGUES TO JOIN ME IN MAKING SURE THAT THESE CRUCIAL BILLS ARE ADEQUATELY FUNDED AND PROPERLY IMPLEMENTED.

MR. CHAIRMAN, THANK YOU ONCE AGAIN FOR THE OPPORTUNITY TO ADDRESS YOUR SUBCOMMITTEE. I WOULD BE PLEASED TO ANSWER ANY QUESTIONS OR PROVIDE ADDITIONAL INFORMATION.

FINDINGS

REPORTS OF CHILD ABUSE, PARTICULARLY SEXUAL ABUSE, ON RISE

- In a survey of the 50 States and the District of Columbia, between 1981-85, the number of children reported to have been abused or neglected rose 54.9 percent. Between 1984 and 1985 alone, child abuse reports increased nearly 9 percent. In addition, many States reported increasingly more serious and complex cases.

- Among the three major child maltreatment categories, physical abuse, sexual abuse, and neglect, reports of sexual abuse rose the fastest. For the 29 States providing complete information, sexual abuse increased 57.4 percent between 1983-84, and increased 23.6 percent between 1984-85.

REPORTS OF CHILD NEGLECT CONTINUE TO INCREASE

- Child neglect continues to represent the majority of maltreatment cases (58.5% in 1985). States providing information by type of maltreatment report a continuing increase in the number of children reported to have been neglected between 1981-85. For 1984-85 alone, these States report an overall increase of 5 percent.

- Despite the large number of child neglect cases, several States indicate growing inattention to neglected children over the past decade as reports of sexual abuse have increased.

DESPITE INCREASED REPORTS OF CHILD ABUSE, STATES UNABLE TO PROVIDE NEEDED SERVICES

- A majority of States report staff shortages, inadequate training, high personnel turnover, and a lack of resources for staffing as the principal barriers to improved child protection and child welfare services.

- For the 31 States able to provide complete information, total resources to serve abused and neglected children increased, in real terms, by less than 2 percent between 1981 and 1985.

- In 27 of these States, resources to serve abused and neglected children declined in real terms, or failed to keep pace with rapidly increasing reports of child abuse. Between 1981 and 1985, States lost more than $170 million, in real terms, in Social Services Block Grant (Title XX) funds alone; for 27 states, Title XX was the largest source of federal funds, and for 15 of them, the largest single source of funds -- federal, state or local -- for providing services to abused and neglected children and their families.

- While child protection and child welfare services require the coordination of many agencies, including social services, health, education, and law enforcement, several States indicate that difficulty in coordinating these efforts is a barrier to better services for children.

STATES CITE TWO PRINCIPAL FACTORS LEADING TO INCREASED CHILD ABUSE REPORTS

- Nearly every State ranked public awareness as a primary factor resulting in increased reports of child abuse and neglect.

- Sixty percent of the States ranked deteriorating economic conditions for families as another primary factor resulting in rising reports of child abuse and neglect.

PREVENTION RECEIVING INCREASED ATTENTION; STATES EMPHASIZING FAMILY-BASED SERVICES TO PREVENT UNNECESSARY PLACEMENT OF CHILDREN OUT-OF-HOME

- Expenditures for public awareness of child abuse and neglect have risen in 27 States. Thirty-eight States have recently established Children's Trust Funds to support prevention programs. Nearly half of the States offer parent education, while at least 15 States provide prenatal and perinatal services to high risk women and teenagers and their infants. In addition, several States provide preventive programs of respite care, crisis nurseries, and early screening for developmental disabilities, for some portion of the population.

- Citing the need for permanency in children's lives and dwindling resources available to aid abused children, States are increasingly providing services to strengthen and maintain families. Homemaker and parent aide services received higher funding in 22 and 17 States, respectively. Eighteen States reported that they are providing family preservation services.

COST-EFFECTIVE PROGRAMS PREVENT OR REDUCE CHILD ABUSE AND NEGLECT, STRENGTHEN FAMILIES AND REDUCE DEPENDENCY

- In addition to the many promising prevention programs, States identified 19 programs which, according to evaluations, have successfully prevented child abuse, improved family functioning, and avoided costly treatment.

- In addition to the many promising treatment programs, States identified 15 treatment programs which, according to evaluations, have reduced recidivism, enhanced parent-child interaction and prevented placement of children in foster care.

STATES LACK SUFFICIENT LAW ENFORCEMENT DATA AND INFORMATION ABOUT HOW FUNDS FOR CHILD ABUSE SERVICES WERE SPENT

- While nearly all States report involvement of Child Protective Services with law enforcement agencies, they cannot report the rate of indictment, prosecution and/or convictions related to child abuse and neglect, nor are they able to report the percent of substantiated cases of abuse and neglect which are referred to law enforcement authorities.

- Most States were unable to report what federal, state, or local resources they dedicated to six major services commonly provided to abused children, or children at risk of abuse. These services include: case investigation and assessment, substitute care, adoption services, casework and treatment services, child care, and staff training and education. In addition, the vast majority of States were unable to identify the number of children provided with each service.

Mr. OWENS. Thank you very much, Congressman.

I have just two basic questions: Since your committee has the advantage of having an overview of the wide variety of activities related to children and families, what would you recommend as the single most important contribution that this small effort--and we are a tiny part of the total constellation of programs designed to deal with children and families—what would you think is most important for us to focus on in the reauthorization process?

Mr. MILLER. Well, it's hard for me to pick the most important services with respect to families and children, but I think what we clearly see is within the child abuse and prevention field, if you will, that we have an opportunity with early intervention to prevent the repeat of the violent episode. We have the opportunity, with the counseling of families, in some cases after the removal of the child or the batterer in some fashion or another, of putting those families back together in a nonviolent situation.

I think the lesson is critical here, in the fact that not only can we allow a greater number of families to survive in a nonabusive situation, but we can dramatically reduce the requirement to remove children from their homes and the entry into foster care, which Mr. Biaggi has addressed and many of us have tried to address, which in many ways becomes almost as abusive, through the system—I'm not talking about individual people in the foster care system, but within the system—of the future of that child.

I think what we are seeing, and what I tried to say in the testimony is, what we are now seeing are a number of very, very hopeful programs around the country where prevention is the key. We have to move away from the notion that we are simply going to treat these kids after a series of abusive episodes. What we really have to look for is to provide the support systems for those families, and without passing judgment, for those families that find themselves under the kind of stress that leads to violence.

The committee is going to make available to your subcommittee just the host of programs that are available in local communities, but they are starved for funding. I just think that absent a Federal contribution to community prevention programs, they are in no way going to be able to compete with the dramatic increase in the reports that we are seeing. This committee should not be misled by what some people are suggesting, that 50 percent of those reports aren't validated and therefore the report is not accurate.

Mr. OWENS. That is the next question I was going to ask you.

Mr. MILLER. There is no evidence that that is true.

Mr. OWENS. Well, even if you make a correction in terms of the extra concern—some call it zeal—about children that might generate some false alarms, even after you make that correction, don't you still have a large number of confirmed cases?

Mr. MILLER. We have a growing number of confirmed cases and a growing number of reported cases. The ratio is remaining the same.

Let's remember where we were just a few years ago. In Virginia, the police could be called to a house in a spousal violence case, a family violence case, and unless there was blood on the woman's body or they actually witnessed the battering, they went home and

said that this wasn't a cause to be concerned and wasn't a reportable case.

What we also know is that the police tell us very often when they visited the site of a family homicide, an intrafamily homicide, they have been to that residence five and six times before but in many instances there is no report of either the violence or what have you, because it is kind of settled down and everybody goes on their way.

I daresay that even if you could believe the critics of the figures—and I don't think you can—there are enough cases, verifiable cases that are overwhelming the system, that it is very clear from all of the jurisdictions that we surveyed, that without additional federal help we are simply not going to have our resources match the political rhetoric of Members of Congress on how terrible a problem child abuse is.

I would just hope that you would make every effort to slant this program toward early intervention and prevention of those violent episodes, because I think the evidence suggests that we have a real opportunity there to certainly have a child have a better shot at healthier development and to teach these families new habits, and to put them back together in a nonabusive situation.

Mr. OWENS. Well, we certainly look forward to consulting your committee as we move forward in this reorganization process.

Mr. MILLER. Thank you, Mr. Chairman.

Mr. OWENS. Mr. Biaggi?

Mr. BIAGGI. I want to thank you for your testimony and commend you for your activity, George.

Clearly the new thrust is prevention. We have tried breaking the cycle of violence after the fact with a limited degree of success. But when you talk about the various prevention programs, some of which are very successful, you are really talking about funding.

In your studies and your activity on oversight, have you found that the various levels of government are participating in any relative degree?

Mr. MILLER. Well, I think one of the things that I pointed out in the testimony, you know, we have seen States move in the direction of a children's trust fund, and very often the central focus of that trust fund is around abuse of children. The States have put money into this trust fund to be expended, and there was an effort on the part of the Congress to see that the Federal Government participate in some kind of match and sharing of that responsibility. The administration just hasn't even risen to that occasion where States have made an effort to create new monies for the purposes of prevention of family violence, because these trust funds speak to different types of violence, but to family violence.

What we have seen is that the 2 percent increase that I'm talking about has really all been at the State and local level. They have tried to come forth with some meager increase in various States with resources, and we have just walked away from the problem, either by funding programs very late in the year—I mean, this administration are geniuses at always asking you to submit additional information, and pretty soon you are broke because you have submitted so much information but the funding has never come, and that community program has gone by the wayside.

In effect, what has happened is that this administration really doesn't believe that this is a proper function for the Federal Government, and they have walked away from it. They have used every notional delay. They have suggested repeal. They have suggested no funding for these programs, and the record is clear.

But you are right: You cannot talk about this problem without talking about money. This is one field where we are blessed with private efforts in terms of local organizations who actively participate in the community care of abused children, but it is not enough. It is not enough, and without being able to additionally leverage some Federal participation, we are going to see what I think the Select Committee found here in the last couple of months. The problem is just going to continue to outstrip whatever local government and local private sector initiatives are taking place. They will just be outstripped by this problem.

All of the evidence is in my county, which is a relatively high-income suburban county, is we are just overwhelmed with the number of cases of abused children and clearly have no ability to properly place those children. If it is happening in this county, it is happening everywhere. I meet with front-line people, and they have no money. What they are doing is engaging in the severest form of triage, in picking and choosing the most serious, the most life-threatening cases. What is happening, obviously, is that the lesser cases over time are becoming more and more difficult, more and more expensive, and certainly more unhealthy to the future of that child and that family.

Mr. BIAGGI. How do you reconcile the Administration's very sympathetic comments and concern about child abuse and their conduct with relation to funding?

Mr. MILLER. Well, you have to—in any other world it would be called fraud, because they have led people to believe that this is a serious concern that they have and they want to do something to eradicate the problem, but all of the words and all of the expressions just won't do anything about it. You know, they have stripped the resources that we were slowly building up to address this problem, and they have stripped unfortunately a great deal of morale out of private sector initiatives and local initiatives, so they have done just the opposite of what they said their real goal was, was to have this taken care of at the local level. It's just not there.

Mr. BIAGGI. Thank you. They are clearly shortsighted, because down the road the cost will be manyfold what it is now, in human terms as well as monetary terms. One day, some Administration will face the problem and face it honestly, and produce the kind of funding necessary. Otherwise, we are just looking at an explosive situation.

Mr. MILLER. I agree. One thing we know is that, left unattended, an abused child can become one of the most expensive citizens this society has as its members, and in many, many ways, not just in money but very expensive to the social fabric of this country.

Thank you again for your time.

Mr. OWENS. Thank you again.

Mr. BIAGGI. Mr. Chairman, I regret but I must leave to attend another subcommittee hearing under Education and Labor. As soon as I am through with that, I will return.

Mr. OWENS. Thank you very much.

Mr. BIAGGI. I have read some of the testimony. I don't know if Ms. Charlotte Fedders is here. I have read that one, and that is pathetic and should make a very emotional presentation.

Mr. OWENS. Thank you very much. I hope you will be able to come back, Congressman.

Our next scheduled speaker is Mr. Eugene Thomas, the president of the American Bar Association.

Mr. Thomas, thank you very much. I notice that there is a representative of the Bar Association who will testify later and will be available for questioning, but I appreciate your indicating your strong support by appearing yourself on behalf of this reauthorization.

STATEMENT OF EUGENE THOMAS, ESQ., PRESIDENT OF THE AMERICAN BAR ASSOCIATION

Mr. THOMAS. Mr. Chairman, thank you for this opportunity to make a statement and take a position publicly on what the American Bar Association considers to be one of the foremost issues of our day, and one which will become a more significant issue in the days ahead if it is not well attended now.

Mr. Chairman, for the record let me note that there are approximately 340,000 lawyers in America who choose voluntarily to become members of the American Bar Association because they wish to make a commitment and provide service to the public and to justice. It is a public service organization of lawyers which no one is obliged to participate in or to be a member of. Nonetheless, it has attracted over 340,000 people who not only sign and join and participate, but pay dues to participate and be members of the organization.

We have a role in America, Mr. Chairman, in every community of this Nation, watching what is transpiring day by day. Therefore, if I may take the few minutes we have together, I would like to remark upon those observations and let the testimony that has been written and filed speak for itself.

Mr. OWENS. Your written statement will be entered into the record.

Mr. THOMAS. Thank you, sir.

The American Bar Association membership is indeed on the front line of much of the activity that is of concern to this committee. We are eyewitnesses to the kinds of abuse and anxiety, stress and threat that is concerning the Congress and this committee today. We have occasion, through the American Bar Association, Mr. Chairman, to study and report upon a wide variety of subjects of concern to the children of this land and therefore to the very heart of this land and its future.

I have compiled for my appearance today a few of the reports that have been addressed by the House of Delegates of the American Bar Association, which recognizes the subject matter of concern, and I will, if I may, supplement the record by providing a copy of this compilation to you.

Mr. OWENS. Without objection, it will be entered in the record.

Mr. THOMAS. The index tells us that the topics addressed in recent years include a major study on child support; a major study on juvenile court proceedings; serious considerations given to the child as a witness; corporal punishment in schools; alcohol and drug abuse amongst minors; juvenile court defense and prosecution services in America; the State and local bar attention to children's issues in America; quality child care resources in our time; learning disabilities and the American child; capital punishment for juveniles; and abuse, neglect and foster home care cases; particularly in recent dates, international child abduction.

Mr. Chairman, in addition to that exhibit which speaks of the work the American lawyer sees as important in our day vis-a-vis children, the most recent issue of the American Bar Association Journal gives you a snapshot oversight of what the lawyers who are practicing in America consider to be important, because these articles all appear in the current issue of the American Bar Association Journal. I picked it at random, but it is a sampling that tells the public how vital this issue is and how right your committee is. This issue of the American Bar Association Journal goes to about 380,000 people in America—the membership, together with law schools, libraries, courts, and a variety of other places.

In this issue this month, a major article deals with spouses alleging child abuse and sexual abuse of children in divorce cases, a traumatic concern not only to the litigation of a divorce matter but to the children that are thrown into that controversy and the subject matter of it. We have an article about an Alabama community that is finding cooperation in children advocacy through a center that they have put together in a cooperative effort—volunteers participating in helping with the problem of children advocacy in a small town in America.

"Are Children Lying?" is the name of the principal article in this magazine this month, and it talks about the child who is accused of lying until case after case is dismissed because of the difficulty that a child has as a witness in a judicial proceeding. Finally, there is a specific public service article on child abuse in out-of-home settings.

Mr. Chairman, these are random selections from one month's publication, and they tell you that the people who practice law in America and do it with sensitivity and concern for justice are placing high priority on the critical needs of children.

As a person who himself has practiced law as a prosecuting attorney, as one who has helped in the development of the juvenile justice code, one who in my work in the ABA chaired the Public Education Division, focused on law-related education, youth education for children, and in particular interested in juvenile justice as it relates to disadvantaged children and illiteracy, I would like to mention, sir, that the lawyers of America are keenly aware that death and severe injury are a part of the life of many children, and the principal cause of death of a significant segment of our society—juveniles. Where we adults think about stroke and heart attack and we worry about cancer, young children have to struggle with murder and manslaughter.

We lawyers know that children's rights in civil matters need to be addressed conscientiously and ethically, and we have written an ethical code for the bar, but there needs to be an oversight for mat-

ters that are not before the courts, so that children's rights can be observed and carefully regarded. That leads us into guardian ad litem programs for children.

Here again, volunteer lawyers are doing what they can to assist but they are observing more than it is possible to put their arms around and embrace and to solve, because not all of the matters of children's rights come before a court of competent jurisdiction where they can be addressed and protected. We must reach out and realize that a tiny tip of the iceberg appears in the courts, and the majority of these matters never find their way there, never find their way into the hands of an ethical lawyer that can see that a child is protected.

Yes, Mr. Chairman, this is a Nation that loves its children, but it is a Nation that has become indifferent, euphoric and insensitive, because we think in our love that we have observed a condition of well-being. In reality, the lawyers of America know that children uniquely live in a time where there is still a segment of anarchy that prevails in this land. There is still a time in your life as a child when the laws do not protect and provide for the essential needs.

If we have a Nation in which postal service, highways, health care are critical, fundamental needs and justify government, then how can we question the critical necessity for the continuation of the laws we have today and the expansion of the funding of those laws for our youth, for our youth and our future?

We have 2,020 entities within the American Bar Association, Mr. Chairman. Some of those are well known to you because they work with projects that are funded under some of the programs that this Congress has provided for, but virtually all of those 2,020 entities are interested and concerned about the law and the child, about justice in America and for that major segment in America that we call juveniles.

Mr. Chairman, in the Founding Fathers' days of presenting the Constitution of the United States to this land, James Madison wrote that if all people in this land, if all people in this land were saints, if all of them were perfect, there would be little need for government, but that is not the case, and with that argument Madison proceeded in the Federalist Papers to persuade many, many people that we needed this government. He was right then.

The closest thing we have to innocence and to saints are indeed the children. Your efforts, sir, which we applaud and support fully, try to keep them that way and let them grow into the optimum human being in society that America needs and deserves. It is good sense and it is compassionate. It lends itself to justice. We support you fully. We stand ready to support this legislation on all calls, in all places, in every way that we can.

Thank you for the opportunity, sir, to be here.

[The prepared statement of Eugene C. Thomas follows:]

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STATEMENT OF

EUGENE C. THOMAS, PRESIDENT

on behalf of the

AMERICAN BAR ASSOCIATION

before the

SUBCOMMITTEE ON SELECT EDUCATION

COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

concerning the

CHILD ABUSE PREVENTION AND TREATMENT ACT
(Public Law 93-247; 42 U.S.C. §5101 et. seq.)

April 29, 1987

80-390 O - 88 - 2

Mr. Chairman and Members of the Subcommittee

Thank you on behalf of the American Bar Association for asking me to present this testimony relating to the Child Abuse Prevention and Treatment Act. I appear today to express the Association's strong endorsement of this important legislation. I also want to say a few words about our Association's long-term support of our in-house Child Advocacy program. It is an effort I hope to see replicated in other national professional associations that have a concern for American society in general and troubled families in particular.

Throughout my tenure as President of the Association, I have paid special attention to the ways in which our children and youth could be better served by the law and the legal process. I have addressed both our own Seventh National Child Advocacy Conference and the National Conference on Juvenile Justice in order to demonstrate my concern for these issues. I believe that an elected association president, particularly in an association with a permanent program focusing on the protection of children, can have real impact in leading the association's volunteer members and related groups to focus on children's needs. For example, I have joined several of my ABA predecessors in calling on each and every state and local bar association in this country to form a special committee on children's issues.

Imagine, if you will, that my counterpart presidents of other national human service oriented professional associations responded to my challenge to do what the ABA has done. What an even greater difference this major private sector venture might make in the lives of troubled children and their families! Imagine what more we might do for abused children if major trade associations, professional societies, and service organizations all established professionally staffed child advocacy programs. Imagine the positive effect these entities could have by participating in a coordinated network to help improve the way our nation deals with this shameful problem.

Our own Child Advocacy Center, for over eight years now, has continued to make what I believe to be a number of significant accomplishments related to abused and neglected children. Through our work on the monthly ABA Juvenile and Child Welfare Law Reporter and quarterly Children's Legal Rights Journal we are keeping lawyers, judges, and child welfare system professionals abreast on the latest developments in this rapidly changing field. Furthermore, I am proud that we are developing a standardized law school course curriculum on child abuse which I hope will be used by every law school in the country, so that our aspiring lawyers can become familiar with this critical area of law and hopefully be drawn to devote their careers to this field.

In addition, we have just published two books to help children's advocates and judges use federal and state laws

effectively to help keep children from being unnecessarily removed from their family homes and placed in foster care. And we are presently developing a manual which will help programs serving abused and neglected children to improve their agency's legal services. Too often, we are hearing that inadequate legal consultation and training cause child welfare workers to misuse the judicial child protection process, and we want to do something about that.

Let me conclude by mentioning that later today you will hear from Alan Kopit, chairman of our Young Lawyers Division, who will direct his remarks to the specific impact of the legislation you are reviewing. We at the ABA have always tried to publicly support laws that contribute positively to our society, and I know that the Child Abuse Protection and Treatment Act is one of these. We not only favor its extension, but also want to help assure that it is effectively implemented throughout America.

Thank you for this opportunity to state my views on behalf of the American Bar Association and our 342,000 members.

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Mr. OWENS. I thank you, Mr. Thomas, for your very informative and strongly stated presentation.

Do you have any questions, Mr. Bartlett?

Mr. BARTLETT. I will pass on questions at this time, Mr. Chairman.

Mr. OWENS. Thank you again, Mr. Thomas.

Mr. THOMAS. Thank you, sir, and may I just provide these two documents for the record?

Mr. OWENS. Yes.

Mr. THOMAS. Thank you.

Mr. OWENS. Mr. Leslie J. Roberts of the National Black Child Development Institute.

Mr. Roberts, you have a time problem and we would like to move you out of order. The bell has just rung for a vote. If you can make your statement in 5 minutes, I will not delay you any further. Your full statement will be entered into the record. Then you will have 5 minutes for the oral statement.

STATEMENT OF LESLIE J. ROBERTS, MEMBER OF THE BOARD OF DIRECTORS OF THE NATIONAL BLACK CHILD DEVELOPMENT INSTITUTE, INC.

Mr. ROBERTS. Allow me to thank you, Mr. Chairman and members of the committee, for your consideration there and for the opportunity to testify in these proceedings. We are pleased to have the opportunity to testify on the Child Abuse Prevention and Treatment Act and the Family Violence Prevention and Services Act.

I am a member of the Board of Directors for the National Black Child Development Institute, Inc., Washington, D.C. I will acknowledge, along with many of the persons who have already testified, that there is a very serious problem in the area of child abuse and protection. We have become aware that although there is considerable evidence that in this country we value and love our children, there is also evidence that we are neglectful of our children, and the latter seems to overwhelm.

We also would call attention to the fact that black children are over-represented, both in incidence reports—black children and families are over-represented—and in foster care and so on. Researchers believe that child maltreatment and family violence have many overlapping causes. According to the 1980 census, black children accounted for about 15 percent of all the children in the United States. However, with respect to reported child abuse after remaining relatively constant for a while at about 19 percent, we see very dramatic and alarming rises in the incidence as reported in the statistics.

The National Black Child Development Institute believes that social and economic factors play a crucial role in child abuse. Therefore, we believe that it is particularly important to the black community and other disadvantaged populations that policies and practices be established that address the social context of abuse, as well as the individualized identification and treatment of the parents concerned.

In an effort to remain within the 5-minute constraint, I want to make one point very clear: that the National Black Child Development Institute very strongly and unequivocally recommend continuation of the Center, of the NCCAN. However, we see that since 1974, a relatively short history, there have been commendable gains, there have been commendable services by NCCAN, and we want to note those, but our support comes also with a concern and with some vision of what needs to be done, and we have some rather specific recommendations in that regard that we would like to move to.

We have already heard testimony as to some of the problems of agencies out there where the tire meets the road, serving very troubled families and children, faced with under-funding, faced with morale problems, faced with staff turnover and the like. These things come back to adequate funding, largely, and we are very, very concerned and have some strong recommendations that we look to these conditions within NCCAN itself. If NCCAN is to carry out this charge as defined in the legislation, there must be a deployment of resources there.

Problems in NCCAN administration and decisionmaking mechanisms have been well documented in previous testimony. Peer review systems should be established.

[The prepared statement of Leslie J. Roberts follows:]

NATIONAL
BLACK
CHILD
DEVELOPMENT
INSTITUTE, INC.

TESTIMONY SUBMITTED BEFORE
THE HOUSE SUBCOMMITTEE ON SELECT EDUCATION

on

Reauthorization of the
"Child Abuse Prevention and Treatment Act"
and the
"Family Violence Prevention Services Act."

Prepared by

Leslie J. Roberts
Board of Directors
National Black Child Development Institute

April 27, 1987

1463 Rhode Island Avenue, N.W., Washington, D.C. 20005 (202) 387-1281

To the members of the House Subcommittee on Select Education, my name is Leslie J. Roberts and I am pleased to have this opportunity to testify in regards to the reauthorization of the "Child Abuse Prevention and Treatment Act" and the "Family Violence Prevention Services Act." I am a member of the Board of Directors for the National Black Child Development Institute, Inc., Washington, D.C.

The National Black Child Development Institute (NBCDI) is a national, membership organization dedicated to promoting the healthy development of Black children. In 33 local affiliates throughout the United States, volunteers engage in advocacy activities and provide services to thousands of children. Our constituency are Black children and families of every economic and social group who want to provide a good life for their children.

It is frequently said that America is a youth-oriented culture. While this is true in many ways - clothing styles, music, choice of foods - in other ways, it is a fact that Americans do not really care very much for children. The size of the problem of child abuse and neglect in the United States is evidence of this.

Children have been ill-treated by adults throughout history, but until recently, the problems of abuse and neglect of children were considered only in terms of individuals cases - "that guy down the street who is hard on his kids." But we now realize that

the "guy down the street" had literally thousands of companions. Findings continue to show that child abuse, far from being rare, isolated events is a chronic condition for many children. We have become aware that the abused child is the "littlest victim" in our society. The problem of child abuse and neglect now ranks as one of the greatest risks to the health of our nation's children.

Arguably, child maltreatment and family violence can be listed among the most serious social problems in Black communities across the country. Some researchers theorize that child abuse and neglect, family violence, and homicide are points on a continuum and not specific and discrete dysfunctions. These researchers believe that child maltreatment and family violence have many overlapping causes.

According to the 1980 census, Black children accounted for about 15% of all children in the United States. From 1976 to 1980, the proportion of child abuse and neglect reports involving Black children remained relatively constant at about 19%. In 1982, the increase in reported cases was obvious as the national data indicated that Black children were the reported victims in 22% of all child maltreatment reports. While Black children appear to be disproportionately over-represented as victims of abuse, this increase in reported cases is not a problem found only in the Black community. Although the true prevalence of child abuse is unknown, the number of reported cases, nationally,

has increased 146% since 1976. The number of reported cases has increased annually, with more than a million reported cases of child abuse in 1983.

The National Black Child Development Institute believes that social and economic factors play a crucial role in child abuse. Therefore, we believe that it is of particular importance to the Black community and other disadvantaged populations that policies and practices be established that address the social context of abuse as well as the individualized identification and treatment of the parents concerned.

The vision, scope, and mission of a National Center on Child Abuse and Neglect are well founded. Since the National Center has come into being, the efficacy of a National Health and Human Services program has been demonstrated. The accomplishments of NCCAN as it pursues the statements of purpose as defined in the law are commendable and there is no question that continuation is warrented. The National Black Child Development Institute, Inc. wishes to go on record as firmly and unequivocally recommending reauthorization of NCCAN. In addition to the many significant contributions and achievements NCCAN has made, it has been sustained by another very significant and necessary development. That is the strong bi-partisan support which was evident in the formulation and development of NCCAN and which must be maintained.

We endorse reauthorization even though we recognize that there have been excesses and errors in judgment as well as accomplishments in the short history of NCCAN. Available data indicate that the need for a national center is greater today than when it was orginally established. It is apparent too that Black children and Black families and some other minorities are at relatively greater risk and are over-represented in the incidence of abuse and neglect statistics, foster care, and so on.

We recommend that Black and other disadvantaged populations be deliberately included in the beneficial work and assets of NCCAN. We want these populations to have a greater share in NCCAN's effective gains in preventing and treating child abuse and neglect. This leads us to urge specific procedural reforms to improve management of the Center and to ensure accountability.

A. Management and accountability of Center needs improvement.

1. Problems in NCCAN administration and decision making mechanisms have been well documented in previous hearings, congressional and administration investigations.

2. The process of allowing some proposals for funding to be administratively reviewed rather than evaluated by some mechanism of peer review should be discontinued.

3. Peer review systems should be established for determining funding for external projects. Reviewers should be

individuals with professional credentials and expertise in the subject matter addressed, with specific terms of appointment staggered to ensure continuity of the review process over time. All proposals responding to a particular priority should be subject to the same review. Excluding application of specific confirming criteria, approval of funding should accurately reflect reviewer priority scores for funding. Procedures need to be implemented which ensure openness of the review and funding process, including written notification of priority scores received, review of reviewer comments, etc., as a matter of standard operating procedure.

4. Specific agency discretionary funds should be set-aside to meet legitimate special agency needs/issues (perhaps 3% - 5% of total), funding on non-responsive, yet promising proposals.

B. Staffing Instability creates problems of leadership.

1. NCCAN is plagued by staff instability, poor morale, and low level of content expertise. We suggest funding of a specific study to address lack of staff stability and low morale within NCCAN with specific procedural recommentations.

a. impact of high frequency of staffing changes and

overall levels of staffing to effectively carry out mandate.

b. lack of expertise/specialization of many current staff reflecting frequent transfer and replacements.

C. Procedures/criteria needed to encourage (rather than discourage) small and minority non-profit organizations.

1. Requirements for 25% or more matching funds functionally discriminate in favor of large, well-established mainstream or affluent non-profit organizations and agencies.

2. Lack of pre-application assistance further limits capacity of small innovative agencies to submit viable applications.

3. Inequities in the decision-making process regarding funding decisions disproportionately result in discouraging innovative groups from submitting grant applications.

4. We would recommend:

a. Elimination of matching funds requirements -- demonstration and research projects should be judged on merits, not on agency or community affluence.

b. Specific set-aside programs for research and demonstration projects focusing on minority populations.

c. Absolute limits be placed on the amount of funds any one agency or organization can receive should be established (suggest 1% of total external project funds).

d. NCCAN should be mandated to provide pre-application assistance to groups/organizations seeking funding based on organizational request.

e. Award processes and procedures need to be standardized and notification of awards needs to be more timely to allow small organizations to better plan their applications and to compete with larger organizations.

D. There is a need for improving policy consistency and agency "openness" and accessibility.

1. Clearinghouse

a. frequent changes in location, policies, and procedures result in confusion and increased "downtime."

2. Reporting Data

   a. data collection for 1986 and 1987 remain unclear

   b. lack of a consistent approach to data over the years makes data difficult to interpret

   c. recommend establishing a consortium of national agencies to develop acceptable procedures for ongoing data collection

3. National Incidence Study

   a. consistency over time is needed; organized as an "in-house" staffed function rather than a competitive grant.

E. Funding periods should be lengthened.

1. One year to 17 months is too short a period of time to conduct meaningful research in this area.
2. The funding period is also too short for meaningful demonstration projects.
3. Increase the funding of projects of three and five-year duration.

F. Non-federal membership on the Advisory Board should be expanded.

1. Should be expanded to ensure adequate representation of non-federal expertise.

2. Should ensure adequate minority representation.
3. Terms of office should be established with staggered terms for non-federal representatives to ensure some continuity across administrations.

G. Funding Level of NCCAN is insufficient.

1. In real dollars, federal effort has declined.
2. Increased funding is needed. In addition to the points made above, specific increases in funding are needed in the following areas:

    a. To promote training and support for minority researchers:

        1. fund a small research grants program for minority researchers;
        2. fund training programs geared toward training of minority researchers and practitioners specializing in child abuse and neglect;
        3. as a matter of policy, all training efforts funded by NCCAN should have specific content addressing minority populations and their needs.

    b. Ensure full implementation of the act

        1. Children's Trust Funds
        2. Service programs (none currently funded) but authorized under Section 5103

In summary, the National Black Child Development Institute, Inc. strongly recommends continuation of NCCAN. We recommend further that appropriations in the area of child abuse be increased to at least 50 million dollars and in the area of adoption to 15 million dollars. Concurrently, we suggest that management and staff be strengthened and the NCCAN process be reviewed. It is important that NCCAN services are developed and delivered in ways that those who are the intended receipients of these services may effectively use the services. This will require the above increase in funding and an increased sensitivity to cultural differences of minorities and at least a proportionate representation of disadvantaged minorities at all staff and advisory levels.

Mr. OWENS. Thank you very much. We have your recommendations in writing. I am sorry we can't explore it in questioning with you but we will, in the child abuse panel, explore some of these same questions with the other witnesses.

Mr. ROBERTS. Thank you again, Mr. Chairman, and thanks to the committee for the opportunity to testify.

Mr. OWENS. Thank you again for coming.

We will recess for 10 minutes while the vote is being taken.

[Recess taken.]

Mr. OWENS. Please be seated.

I will have to beg your indulgence today. We have a very important bill with many amendments, so we may have interruptions again to vote.

We will now proceed with the panel on family violence. Is Ms. Fedders, Charlotte Fedders, here? Susan Kelly-Dreiss? Is that the pronunciation, Dreiss?

Ms. DREISS. Dreiss.

Mr. OWENS. And Gwendolyn Wright.

Ms. Fedders, would you like to begin?

STATEMENT OF CHARLOTTE FEDDERS

Ms. FEDDERS. Thank you, Mr. Chairman, and thank you for the opportunity to be able to testify today before the Subcommittee on Select Education in the House Education and Labor Committee.

Mr. OWENS. Excuse me, Ms. Fedders. I do hope you know your entire written statement will be entered into the record. You have 5 minutes to make any remarks you wish, and you don't have to confine yourself to the written statement.

Ms. FEDDERS. Okay, I have 5 minutes.

I am an abused spouse. As you listen to me today, I am probably being presumptuous but I do consider myself an expert on domestic violence, since I have lived domestic violence. I never wanted to speak out on any issue. I wanted to just be a housewife and a mother, and to most people I probably achieved this goal.

There was a great deal of love in my marriage, a honeymoon-like environment at times. These were the times that made the years of abuse tolerable. I was physically abused. I had black eyes, bruises, a broken eardrum, a wrenched neck, and I was emotionally abused. I had weeks and months of long silences, and eventually I really feel I became a non-person.

Years passed, and I told some people but other people I was too embarrassed to tell. Emotional control tightened. I kept trying to figure out what I was doing wrong in my marriage. I went to psychiatrists, who never said there was anything wrong with my husband. I was always trying to figure out what the weakness is in me. I talked to priests, a priest who told me to go home and love my husband. I talked to internists. I talked to my husband's internist, who said he could do nothing unless he had my husband come in for some regular exam, where there would be headaches or something that could indicate that there was some mental problem.

The episodes became more frequent, and my children began to witness the violence. I might add that I think this is a very devas-

tating and subtle form of child abuse that begins a vicious cycle of creating another abuser as an adult.

I called the county police several times. This was over 17 years of the marriage, which means it is over the period of 20 years. I don't think I ever called the police until maybe 12 years ago, 8 years ago. I was never given any support of where to go. It was never suggested that I call a hot line. There was no shelter that was ever recommended to me. I know they exist now, but this was in Montgomery County, Maryland, which is a rather progressive place to live. As recently as 1983, when I had a bruise forming on my eye, I went to a police station and was given the same—"You may issue a warrant for his arrest"—but no other advice.

At one point a police officer was called and came to my home. I had been hit by a bowl and I was having a bruise formed, and my husband had been hit by the flying glass and accused me of having hurt him. Although I had two witnesses, because he said that I attacked him we were both advised of our rights and what we could do to issue warrants for each other's arrest, and there was no intervention by the police officer.

My trial created national attention because my husband held a sensitive Government position. During the trial he admitted that he had beaten me the seven times that I had some sort of proof for, but he said I greatly exaggerated these episodes, although I say, "How can you exaggerate a black eye or a bruise?" A question that friends of mine are often asked is, "Did you ever see him hit her?" —which indicates that perhaps the authorities think these are self-inflicted injuries. One of his lawyers at one point on national television even suggested that one does not know what goes on behind the closed doors in a marriage, and that it did only happen seven times. I say once is too often.

At the trial my husband broke down and cried. The judge then let him have an extension or a continuation of the trial so he could try for a reconciliation. This man said he was sorry; therefore, the judge believed that he was sorry and it would not happen again. I did try a reconciliation, and when it fell through my husband and his lawyers accused me of not knowing what was in my own mind, and that the end of the reconciliation was forced on me.

In the past few years I have learned a lot about domestic violence. I know it has no social barriers. The FBI reports that every 18 seconds a woman is battered in the United States, and that every day four are beaten to death. Four million women a year are battered by their husbands or boyfriends. Violence against wives is not a phenomenon of this century. The "rule of thumb" came from the English common law that gave the husband, the head of household, the right to discipline his wife with a rod no bigger than his thumb.

Sadly, I now know that unless the system changes, more women will be beaten to death. Police reports indicate that 80 percent of men arrested and prosecuted for wife abuse are found guilty, and that if the court intervenes in an effective way, a woman is 50 percent less likely to be subjected to the abuse again. I also know that unless the court system changes, the abuser continues to seek and find control over his victim by continuing legal battles that waste

energy, money and time that are all needed for these victims and their families to begin some sort of recovery.

We cannot begin cutting funds for programs that have only begun to exist. Domestic violence is a fact of our society. In his State of the Union Address in 1985, President Reagan said that his administration would intensify its drive against horrible crimes like sexual abuse and family violence.

There are those who say I really haven't been hurt very seriously. There are those who say I am being exploited, that I should suffer in silence. I believe if more "ladies" refused to suffer in silence, that perhaps domestic violence would be on its way to complete elimination, not fighting for Federal and State funding.

No one human being has the right to terrorize another, especially his spouse or his children, and especially at home, a supposed place of love and safety from harm. This is a national problem and we need national legislation and help. Many States and local jurisdictions have made progress.

Mr. OWENS. Could you take a minute to sum up?

Ms. FEDDERS. I will.

Abusers are being arrested, but it is only the beginning. This is absolutely the wrong time to cut even a penny from the domestic violence program. Mr. Chairman, I urge the reauthorization of the Family Violence Prevention and Services Act. We need education. We need education of the children who will grow up to be the couples of the world, and we need education of the court system, police officers, judges, everyone.

The system needs to be changed to provide protection for the real victims. The fundamental issue, that a man can beat his wife whenever he feels he is justified, cannot continue to get lost in the existing legal system. This happened to me, and it is still happening to me. It should happen to no one else.

Thank you, Mr. Chairman.

[The prepared statement of Charlotte Fedders follows:]

TESTIMONY OF CHARLOTTE FEDDERS APRIL 29, 1987

As you listen to me today, I hope you will keep in mind that I consider myself an expert on domestic violence. One might feel that this is presumptious of me, for although many thought I lived a "fairy tale" existence, in truth I lived seventeen years as a victim of domestic violence. The very fact that I have survived this violence makes me an expert, for, unless one has experienced this particular type of abuse it is virtually impossible to comprehend all the intricasies of the "battered wife syndrome". Just believe that what I say IS so.

My childhood ambition was not to speak out for or against anyone or anything. I only wanted to be a wife and mother. Through what I saw as incredible luck, I achieved this goal. I married the man of my dreams - tall, dark, handsome, ambitious, personable, Catholic, willing to give me children and a comfortable life, filled with little strife.

We had 6 sons together. We always lived in a lovely home in the "right" neighborhood, joined Congressional Country Club and even had the traditional station wagon and labrador retriever.

Our lives were shattered for a while when we lost one son

to Spinal Meningitis, but as a strong Catholic family would, we handled this tragedy with strength and dignity. People said "there is so much love there."

And LOVE there was - a great deal of high, happy "honeymoon-like" times. These are the times that made those years of abuse tolerable. I was a battered wife - abused physically (black eyes, bruises, a broken ear drum, wrenched neck and more) and emotionally (weeks and months of long silences, constant criticism, insults and control of me to the point that I became a "non-person".)

Within the first years of my marriage, I admitted to my family that my husband had given me a broken ear drum and beaten me during my first pregnancy. They told me to leave him, but they could not bodily remove me from this situation. In the late 60's, I don't think there were any safe houses or shelters for women and to be honest, I would not have had the courage to go anyway since things like this were not supposed to happen to good wives. I was ignorant and ashamed and I was young and becoming increasingly insecure about my ability to survive without him. Even if I had known of a refuge I could not have left. I did not tell the doctor how my ear drum was ruptured, for I was sure that he would wonder what I had done to deserve such an act by my husband. I felt that no one would

do this to someone he loved unless she had done something very bad. I decided I had to be better wife. I admitted the one beating to my obstetrician since I was frightened for my baby. He too suggested that I leave the marriage, but offered no other counsel or suggestion the the problem was not mine alone. The thought of leaving emotionally paralyzed me and I prayed that the marriage would change for the better once the baby was born.

Years passed and the abuse escalated to once or more a year. The emotional control tightened. I would get desparate at times and tell family or friends about specific episodes, but after each reconciliation I would ignore their suggestions of separation and would avoid telling them about subsequent beatings. Meanwhile, I kept trying to figure out what I continued to do wrong.

In the first few years, I saw two psychiatrists, neither of whom offered any suggestion that the problem was something other than a horrible weakness of mine. At one point, I went to my internist to show him the many bruises from one particularly brutal beating. He suggested that my husband was immature. But I knew that the fault must have been mine too - I just KNEW it was.

In the next year, I saw another psychiatrist who spent 6 months helping me change myself. I lost weight and made some

attempt at telling my husband that this type of behavior was unacceptable, but the doctor offered no diagnosis to indicate that anyone other than myself was "troubled.

Awhile later I again despaired at the lack of improvement in my marriage. I could not find a way to avoid these outbursts and I felt like I was going crazy. Surely a priest could find a way to help us. I went to my pastor, who listened patiently and sent me home wtih the advice that I should give my husband some space and LOVE him. I thought I had been loving him.

As the episodes became more frequent and my children began to witness this violence (I might add that this is a very subtle and devastating form of child abuse) I became frantic for help. Twice I mustered the courage to call the county police who advised me of the procedure for issuing a warrant for my husband's arrest.(A friend also called for me once, only to be given the same routine) I had threatened to call the police before and my husband advised that such action would ruin his successful legal career and then, where would I be? The police offered no suggestion of intervention and no encouragement to call a social agency or hotline. I felt like I was a bother to the police. Years later - in 1983 - I was to experience the same feeling when I actually went to the police station with a rapidly forming black eye. I had finally found the courage to seek some protection and I left the station

feeling like a crybaby. One other time a police officer came to my home. My husband had hit me with a heavy glass bowl. A bruise was developing on my hip, but since he had been cut by some of the thrown glass, the officer advised us both that we could issue arrest warrants for each other. This time, I had two witnesses who corroborated my story, but the police officer was equally sympathetic to my 6ft. 10 in. husband. I could not believe it.

One time I even called HIS internist and told him of my husband's moods and advised him of the physical violence. This doctor, who we also saw socially and was supposedly a "friend" said he could do nothing unless my husband came in for a visit with some symptoms of headaches or a related problem. He never followed up with me or my husband.

Finally, I had the good fortune to find a psychologist who encouraged me in the realization that this was not the normal behavior of a husband towards his wife and children. As ignorant as it must sound, I was shocked to be told that I was a battered wife, a victim of domestic violence - a victim of a CRIME! It took a lot of hard work, but I finally realized the strength to file for divorce from this man I had loved so much. Had I known the many pitfalls that I would encounter in obtaining my freedom, I will tell you that I would have felt depressed, but would have gone forward, for I was finally

READY.

My husband refused a reasonable settlement proposal and our divorce was forced into open court. Our hearing created quite a sensation, for, as you know, my husband had a sensitive government position. He admitted that he had beaten me the 7 times I had some sort of proof for, although he said I had "greatly exagerrated" these episodes. How do you "exagerrate" a bruise or black eye? (By the way, a question that friends who have gone to my defense have been frequently asked is "did you ever see him hit her?" As if perhaps they were self inflicted injuries. A lawyer for my husband even went on national television to say that we do not know what goes on behind closed doors and besides, it had ONLY happened "7 times" as if that was not enough.)

I stated at the trial that this man was "the great love of my life". He cried on the stand that he was sorry and he loved and adored me. The judge postponed the hearing at my husband's request and sent us away with the suggestion that we "try again" to see if things could work out. I was incredulous! I had been so positive that I was finally doing the right thing for my children and myself. And now here was a judge telling me that maybe I needed time to think things over and after all, my husband had confessed to this silent crime; he promised he

would undergo therapy; he was a changed person! Somehow, the victimization had shifted from me and my family to my husband. It was incredible to experience!

He was so repentive, so persistent, so loving, so full of promises of reform. I had loved him so much - maybe this time would be different. So I tried for about 3 weeks and although there was no violence, I knew that there was little change, for the need to control was obvious. I ended the reconciliation attempt. Of course, when the trial resumed, the judge postponed it again since so little time had elapsed since the end of the reconciliation attempt and the trial date. Again, I was denied an end to this legal nightmare. My husband's lawyer argued that I had been forced out of the reconciliation by my lawyer and therapist, implying that I did not know what was in my own mind and heart. But at last, the judge did not take the bait and I was granted a limited divorce. In the state of Maryland, a limited divorce means that one cannot remarry and there is no final monetary award. In other words, I was still not free. I still am not. The legal hassles go on. I cannot go into the details of my present situation, but suffice it to say, my case could have been handled differently. I pray in the upcoming months that it WILL be handled more intelligently and sensitively, but I am pessimistic.

domestic violence. It knows no social barriers. The FBI reports that every 18 SECONDS a woman is battered in the United States and that every day 4 are beaten to death. Four million women a year are battered by their husbands or boyfriends. Violence against wives is not a phenomenon of this century. The phrase "rule of thumb" comes from the English common law which gave the husband the "head of household" right to discipline his wife "with a rod no bigger than his thumb." We even laughed when Ralph clenched his fist and threatened to send wife Alice "To the moon!"

Sadly, I know now that unless the system changes, more women will be beaten to death. Police reports indicate that 80% of men arrested and prosecuted for wife abuse are found guilty and that if the court intervenes in an effective way, a woman is 50% less likely to be subjected to abuse again. I also know that unless the court system changes, the abuser continues to seek and find control over his victim by continuing legal battles that waste energy, money and time that are all needed for these victims and their families to begin some sort of recovery.

We cannot begin cutting funds for programs that have only begun to exist. Domestic violence is a fact of our society.

In his State of the Union address in 1985, Ronald Reagan stated that his administration would intensify its' drive against horrible crimes like "sexual abuse and family violence." But like so many who prefer to ignore this crime when it hits too close to home, the White House said that this was a "private matter" and although presidential advisors were aware of the wife abuse allegations, they did nothing until forced to when the divorce received publicity.

There are those that say I was never hurt that seriously. There are those that say I must have "liked it" or why would I have stayed. There are those that say I am being exploited and should recognize this and keep silent. Let someone else speak out. If more "ladies" refused to suffer in silence, perhaps domestic violence would be on the way to complete elimination, not fighting for federal and state funding.

No one human being has the right to terrorize another, especially a spouse and/or children and especially at home - a supposed place of love and safety from harm. This is a national problem and we need national legislation. Many states and local jurisdictions have made progress. Abusers ARE being arrested. It is a beginning, but it is ONLY a beginning. So much needs to be done.

This is the absolute wrong time to cut even one penny from the

This is the absolute wrong time to cut even one penny from the domestic violence program.

I believe that [redacted] is crucial to this issue. Yes, we can try to play "catch up" within the existing system, but it will not take care of the real problem. Surely a simple seminar or even "MEMO" or other directive outlining the "battered wife syndrome" that would be [redacted] every [redacted] could make a dent. This approach might sound simplistic, but the [redacted] is fairly universal and academically easy to understand. But education, day care, rehabilitation, shelters and other programs cost money. States need the incentive of [redacted]

The [redacted] - not the abusers who say they are sorry. The [redacted], that a [redacted] by a [redacted] addressed. This fundamental issue cannot continue to get lost in the existing legal system. It has happened to me - it is still happening to me, it should happen to no one else!

Thank you!

Wife Abuse: The Facts

The Problem

Violence against wives is a crime of enormous proportions. It occurs in families from all racial, economic, educational, and religious backgrounds. The police department in Norwalk, Connecticut, a city with a wide socio-economic range, receives the same number of wife abuse calls as the police department in Harlem, New York, a city of comparable size. Battered women with few economic resources are more visible because they seek help from public agencies; however middle and upper class women also seek refuge and assistance, although more often in hotels and from private agencies.

Carolyn Barden and Jim Barden. "The Battered Wife Syndrome"

Each year 1.8 million wives are severely assaulted by their husbands, according to a 1976 national survey. Dr. Murray Straus, a principal researcher for this study, believes that this estimate substantially underrepresents the true extent of the problem.

Murray Straus, Richard Gelles, and Suzanne Steinmetz, *Behind Closed Doors: Violence in the American Family*

Violence against wives will occur at least once in two-thirds of all marriages, estimates researcher Maria Roy. Straus, Gelles, and Steinmetz estimate that 25 percent of wives are severely beaten during the course of their marriage.

Maria Roy, *The Abusive Partner*; Straus, Gelles and Steinmetz, *Behind Closed Doors*

In almost three quarters of reported spouse assaults, the victim was divorced or separated at the time of the incident. This finding suggests that battering may be more prevalent than currently estimated, since most incidence surveys limit their samples to married couples.

Department of Justice, *Report to the Nation on Crime and Justice*

A battering incident is rarely an isolated occurance; it usually recurs frequently. According to a 1982 survey of women in Texas, 19 percent of the women who were abused during the previous year, and 25 percent of the women abused during their lifetimes had been victimized at least once a week.

Raymond H.C. Teske and Mary L. Parker, *Spouse Abuse in Texas: A Study of Womens Attitudes and Experiences*

Battering tends to escalate in severity over time. Many of the injuries sustained by battered women require medical attention. More than one million abused women seek medical help for injuries caused by battering each year. Twenty percent of visits by women to emergency medical services are caused by battering. Twelve percent of the injuries sustained in reported incidences of battering in Minnesota required hospitalization.

Evan Stark and Anne Flitcraft, "Medical Therapy as Repression: The Case of the Battered Women"; Minnesota Department of Corrections, *Data Summary Report*

Thirty percent of female homicide victims are killed by their husbands or boyfriends, according to an FBI report. Researchers Stark and Flitcraft found in their study that battering accounted for 25 percent of suicide attempts by women.

Federal Bureau of Investigation, *Uniform Crime Reports 1982*; Evan Stark and Anne Flitcraft, "Domestic Violence and Female Suicide"

Men commit 95 percent of all assaults on spouses, according to National Crime Survey Data from 1973 to 1977. In addition, the severity and extent of injuries incurred by men are insignificant and incomparable to those sustained by women.

Department of Justice, *Report to the Nation on Crime and Justice*

The Response

There are over 500 shelters in the country that offer emergency refuge and services to battered women and their children; it is estimated that these shelters provide only one quarter million beds annually for the several million women and children who need them. Data from the Minnesota Department of Corrections indicates that in that state alone, well-known for its extensive and innovative services for battered women, 65 percent of requests for shelter could not be met during 1981. My Sister's Place, a shelter for battered women in Washington, DC, has to turn away 7 families for every 1 they can accept.

Minnesota Department of Corrections, *Data Summary Report*

Recent federal cutbacks on funds for social services have forced many shelters to reduce their services or close their doors. Seventy-six percent of domestic violence programs have reduced their ser-

vices and 79 percent are not able to meet the needs of battered women in their communities because of federal funding cutbacks on programs such as CETA, Title XX, VISTA, and CSA.

Center for Women Policy Studies, "Federal Budget Cuts Jeopardize Domestic Violence Programs: A National Survey Report"

Police rarely file reports on domestic violence and even more rarely arrest men for battering. During a 9 month period, Cleveland police received approximately 15,000 domestic violence calls. Reports were filed in 700 of these cases, and arrests were made in 460, or one out of every 32 calls.

Ohio Attorney General, *The Ohio Report on Domestic Violence*

Although over 33 percent of nonstranger assaults involved the use of guns, knives, bludgeons, or other weapons, and over 80 percent of the victims wanted the police to make an arrest, the assailant was arrested in only 41 percent of the cases. Most of the cases were prosecuted as misdemeanors rather than felonies.

Barbara Smith, *Non-Stranger Violence: The Criminal Court Response*

Current research indicates that police should re-evaluate their common practice of temporarily separating husbands and wives following a violent incident. A recent study conducted by the Police Foundation found that there was a lower incidence of further violence when the batterer was arrested than when the police separated the parties, or informally mediated the conflict.

Lawrence Sherman and Richard A. Berk, *Police Response to Domestic Assault: Preliminary Findings*

Medical clinicians often fail to recognize women's injuries as a result of wife abuse. Abuse is identified in fewer than one out of 25 battery cases and, as a result, the medical response rarely addresses the cause of the problem. Treatment is usually symptomatic, limited to the dressing of wounds, setting of bones, and prescriptions for analgesics and tranquilizers. Often the patient is seen as the problem because of her repeated requests for help and failure to recover.

Evan Stark and Anne Flitcraft, "Medical Therapy as Repression: The Case of the Battered Woman"

All states and the District of Columbia have enacted legislation designed to protect battered women. Laws in the District and 43 states now enable battered women to obtain civil protection orders without initiating divorce or other civil proceedings, as previously required. Eleven states have enacted legislation making spouse abuse a criminal offense separate from other types of criminal offenses. Thirty-three states have expanded police power to arrest in domestic abuse cases, and 29 states have appropriated funds for services for families suffering from violence.

Lisa Lerman and Frenci Livingston, "State Legislation on Domestic Violence"

To date, no federal legislation has been enacted to address the problem of wife abuse, although at least one bill providing federal funds to shelters and other domestic violence programs has been introduced in Congress every year since 1978. As of January 1984, there were 140 cosponsors in the House of Representatives for the Family Violence Prevention and Services Amendment to the Child Abuse Prevention and Treatment Act, that would appropriate $65 million over a three-year period to fund services for domestic violence victims.

Commenting on the need for passage of the Amendment, Congresswoman Barbara Mikulski states, "Being pro-family means providing this desperately-needed support to ensure that the institution of the family is free from violence. We must begin to break the cycle of violence now."

Barbara Mikulski (D.MD), November 17, 1983

Sources

Bardwick, Carolyn and Barden, Jim. "The Battered Wife Syndrome." *Viva Magazine*, May 1978, pp. 79-81, 108-110.

Center for Women Policy Studies. "Federal Budget Cuts Jeopardize Domestic Violence Programs: A National Survey Report." *Response to Violence in the Family and Sexual Assault*, Maryfrune 1983, pp. 1-4, 12-15.

Federal Bureau of Investigation. *Uniform Crime Reports 1982*. Washington, DC: U.S. Department of Justice, 1982.

Lerman, Lisa and Livingston, Frenci. "State Legislation on Domestic Violence." *Response to Violence in the Family and Sexual Assault*, September/October 1983, pp. 1-3.

Minnesota Department of Corrections. Programs for Battered Women. *Data Summary Report*. St. Paul, MN: Minnesota Department of Corrections, 1982.

Ohio Attorney General. *The Ohio Report on Domestic Violence*. Columbus, OH: Bureau of Criminal Investigation, 1979.

Roy, Maria, ed. *The Abusive Partner*. New York: Van Nostrand Reinhold, 1982.

Sherman, Lawrence W. and Berk, Richard A. *Police Responses to Domestic Assault: Preliminary Findings*. Washington, DC: Police Foundation, 1983.

Smith, Barbara E. *Non-Stranger Violence: The Criminal Court Response*. Washington, DC: National Institute of Justice, 1983.

Stark, Evan; Flitcraft, Anne; et al. "Domestic Violence and Female Suicide Attempts." Paper presented at the 107th Annual Meeting of the American Public Health Association, New York City, November 3-7, 1979.

Stark, Evan and Flitcraft, Anne. "Medical Therapy as Repression: The Case of the Battered Woman." *Health and Medicine*, Summer/Fall 1982, pp. 29-32.

Straus, Murray; Gelles, Richard; and Steinmetz, Suzan. *Behind Closed Doors: Violence in the American Family*. Garden City, NY: Anchor Press, 1980.

Tsoka, Raymond H. C., Jr. and Parker, Mary L. *Spouse Abuse in Texas: A Study of Women's Attitudes and Experiences*. Huntsville, TX: Criminal Justice Center, 1983.

U.S. Department of Justice. *Report to the Nation on Crime and Justice: The Data*. Washington, DC: Government Printing Office, 1983.

BATTERER	BATTERED MATE	CHILDREN
The batterer is characterized by	The battered mate is characterized by	Children in battering homes exhibit
. . . containment of mate and employment of espionage tactics against ner (e.g., checks mileage and times errands) — cleverness depends on evel of sophistication	. . . allowing containment or confinement/restriction by mate, interpreting as sign that partner "cares"	. . . increasing deceptiveness: lying, excuses for outings, stealing, cheating
. . . no sense of violating others' personal boundaries — accepts no blame for failures (marital, familial, or occupational) or for violence	. . . gradually losing sight of personal boundaries for self and children (unable to assess danger accurately) — accepts *all* blame	. . . poor definition of personal boundaries — violation of others' personal boundaries, blame-projections
. . belief that his forcible behavior s aimed at securing the family nucleus (for the good of the family)	. . . belief that transient acceptance of violent behavior will ultimately lead to long term resolution of family problems	. . . little or no understanding of the dynamics of violence (often assumes violence to be the norm)
. . apparently feeling no guilt on motional level even after intellectual recognition	. . . emotional acceptance of guilt for mate's behavior — thinks mate "can't help it" — considers own behavior provocative	. . . self-blame (depending on age) for family feuding, separations, divorce, etc. — internal conflicts
. . generational history of family iolence	. . . generational history of family violence	. . . continuation of pattern of family violence pattern in own adulthood
. participation in pecking order attering	. . . participation in pecking order battering	. . . pecking order battering — kills animals, batters younger siblings and sometimes parents in later years
. assaultive skills which improve th age and experience accompanied y arise in danger potential and thality risks	. . . learning which behavioral events will either divert or precipitate mate's violence but level of carelessness increases — judgment of lethality potential deteriorates over time	. . . use of violence as problem solving technique in school, with peers, with family (appears as early as preschool)
. demanding and often times assultive role in sexual activities — metimes punishes with abstinence at times experiences impotence	. . . poor sexual self-image — assumption that role is to accept totally partner's sexual behavior (attempts to punish partner with abstinence result in further abuse)	. . . poor sexual image — uncertainty about appropriate behavior — confuses model identification — immaturity in peer relationships
. increase in assaultive behavior en mate is pregnant — pregnancy en marks the first assault	. . . being at high risk for assault during pregnancy	. . . higher risk for batterment (either as witnesses or victims) during mother's pregnancy
exerting control over mate by eatening homicide and/or suicide ften attempts one or both when tner separates — known to comte either or both	. . . frequent contemplation of suicide — history of minor attempts — occasionally completes either suicide or homicide of partner	. . . heightened suicide attempts — increased thoughts of doing away with self and/or murdering parents — proneness to negligence and carelessness

Ovieki O. Boyd, PhD
Karil S. Klingbeil, MSW
Seattle, Washington

BEHAVIORAL CHARACTERISTICS OF DOMESTIC VIOLENCE

icki D. Boyd, Ph.D.; Karil S. Klingbeil, M.S.W. Revised, 1979 Seattle, Washingto

BATTERER	BATTERED MATE	CHILDREN
Batterers are found in all socio-economic levels, all educational, racial, age groups	*Battered mates are found in all socio-economic levels, all educational, racial, age groups*	*Children of domestic violence are found in all socio-economic levels, educational, racial and age groups*
The batterer is characterized by	The battered mate is characterized by	Children in battering homes exhibit
. . . poor impulse control — explosive temper — limited tolerance for frustration	. . . long suffering, martyr-like endurance of frustration	. . . a combination of limited tolerance, poor impulse control and martyr-like long suffering
. . . stress disorders and psychosomatic complaints — sophistication of symptoms and success at masking dysfunction vary with level of social and educational sophistication	. . . blatant depressive and/or hysterical symptoms — stress disorders and psychosomatic complaints	. . . depression, much stress and psychosomatizing, absences from school, pre-delinquent and delinquent behavior
. . . emotional dependency — subject to secret depressions known only to family	. . . economic and emotional dependency — subject to depression, high risk for secret drugs and alcohol, home accidents	. . . economic and emotional dependency, high risk for alcohol/drugs, sexual acting out, running away, isolation, loneliness, fear
. . . limited capacity for delayed reinforcement — very "now" riented	. . . unlimited patience for discovery of "magic combination" to solve marital and battering problems — "travels miles" on tiny bits of reinforcement	. . . combination of poor impulse control and continual hopefulness that situation will improve
. . . inordinate ego needs — quality of childlike narcissicism (not generally detectable to people outside family group)	. . . unsure of own ego needs — defines self in terms of family, job, etc.	. . . very shaky definition of self — grappling with child-like responses of parents for modeling — poor definition of self and/or defines self in parenting role
. . low self-esteem — perceived unachieved ideals and goals for self — disappointment in career even if successful by others' standards	. . . low self-esteem — continued faith and hope battering mate will get "lucky" break	. . . low self-esteem — sees self and siblings with few options or expectations to succeed
. . qualities which suggest great potential for change and improvement, i.e., frequent "promises" or the future	. . . unrealistic hope that change is imminent — belief in "promises"	. . . mixture of hope/depression that there is no way out — peer group can be most important contact, if available
. . perception of self as having poor social skills — describes relationship with mate as closest he has ever known — remains in contact with own family	. . . gradually increasing social isolation, including loss of contact with own family	. . . increased social isolation — increased peer isolation or complete identification with peers
. . accusations against mate — jealousy — voices great fear of being abandoned or "cheated on"	. . . inability to convince partner of loyalty — futilely guards against accusations of "seductive" behavior toward others	. . . bargaining behavior with parents — gets into proving self as does mother

Mr. OWENS. Thank you.
Susan Kelly-Dreiss?

STATEMENT OF SUSAN KELLY-DREISS, EXECUTIVE DIRECTOR, PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

Ms. DREISS. Good morning.

My remarks are related to how one State utilized family violence prevention funds. When the Family Violence Prevention and Services Act was passed by Congress in 1984, there were 45 domestic violence programs in Pennsylvania, serving approximately 40,000 victims a year. Since then, Pennsylvania's statewide network of domestic violence programs has grown to 55 programs, assisting over 55,000 persons a year.

One of the reasons why our State has been able to help a growing number of victims is because of support from the Federal Government through the Family Violence Prevention and Services Act. In Pennsylvania, as throughout the country, local community-based programs are still developing in their attempts to meet the needs of domestic assault victims.

These are private, nonprofit organizations providing emergency shelter, hot lines, safe homes and counseling centers. They act as a coordinator of information and referral services for victims, as well as helping the victim to assess the situation and the available options. Many shelters have developed child care, realizing that the children are in crisis, too, and in need of assistance and support. Domestic violence programs have become a community resource center for victims, linking them with other community agencies and programs such as job training programs.

We have seen that domestic violence programs do make a difference. They literally save lives. They bring tremendous support and community resources together for victims to use at a time of crisis, and they enable victims to move into a violence-free future.

The inspiration for the development of domestic violence programs has frequently come from the victims themselves, particularly from battered women. In fact, local communities have demonstrated a commitment to services for victims of domestic violence which involves many segments of the community.

Most notable are the volunteers who come from the community and perform many tasks such as hot line coverage, child care and transportation. Domestic violence services truly depend upon volunteers. Last year in one State alone, Pennsylvania, over 350,000 hours of volunteer time were contributed.

Likewise, local community fundraising efforts are helping to fund programs. In Pennsylvania we have been fortunate to receive some State funding. This is not true in every State. However, for us family violence funds are a partner within a local, State and Federal effort that is assisting domestic violence victims.

When the family violence funding that was allocated to Pennsylvania was made, our State—as most States—was better able to respond to the developmental needs of a relatively new service system. Family violence funds were spent first of all in unserved areas. While Pennsylvania has many programs that have been established for some time, we also had many counties—14 in all—

that had no services at all for domestic violence victims. All were rural and poor counties. Seven of those are now receiving funding for the first time because of family violence funds.

The allocation of these funds was made with the help of a needs assessment that was paid out of family violence funds and conducted in all 14 unserved counties. The needs assessment also identified community people and agencies who were interested in providing domestic violence services. In these counties, family violence funds provided the initiative and served as the catalyst for program development.

Family violence funds were also given to existing programs which demonstrated great need. For example, a shelter in one county had opened with a budget of $3,500 for the year. This shelter was only able to operate by having a group of volunteers. The family violence funds helped to pay for a staff person to operate that shelter.

We also have a tremendous statewide problem with lack of shelter space. We have over 8,000 turnaways each year. Our family violence funds were then used to provide funding for those programs with the highest turn-away rate.

I think that the turnaways are just one indicator of a national problem. What has happened in the last few years is that there have been a number of bills passed in-State, such as probably cause arrest bills and protection from abuse bills. Many of these have a notification of rights in the bill, and what is happening out of that is that more than ever the police are making referrals to shelters for battered women. When we just conducted a survey of how many referrals we are seeing from police, the increase in some counties was up to 100 percent.

I think we are just really beginning to document the extent of domestic violence in our country. We know that battering is the single major cause of injury to women, occurring more often that auto accidents, rapes, or muggings. We would hope that because there is a growing need for services for victims of domestic violence, that the Family Violence Prevention and Services Act will be reauthorized.

Local communities and the States continue to need the support of the Federal Government in developing our services. We would hope that this continued support and partnership between local, State and Federal resources can continue through this act.

Thank you.

[The prepared statement of Susan Kelly-Dreiss follows:]

Pennsylvania Coalition Against Domestic Violence

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TESTIMONY TO THE SELECT EDUCATION COMMITTEE
APRIL 29, 1987

REMARKS BY SUSAN KELLY-DREISS
EXECUTIVE DIRECTOR
PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

WHEN THE FAMILY VIOLENCE PREVENTION & SERVICES ACT (FVPS ACT) WAS PASSED BY CONGRESS IN 1984, THERE WERE 45 DOMESTIC VIOLENCE PROGRAMS IN PENNSYLVANIA, SERVING APPROXIMATELY 40,000 VICTIMS PER YEAR. SINCE THEN, PENNSYLVANIA'S STATEWIDE NETWORK OF DOMESTIC VIOLENCE PROGRAMS HAS GROWN TO 55 PROGRAMS ASSISTING OVER 55,000 PERSONS PER YEAR. ONE OF THE REASONS WHY OUR STATE HAS BEEN ABLE TO HELP A GROWING NUMBER OF VICTIMS IS BECAUSE OF SUPPORT FROM THE FEDERAL GOVERNMENT THRU THE FVPS ACT.

IN PENNSYLVANIA, AS THROUGHOUT THE COUNTRY, LOCAL COMMUNITY-BASED PROGRAMS ARE STILL DEVELOPING IN

MEMBERSHIP

- Domestic Abuse Project, Delaware County
- Domestic Violence Center of Chester County
- Women in Transition, Philadelphia
- Women Against Abuse, Philadelphia
- Lutheran Settlement House, Philadelphia
- Laurel House, Montgomery County
- Women's Center of Montgomery County
- A Woman's Place, Bucks County
- Turning Point of Lehigh Valley
- Berks County Women in Crisis
- ACCESS - York, Inc.
- Survivors, Gettysburg
- Lancaster Shelter for Abused Women
- Women in Crisis, Harrisburg
- Women in Need, Chambersburg
- Women's Center, Bloomsburg
- Domestic Violence Service Center, Wilkes-Barre
- Women's Resource Center, Scranton
- Women's Resources of Monroe County
- Towanda Area Women's Center, Inc.
- Susquehanna Valley Women in Transition
- Clinton County Women's Center
- Centre County Women's Resource Center
- Wise Options for Women, Williamsport
- Hospitality House for Women, Erie
- Horizon House, Union City
- Women's Center YWCA, Warren
- YWCA Women's Center, Titusville
- Women's Center of Lawrence County
- AWARE, Inc., Mercer County
- Volunteers Against Abuse Center, [illegible]
- Women's Services, Inc., The Greenhouse, Meadville
- Women's Help Center, Johnstown
- C.A.P.S.E.A., Ridgeway
- Bradford Domestic Violence Program
- HAVIN, Kittanning
- Women's Center of Beaver County
- Women's Center and Shelter of Greater Pittsburgh
- Crisis Center North, Allison Park
- Fayette County Family Abuse Council
- Womansplace, McKeesport
- Alle-Kiski Area HOPE Center, Tarentum
- Women's Services of Westmoreland County
- Alice Paul House

THEIR ATTEMPTS TO MEET THE NEEDS OF DOMESTIC ASSAULT VICTIMS. THESE ARE PRIVATE, NON-PROFIT ORGANIZATIONS PROVIDING EMERGENCY SERVICES SUCH AS 24-HOUR HOTLINE, EMERGENCY SHELTER, SAFE HOMES, AND COUNSELING CENTERS. THEY ACT AS A COORDINATOR OF INFORMATION & REFERRAL SERVICES FOR VICTIMS, AS WELL AS HELPING THE VICTIM TO ASSESS THE SITUATION AND THE AVAILABLE OPTIONS. MANY SHELTERS HAVE DEVELOPED CHILD CARE, REALIZING THAT THE CHILDREN ARE IN CRISIS, TOO, AND IN NEED OF ASSISTANCE AND SUPPORT. DOMESTIC VIOLENCE PROGRAMS HAVE BECOME A COMMUNITY RESOURCE CENTER FOR VICTIMS, LINKING THEM WITH OTHER COMMUNITY AGENCIES, SUCH AS JOB TRAINING PROGRAMS.

WE HAVE SEEN THAT DOMESTIC VIOLENCE PROGRAMS DO MAKE A DIFFERENCE. THEY LITERALLY SAVE LIVES; THEY BRING TREMENDOUS SUPPORT AND COMMUNITY RESOURCES TOGETHER FOR VICTIMS TO USE AT A TIME OF CRISIS AND THEY ENABLE VICTIMS TO MOVE INTO A VIOLENCE FREE FUTURE.

THE INSPIRATION FOR THE DEVELOPMENT OF DOMESTIC VIOLENCE PROGRAMS HAS FREQUENTLY COME FROM THE VICTIMS THEMSELVES, PARTICULARLY BATTERED WOMEN. IN FACT, LOCAL COMMUNITIES HAVE DEMONSTRATED A COMMITMENT TO SERVICES FOR DOMESTIC VIOLENCE VICTIMS WHICH INVOLVES MANY SEGMENTS OF THE COMMUNITY. MOST NOTABLE ARE THE VOLUNTEERS WHO COME FROM THE COMMUNITY AND PERFORM MANY FUNCTIONS, INCLUDING HOTLINE COVERAGE, TRANSPORTATION, AND CHILD CARE. DOMESTIC VIOLENCE SERVICES DEPEND UPON VOLUNTEERS - LAST YEAR IN PENNSYLVANIA OVER 350,000 HOURS WERE CONTRIBUTED BY VOLUNTEERS. LIKEWISE, LOCAL COMMUNITY-FUNDRAISING EFFORTS ARE HELPING FUND PROGRAMS. IN PENNSYLVANIA, WE HAVE BEEN FORTUNATE TO RECEIVE SOME STATE FUNDING FOR DOMESTIC VIOLENCE SERVICES; THIS IS NOT TRUE FOR EVERY STATE. HOWEVER, FOR US, THE FVPS ACT PROVIDED FOR A PARTNERSHIP OF LOCAL, STATE, AND FEDERAL FUNDING IN SUPPORTING SERVICES FOR DOMESTIC VIOLENCE VICTIMS.

WITH THE FAMILY VIOLENCE FUNDING THAT WAS ALLOCATED TO PENNSYLVANIA, OUR STATE -AS MOST STATES-WAS BETTER ABLE TO RESPOND TO THE DEVELOPMENTAL NEEDS OF A RELATIVELY NEW SERVICE SYSTEM. FAMILY VIOLENCE FUNDS WERE SPENT FIRST OF ALL ON UNSERVED AREAS. WHILE PENNSYLVANIA HAS MANY PROGRAMS THAT HAVE BEEN ESTABLISHED FOR SOME TIME, WE ALSO HAD MANY -14- COUNTIES - THAT HAD NO SERVICES AT ALL FOR DOMESTIC VIOLENCE VICTIMS. ALL WERE RURAL AND POOR COUNTIES. SEVEN OF THOSE COUNTIES ARE RECEIVING FUNDS FOR THE FIRST TIME THROUGH FAMILY VIOLENCE MONIES.

THE ALLOCATION OF THESE FUNDS WAS MADE WITH THE HELP OF A NEEDS ASSESSMENT - PAID FOR OUT OF FAMILY VIOLENCE FUNDS - CONDUCTED IN ALL 14 COUNTIES. THE NEEDS ASSESSMENT ALSO IDENTIFIED COMMUNITY PEOPLE AND AGENCIES WHO WERE INTERESTED IN PROVIDING DOMESTIC VIOLENCE SERVICES. IN THESE COUNTIES, FAMILY VIOLENCE FUNDS PROVIDED THE INITIATIVE, AND SERVED AS THE CATALYST FOR PROGRAM DEVELOPMENT.

FAMILY VIOLENCE FUNDS WERE ALSO GIVEN TO EXISTING PROGRAMS WHICH DEMONSTRATED GREAT NEED. FOR EXAMPLE, A SHELTER IN ONE COUNTY HAD OPENED WITH A BUDGET OF $3500 FOR THE YEAR. THIS SHELTER WAS ONLY ABLE TO OPERATE BY HAVING A COMMITTED GROUP OF VOLUNTEERS WHO WERE WILLING TO STAFF THE SHELTER FOR AN INITIAL PERIOD OF TIME. FAMILY VIOLENCE FUNDS HELPED TO PAY FOR A STAFF PERSON. WE ALSO HAVE A TREMENDOUS STATEWIDE PROBLEM WITH LACK OF SHELTER SPACE. THE DEMAND IS SIMPLY FAR GREATER THAN THE SUPPLY. THE RESULT IS THAT VICTIMS ARE FREQUENTLY PUT ON A WAITING LIST OR REFERRED ELSEWHERE UNTIL SPACE IS AVAILABLE. WE HAVE REFERRED TO THESE CASES AS "TURN AWAYS"-PENNSYLVANIA HAS OVER 9000 TURN AWAYS A YEAR. WE ARE NOT PROUD OF THAT FACT AND WE ARE TYRING VERY HARD TO FIND MORE ADEQUATE FACILITIES AND MORE BEDSPACE. FOR THIS YEAR, FAMILY VIOLENCE FUNDS WILL BE GOING TO SOME OF THE PROGRAMS WITH THE HIGHEST "TURN AWAY" RATE IN ORDER TO HELP ALLEVIATE THIS PROBLEM.

THE DILEMNA OF "TURN AWAYS" IS ILLUSTRATIVE OF A NATIONAL PROBLEM. INCIDENTS OF DOMESTIC VIOLENCE SEEM TO BE INCREASING. OR, IF THEY ARE NOT INCREASING, THEN PUBLIC AWARENESS HAS GROWN TO THE EXTENT THAT VICTIMS AND AGENCIES ARE REQUESTING MORE HELP THAN EVER BEFORE. NOWHERE IS THE INCREASE IN REFERRALS MORE NOTABLE THAN WITH THE POLICE. DURING THE PAST 5 YEARS MORE STATES HAVE ENACTED DOMESTIC VIOLENCE LEGISLATION THAN THROUGHOUT ANY PERIOD OF HISTORY. PROTECTION FROM ABUSE AND PROBABLE CAUSE ARREST LEGISLATION ARE THE MOST COMMON. BOTH LAWS ADDRESS THE INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM IN CASES OF DOMESTIC VIOLENCE. MANY OF THESE LAWS INCLUDE A "NOTIFICATION OF RIGHTS" FOR THE VICTIM WHICH DIRECTS POLICE TO PROVIDE VICTIMS WITH INFORMATION ABOUT THE LOCAL DOMESTIC VIOLENCE PROGRAM. AFTER THE PASSAGE OF PROBABLE CAUSE ARREST LEGISLATION IN PENNSYLVANIA (ONE CONTAINING A NOTIFICATION SECTION), OUR COALITION WAS TOLD BY PROGRAMS THAT POLICE WERE REFERRING AS NEVER BEFORE. IN A SURVEY WHICH WE CONDUCTED WE FOUND THAT POLICE REFERRALS HAD INCREASED DURING THE 12 MONTHS AFTER THE ENACTMENT OF PROBABLE CAUSE ARREST LAW BY AN AVERAGE OF 50 TO 60 %. IN

SOME COUNTIES POLICE REFERRALS WERE UP BY 100%.

PERHAPS WE ARE JUST BEGINNING TO UNDERSTAND THE EXTENT OF DOMESTIC VIOLENCE IN OUR COUNTRY. WE KNOW THAT BATTERING IS THE SINGLE MAJOR CAUSE OF INJURY TO WOMEN, OCCURRING MORE OFTEN THEN AUTO ACCIDENTS, RAPES OR MUGGINGS. A BUREAU OF JUSTICE STATISTICS SPECIAL REPORT ON THE 1970-1982 CRIME SURVEY DATA ALSO INDICATES THAT AS MANY AS ONE HALF OF REPORTED DOMESTIC ASSAULTS INVOLVED BODILY INJURY AS SERIOUS OR MORE SERIOUS THAN 90% OF ALL THE RAPES, ROBBERIES AND AGGRAVATED ASSAULTS THAT WERE EXAMINED.

SOME 2,000 TO 4,000 WOMEN ARE BEATEN TO DEATH ANNUALLY ACOUNTING FOR ONE-EIGHTH OF ALL HOMICIDES IN THE UNITED STATES. ONE THIRD OF ALL REPORTED HOMICIDES, AS WELL AS A LARGE PERCENTAGE OF SUICIDES, ARE DIRECT OUT-GROWTHS OF DOMESTIC VIOLENCE.

IN THIS COUNTRY A WOMEN IS MORE LIKELY TO BE MURDERED BY A MEMBER OF HER OWN FAMILY OR AN ACQUAINTANCE THAN BY A STRANGER. ACCORDING TO THE FEDERAL BUREAU OF INVESTIGATION'S 1984 UNIFORM CRIME REPORTS, IN 18% OF THAT YEARS 18,692 MURDERS, THE VICTIM WAS A FAMILY MEMBER. AN ACQUAINTANCE WAS THE VICTIM IN 30% AND A STRANGER IN 18%.

BECAUSE OF THE GROWING NEED FOR SERVICES FOR VICTIMS OF DOMESTIC VIOLENCE, IT IS CRITICAL THAT THE FVPS ACT BE REAUTHORIZED. LOCAL COMMUNITIES AND THE STATES CONTINUE TO NEED THE SUPPORT OF THE FEDERAL GOVERNMENT. ALL STATES HAVE SERVICES WHICH ARE UNDER DEVELOPMENT. THE INITIATIVE WHICH STARTED TWO YEARS AGO NEEDS A FAIR CHANCE TO SUCCEED. PREVENTING FAMILY VIOLENCE AND PROVIDING SERVICES TO ITS VICTIMS IS AN AWESOME TASK. IT REQUIRES THE CONTINUED SUPPORT AND PARTNERSHIP OF LOCAL STATE, AND FEDERAL RESOURCES. IF WE ARE TRULY SERIOUS ABO TOP-ING FAMILY VIOLENCE, WE NEED TO COMMIT ADEQUATE RESOURCES TO THE EFFORT. WE CAN MAKE A DIFFERENCE.

Mr. OWENS. Thank you.
Ms. Gwendolyn Wright?

STATEMENT OF GWENDOLYN WRIGHT, DIRECTOR, COMMUNITY EDUCATION, NEW YORK COALITION AGAINST DOMESTIC VIOLENCE

Ms. WRIGHT. Thank you.

The noise of things being broken in the night were familiar childhood sounds at my house. At the age of 10, I first saw my father hit my mother, and for the next 6 years of my life, my siblings and I were to witness my mother repeatedly battered by our father. I made a vow then to never let that happen to me, but it did.

I had been married 6 years, had two daughters, and was 7 months pregnant. My husband and I had separated 2 months earlier and had an informal arrangement around child visitation and support. In an earlier separation, when I had turned to the courts for legal disposition, a Queens, New York Family Court judge ordered support in the amount of $50 a month and told me that my husband seemed like a nice guy, so "work out visitation between yourselves."

When we separated the second time, I was reluctant to use the court system again. The night my husband beat me up, I was terrified and shocked. I didn't know what to do. The next day I felt I had no choice but to try the court system again. I was awarded a Temporary Order of Protection and was told by a kind Family Court judge that there was a shelter in our county for battered women and their children. I had never heard of such a place and was reluctant to put my life and the lives of my children into the hands of strangers, yet I knew that I could not return home if my husband were still there.

So I tried police intervention, to no avail. Not only did they refuse to remove him from my home, but stood by and watched as he dismantled my car, my only means of transportation in a rural community.

The only option left to me was to take the advice of the judge and go to the shelter. I didn't know what to expect upon arrival at the family shelter, but what I found there was a wonderful, supportive staff and an opportunity to learn and grow.

When my mother was being battered, there were no shelters. The first shelter in New York State opened in 1977 and now, 10 years later, there are only 49 shelter/safe home projects throughout the State. In 1986 a total of 7,621 women and children were sheltered in New York, while another 11,600 were denied, primarily due to lack of space.

In a State with 62 counties, almost 20 counties remain with few if any domestic violence services. In 1986 a shelter in upstate New York closed due to lack of funding. As a result, a woman who had previously used that shelter, and had no means to travel through several counties to another shelter, was killed.

Although many gains have been made over the years, not enough has been done to remedy this problem. This problem has national implications. The Federal Government must reappropriate

and increase funding in the Family Violence Prevention and Services Act. States are trying, but cannot do it alone.

Federal domestic violence moneys helped 11 programs in New York State last year, programs that were struggling to survive. Let's not force the closing of other programs committed to providing refuge to thousands of women and children each year. Instead, let's celebrate these gallant efforts by the continuation of funds which will ensure that the doors will remain open.

Thank you, Mr. Chairman.

Mr. OWENS. I want to thank you all for your testimony. Certainly the personal testimonies leave an impression far greater than that of many others.

I would like to know from all of you what you think we can do in the process of reauthorizing this legislation which would have a significant impact on the problem. If you had as many males being injured and killed by any process as is occurring in this situation, I assure you it would be high on the political agenda and something would be done about it. What can we do in the act itself which would give greater impetus to citizen action to deal with this problem?

Ms. DREISS. I think the primary need is for funding. I think, as Representative Miller remarked, there is a very strong contingent of support out there. I think right now we are really hurting for lack of Federal funds. I think one of the things that we would like to see recognized in the authorization act itself is the importance of that volunteer component. There may even be a way of saying that that part of it needs to be developed.

Mr. OWENS. We should pay greater attention to the volunteer component in the act itself, find ways to give greater assistance to volunteer groups?

Ms. DREISS. Yes.

Mr. OWENS. Are you the executive director of a governmental group or a citizen advocacy group?

Ms. DREISS. It is a citizen advocacy group. Our group is made up of all the shelters in the State of Pennsylvania.

Mr. OWENS. The funding from your operation comes from where?

Ms. DREISS. The funding comes from private, State, and Federal resources, all three combined.

Mr. OWENS. A number of things have been done in Pennsylvania. There were some things being done before the act was passed, but since then it has certainly multiplied geometrically, it seems. The effort has greatly increased. To what degree is the Federal program a stimulant in your State effort? The State funds that you have received, that you mentioned, are those matching funds or were they as a result of Federal funds? Can you tell us a little bit more about it?

Ms. DREISS. In Pennsylvania there is a requirement, whenever the State funds programs they do have a requirement for matching funds, but even aside from that the programs had already done massive fundraisers, so that I would say about 50 percent of the program funding really is from private sources rather than from government sources.

I think the really important thing that happened with family violence moneys in our State was that it did give us the opportunity

to look at the State in terms of areas that were totally unserved, and this money really enabled the State to contact those county people and set up programs, which is the first time the State had ever taken that initiative. That was really important for us in those seven counties. That would have never ever happened without this money.

Mr. OWENS. Ms. Wright, there are some people who argue that we are generating statistics and generating a problem by establishing shelters and making such an issue out of family violence. You mentioned that before your experience, you had watched your mother go through the same experience. What would be your comment on those people who say that the problem is not as great as we make it, as we want to make it out to be, and our own attention to it is encouraging people to come forward and exaggerate situations?

Ms. WRIGHT. I would beg to disagree with those kinds of comments, primarily because, as I said in my testimony, my mother had been beaten and there was no attention given to that, and I think that that is so in most battering cases. The women and children that we see in programs are just the tip of the iceberg. There are thousands and thousands of women that never come through domestic violence programs, that somehow figure out, as my mother did, on their own, how to get out and how to live violence-free lives.

Prisons, women's prisons, are full of women who have seen killing their abusers or assaulting them seriously as their only means of getting out, because they don't know of programs, and that is around this Nation, so that I don't think that just talking about it—any more so than in cases of child abuse or child sexual abuse—that talking about it is going to increase it. I think what happens when we bring it out to the open, people look for resources, and the resources are there to some extent. What I think is that we need to increase those resources, to make them more available, to increase public awareness so that we can in fact as a Nation grant women the permission to talk about spouse abuse.

Mr. OWENS. Would either one of you, in view of your personal experiences—I think in both cases you commented rather negatively about the police and the courts—in view of your personal experiences, would you have any recommendations in terms of what we can do with a program like this? We are very small, very limited. Courts and police of course are major agencies that really have much more latitude and resources to deal with these problems. Effecting some changes there would do far more for you than anything that we could ever do, no matter how much funding we get, so what kinds of changes would you recommend as a result of your personal experiences, in terms of the police and the courts?

Ms. FEDDERS. I have one thing to say about that, and it may even sound too simplistic. The battered wife syndrome is, I feel, unless you have been through it, almost impossible to believe that men and women can do this to each other, but I think a way of starting to take care of this situation might be making every police officer, every judge, every lawmaker, every whoever you can get to read it, to read what I have included in my testimony—just the basic bat-

tered wife syndrome, the male profile, the female profile—and to try to convince these people that it really is the truth.

In other words, when you have a person goes in to the judge when he has just beaten his wife and says, "I am sorry; I will never do this again," that the judge knows that more intervention has to be taken because this is not enough; this is part of the syndrome. In my naivete, I feel it would be a very simple thing to do. It is almost a pamphlet-type thing: Read and believe that this is what——

Mr. OWENS. Well, some groups have sponsored sensitivity training with some of the funds.

Ms. FEDDERS. I think that type of thing is very important, but in my opinion it almost has to be—you know, nationally I guess we can't do it, but nationally indicated that this is such a severe problem, that these people in this particular position must read and believe that this really is so.

Ms. WRIGHT. I just would like to make a comment on that issue. I think also that if we as a Nation take the lead and say that this is a serious enough problem, that that will then filter down, and that part of that sensitization or understanding of what a battered woman endures will be somehow picked up along the way. Police officers are born as children, and we teach our children in various ways. I think that a lot of the ways that we teach our children have negative impacts. Perhaps if we start looking at that now and grooming those young people, somewhere in the future it will be inherent in each of us to realize that women do not deserve to be treated in this manner.

Mr. OWENS. Mr. Bartlett?

Mr. BARTLETT. Thank you, Mr. Chairman.

I apologize to the witnesses for not being here for your entire testimony. I have read your testimony, however, and find it to be quite helpful and quite productive.

A couple of questions: First of all on the response of law enforcement agencies themselves, do any of you see changes as you visit around the country or visit with people in your areas? Do you see law enforcement agencies changing and becoming more willing to make arrests, or do you think that making an arrest in a spouse abuse case is the correct response, and do you find that changing at all?

Ms. DREISS. Well, I think that we do see the proliferation of probable cause arrest legislation. We just passed a bill last year that has now been in effect for one full year. What happened with that bill is that about four police departments throughout the State set up policy that would implement that bill, but the real piece of the bill that is being fully utilized is the notification of rights section. So what is happening is, I think the police are looking at the victim and trying to connect her more with the assistance that shelters can provide, but I think we still have a long way to go with recognizing that this is a crime.

Ofttimes the police will even tell us, even when they do arrest and they take this to a preliminary hearing, a district magistrate may either lower or drop the charges because they don't believe that this is a serious case, so I do think there is a whole criminal justice system need, therefore, for training actually and also for im-

plementation of laws. I think we have one way of looking at stranger assaults and another way of looking at domestic assaults.

Ms. WRIGHT. I would agree. What we have seen happen in New York is that the Department of Criminal Justice Services has mandated that police officers do training, each new class of police officers, so what happens is that we provide training for the rookies. There is no mandate for inservice training, so those officers who have been in for many years may not necessarily even get wind of some of the material that we are providing.

This is particularly significant, I feel, in rural areas. I live in an upstate New York community, and we have police forces that may be five or six people who have been on that force for 10 or 12 years, so that they may never have an opportunity to have any kind of training on domestic violence other than what they got in their original classes, and may never request the voluntary training. So I think that some strides have been made but certainly not enough.

Mr. BARTLETT. Does your training emphasize making an arrest and treating it as a crime?

Ms. WRIGHT. Yes, and treating it as a crime, and I do agree with what Susan has said, that what happens then is that the police feel that they are in a "Catch 22" because the district attorney does not take it seriously or the judge does not take it seriously, and so they feel that no matter what they do, it is never going to go any further. They are then much more reluctant to do anything.

Mr. BARTLETT. Ms. Fedders?

Ms. FEDDERS. I heard a hospital worker in Virginia speak recently that there needs to be legislation to protect people like hospital workers who see a woman come in repeatedly and, as in child abuse cases, when there is abuse suggested, that intervention could be taken. That type of legislation or push would help also, because these type of people who perhaps could intercede are not protected by any law and they could be sued.

As I said in my testimony, I know Connecticut has made strides in the probable cause arrest, and this does reduce the danger to a woman when her husband either comes back into her home. Many times they don't even come back, but it does reduce by at least 50 percent if the man has been arrested and prosecuted.

Mr. BARTLETT. Do you think that would be a useful area of inquiry for the reauthorization of this act, to emphasize both arrest and, as you said, Ms. Wright, quite correctly, not only arrest but also using the whole criminal justice system to treat what is a crime as a crime, and to begin with that supposition? Would that be a useful area for the Federal Government to provide incentives or encouragement or grants or something to help guide States towards changing their basic response to this at the criminal justice level?

Ms. DREISS. Yes, I think it could be. As I recall, in the first authorization there was something about an eviction of a spouse, similar to protection from abuse, in the act. That possibly could be true of probable cause arrest as well.

Mr. BARTLETT. Ms. Kelly-Dreiss, you have a very impressive program in Pennsylvania, which you have discussed, serving some 40,000 victims a year, 55 programs and such. I wonder if you could

isolate for us, though, what Federal money was used for and how much was used as a proportion of other resources?

Ms. DREISS. In terms of those services particularly, I would say that——

Mr. BARTLETT. Domestic violence programs.

Ms. DREISS. I am trying to think in terms of how the dollars broke down, but I would say that about one-third to one-fourth of the funds that were used to provide those services came from Federal sources.

Mr. BARTLETT. Of the operating costs or the capital costs?

Ms. DREISS. Of the operating costs. We don't have any capital, but the operating costs, one-fourth to one-third was from Federal sources.

Mr. BARTLETT. Was it from the domestic violence program or was it from other Federal sources?

Ms. DREISS. It was from a combination of the Family Violence Prevention and Services and from a social services block grant, the combination of those two.

Mr. BARTLETT. Mr. Chairman, it would be, if the chairman would hold the record open, it would be helpful for us to get a sense of where those Federal funds came from in some sort of analysis, or how much came from which agencies. It would be helpful if the chairman would hold the record open.

Mr. OWENS. Without objection. Please submit that for the record.

Ms. DREISS. I will do that, and be glad to.

[Material to be supplied follows:]

PENNSYLVANIA COALITION AGAINST DOMESTIC VIOLENCE

FUNDING BREAKDOWN
Fiscal Year 1987/88

COUNTY	PROGRAM	TITLE XX/ * ACT 157 MONEY	FAMILY VIOLENCE MONEY	LOCAL MATCH MONEY **	TOTAL
Adams	Survivors, Inc.	45,522	14,478	100,495	160,495
Allegheny	Alle-Kiski Area Hope Ctr.	58,588	2,790	88,484	149,862
	Crisis Center North	53,318		31,332	84,650
	Women's Ctr./Pittsburgh	199,650		455,753	655,403
	Womansplace	87,413		79,532	166,945
Armstrong	HAVIN	55,000	5,000	13,457	73,457
Beaver	Women's Ctr.	129,750		39,022	168,772
Bedford	Bedford Co. Abuse Network		15,000	3,000	18,000
Berks	Berks Co. Women In Crisis	128,012		109,159	237,171
Blair	Domestic Abuse Project	55,000	5,000	43,917	103,917
Bradford	Abuse & Rape Crisis Ctr.	55,000	5,000	11,000	71,000
Bucks	A Woman's Place	122,588		102,159	224,747
Butler	Volunteers Against Abuse Ctr.	70,582		50,750	121,332
Cambria	Women's Help Center	104,980		19,922	124,902
Cameron	See Elk County				
Carbon	Carbon Co. Women In Crisis		15,000	4,922	19,922
Centre	Women's Resource Center	85,755		40,293	126,048
Chester	Domestic Violence Center	108,787		115,066	223,853
Clarion	SAFE	35,000	5,000	17,029	57,029
Clearfield	DuBois Women's Help Ctr.		25,000	15,216	40,216

* State Funds

** Local Match includes United Way, Foundations, Corporations, small fundraising efforts such as bake sales, and individual donations.

COUNTY	PROGRAM	TITLE XX/ ACT 157 MONEY	FAMILY VIOLENCE MONEY	LOCAL MATCH MONEY	TOTAL
Clinton	Clinton Co. Women's Ctr.	57,750	7,750	10,071	75,571
Columbia	Women's Ctr./Bloomsburg	124,291		75,449	199,740
Crawford	Women's Services/The Greenhouse	87,302		23,055	110,357
	Titusville Women's Ctr.	27,000	21,000	7,800	55,800
Cumberland	See Dauphin County				
Dauphin	Women In Crisis	156,673		205,641	362,314
Delaware	Domestic Abuse Project	132,963		289,870	422,833
Elk	CAPSEA	32,000	13,000	26,216	71,216
Erie	Hospitality House	122,480		8,459	130,939
Fayette	Family Abuse Council	112,097		23,672	135,769
Forest	See Warren County				
Franklin	Women In Need, Inc.	100,331	5,000	54,181	159,512
Fulton	See Franklin County				
Greene	Greene Co. Domestic Violence Prog.	20,000		8,398	28,398
Huntingdon	Huntingdon House	29,700	10,300	8,573	48,573
Indiana	Alice Paul House	88,143		22,861	111,004
Jefferson	JCCEOA, Inc. - Crossroads Project	25,000		10,350	35,350
Juniata	See Mifflin County				
Lackawanna	Women's Resource Ctr., Scranton	106,779	5,000	67,967	179,746
Lancaster	Shelter for Abused Women	127,776		240,602	368,378

COUNTY	PROGRAM	TITLE XX ACT 157 MONEY	FAMILY VIOLENCE MONEY	LOCAL MATCH MONEY	TOTAL
Lawrence	Women's Shelter	100,062		62,558	162,620
Lebanon	See Dauphin County				
Lehigh	Turning Point of Lehigh Valley	203,380	15,346	266,761	485,487
Luzerne	Domestic Violence Service Ctr.	121,857		68,203	190,060
Lycoming	Wise Options for Women	93,285	10,858	21,663	125,806
McKean	Domestic Violence Prog./Bradford	44,406		9,189	53,595
Mercer	AW/ARE, Inc.	76,809		27,531	104,340
Mifflin	Mifflin Co. Abuse Network	26,935	18,065	5,387	50,387
Monroe	Women's Resources	73,197	24,000	41,273	138,470
Montgomery	Laurel House	137,214		176,745	313,959
	Women's Center	35,000	5,000	47,520	87,520
Montour	See Columbia County				
Northampton	See Lehigh County				
Northumberland	See Columbia and Union Counties				
Perry	See Dauphin County				
Philadelphia	Lutheran Settlement House	86,825		41,439	128,264
	Women Against Abuse	269,426	30,000	1,335,357	1,634,783
	Women In Transition	66,276		47,704	113,980
Pike	See Monroe County				
Potter	See Clinton County				

COUNTY	PROGRAM	TITLE XX ACT 157 MONEY	FAMILY VIOLENCE MONEY	LOCAL MATCH MONEY	TOTAL
Schuylkill	Schuylkill Co. Task Force on D.V.	37,226	2,774	28,926	68,926
Snyder	See Union County				
Somerset	See Cambria County				
Sullivan	See Lycoming County				
Susquehanna	See Lackawanna County				
Tioga	Women's Coalition	32,000	8,000	6,400	46,400
Union	Susquehanna Valley WIT	64,776	10,000	28,889	103,665
Venango	See Crawford (Titusville)				
Warren	Women's Center	36,464	14,639	8,321	59,424
Washington	Women's Shelter	66,000		24,312	90,312
Wayne	See Lackawanna County				
Westmoreland	Women's Services	94,330		92,742	187,072
	See Allegheny (Alle-Kiski)				
Wyoming	Victim's Resource Ctr.	1,000	24,000	8,100	33,100
York	ACCESS - York, Inc.	133,007		161,907	294,914
	TOTAL	$4,544,705	$317,000	$4,934,600	$9,796,305

Mr. BARTLETT. Thank you. I yield back the balance of my time.

Mr. OWENS. Thank you very much for your testimony. It is very useful to the process that we will have to pursue in the next few weeks. Thank you very much.

Mr. Bartlett, did you want to make your statement now or wait?

Mr. BARTLETT. I will do that at the beginning of the next panel, if that's all right with you.

Mr. OWENS. The next panel—we can have you seated but we are going to have to break for a vote—is the panel on adoption opportunities and children's justice: Ms. Tony Oliver, Ms. Kay Donley, Richard J. Arcara and Alan S. Kopit. Ms. Oliver and Ms. Donley, Mr. Arcara—I understand you have a time problem, Mr. Kopit. We will have to leave to vote in 5 minutes. Can you wait until we come back or do you want to make a statement?

Mr. KOPIT. I believe I can wait. I can give an initial statement, if you would like, but I would like Mr. Davidson here for any questions as well.

Mr. OWENS. All right. We are going to recess for 10 minutes to vote.

[Recess taken.]

Mr. OWENS. Thank you for waiting.

Mr. Kopit, you may begin.

STATEMENT OF ALAN S. KOPIT, ESQ., CHAIRPERSON, YOUNG LAWYERS DIVISION, AMERICAN BAR ASSOCIATION, ACCOMPANIED BY HOWARD DAVIDSON, DIRECTOR, NATIONAL LEGAL RESOURCE CENTER FOR CHILD ADVOCACY AND PROTECTION

Mr. KOPIT. Thank you, Mr. Chairman, and thank you for taking me out of order to accommodate our plane schedules.

My name is Alan Kopit, and I am an attorney from Cleveland, Ohio. I appear here today on behalf of the American Bar Association, where I presently serve as the Chair of the ABA's Young Lawyers Division. You heard Gene Thomas mention the 2,020 entities of the American Bar Association, and the Young Lawyers Division is the largest single entity in the association, representing lawyers under the age of 36 or those who have practiced law fewer than 5 years.

We also sponsor the National Legal Resource Center for Child Advocacy and Protection in Washington. Joining me today on my right is Howard Davidson, who is the director of the association's Child Advocacy Center. We are delighted to have been given the opportunity to provide testimony to this subcommittee related to the 1974 Federal Child Abuse Prevention and Treatment Act, and we urge this subcommittee to support its extension for 4 years.

You have before you the written remarks which I have presented to the subcommittee. I will deviate from those remarks entirely and stress just two things that I think are important, so that you understand why I am sitting here today.

First I want to mention that the Young Lawyers Division and the young lawyers generally of America are the body of lawyers that Gene Thomas spoke of, in large part, who are so committed and have started being committed to the issues of child abuse and neglect very early in their legal careers. We support this legislation

and we have demonstrated our support of legislation such as this for a number of years.

First of all, in 1978 we started the National Legal Resource Center for Child Advocacy and Protection, which I believe is the preeminent legal resource center in the country dealing with issues of child abuse. Starting in 1978 with a staff of two, it has grown to a staff of 15 full-time staff. Howard Davidson is the director, and on a day-to-day basis he addresses the full variety of child abuse issues. He is here to answer questions that you may have specifically related to the legal issues.

Second, in addition to the staff that we have here in Washington, we have a child advocacy committee which coordinates the activities of 275 affiliated young lawyer organizations throughout the country. One such example of the way we coordinate this network is, we are currently undertaking a 50-State survey of all the child advocacy legislation throughout the country. We have volunteers which we have found in every State of the United States, who will be responsible for reporting to us the state of the law, if you will, in this area.

Next, I would like to bring to the attention of this body some statistics from my State of Ohio and my county of Cuyahoga County, Ohio, which is the greater Cleveland area, which I think point up how important this Federal legislation has been to the States in inducing them to get legislation and to work harder in the area of getting the child abuse and neglect cases reported. A look at the reports received by children's services agencies in Ohio—and these statistics, by the way, are from the Ohio Department of Human Services— shows the incredible increase in the reporting of child abuse and neglect cases.

From 1976 through 1985 the following is revealed: In 1976, 6,861 cases of child abuse and neglect were reported, but by 1980 that number had risen to 15,114 cases, and by 1985 the number had risen to the incredible number of 70,923 cases. Thus, in the 10 years from 1976 through 1985, reports received by children's services agencies in Ohio increased almost 10.5 times.

Similarly, in my county of Cuyahoga County I have statistics since 1978 which show that in that year 1,665 cases of child abuse and neglect were reported to county agencies. That number increased to 2,431 cases in 1980, and 8,727 cases in 1985. Thus, between the years of 1978 and 1985 the reported cases increased almost 5.25 times.

Another very important area that this legislation has developed, if you will, is the appointment of guardians at litem—court-appointed legal representation of children. In 1967 the United States Supreme Court ruled in in re Gault that a juvenile charged with acts of delinquency had a constitutional right to court-appointed lawyers, but the Gault case did not address cases involving children who are alleged to be abused and neglected. The Federal Child Abuse Act, however, did encourage this type of representation.

I have statistics from Cuyahoga County which demonstrate how this has improved the situation in the States, in the guardian ad litem programs, and let me give you those very briefly. In 1979——

Mr. OWENS. Would you take about one minute to sum up?

Mr. KOPIT. Yes, I will.

In 1979 there were 215 court appointments, and that number by 1985 had jumped 2½ times to 546 appointments.

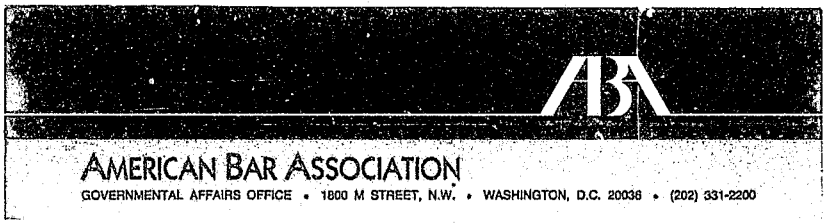
In conclusion, the ABA views as essential the extension of this act and the enhanced support of the National Center on Child Abuse and Neglect. It is the only Federal program specifically targeted to prevention, identification and treatment of child abuse.

We thank the subcommittee members and staff for inviting us to present this testimony, and I pledge the assistance of the ABA's Young Lawyers Division and the National Legal Resource Center for Child Advocacy and Protection in any further explorations of how the law can improve the ways in which we respond to the needs of abused and neglected children.

If the subcommittee has any specific questions that they could address at this time dealing with legal aspects, Howard Davidson is here. He has to catch a plane to speak at a child advocacy conference in Vermont, but I would like to give him the opportunity to answer any questions you have, if that is at all possible.

Thank you.

[The prepared statement of Alan S. Kopit follows:]



STATEMENT OF

ALAN S. KOPIT, CHAIRPERSON
YOUNG LAWYERS DIVISION

on behalf of the

AMERICAN BAR ASSOCIATION

before the

SUBCOMMITTEE ON SELECT EDUCATION

COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

concerning the

CHILD ABUSE PREVENTION AND TREATMENT ACT
(Public Law 93-247; 42 U.S.C. §5101 et. seq.)

April 29, 1987

Mr. Chairman, Members of the Subcommittee:

My name is Alan S. Kopit, and I am an attorney from Cleveland, Ohio. I appear today on behalf of the American Bar Association. Joining me is Howard A. Davidson, Director of the Association's Child Advocacy Center. I presently serve as Chair of the ABA Young Lawyers Division, the largest single membership entity in the Association and the sponsor of its Child Advocacy program. We are delighted to have been given the opportunity to provide testimony related to the 1974 Federal Child Abuse Prevention and Treatment Act, Title 42 U.S. Code, Section 5101, and we urge this Subcommittee to support its extension for four years.

The ABA has for many years been involved in both the study of the legal system related to the protection of children and in the process of helping to improve that system. In 1973, as the Child Abuse Prevention and Treatment Act was being developed, our Association was in the process of drafting a comprehensive set of Juvenile Justice Standards, which included numerous proposals for improving judicial intervention in child abuse and neglect cases. These recommendations included a call for mandatory court appointment of an independent legal representative for every child alleged to be abused or neglected. This position was identical to an important provision of the federal act, and we will comment upon its impact shortly.

In October, 1978, the ABA National Legal Resource Center for Child Advocacy and Protection was created. Its principal mission was to serve as a national clearinghouse of legal information and technical assistance for professionals involved with child abuse and neglect cases. A summary of the work of this Center and other ABA activities related to child maltreatment is appended to this statement. We are proud that the ABA has done so much since 1978 to assist the federal government in carrying out the requirements of Section 2 of the federal act related to the dissemination of training materials and the provision of technical assistance. Next month, we will be assisting the government's National Center on Child Abuse and Neglect in examining issues related to Section 3 of the federal act, through our sponsorship of an invitational conclave which will attempt to refine the definitions of "child abuse" and "child neglect" as they apply to the legal obligations of state and local child protective service agencies.

The focus of our remarks today will be on some of the major effects of Section 4 of the federal act, specifically Subsection 4(b)(2) which sets forth the criteria for state eligibility for direct federal grants under the act. Most of these requirements have induced the participating states to change their laws since 1974. Thus, the volume of new state child abuse and neglect legislation attributable in some way to the federal act has been immense. Here are some examples:

1) Subsection 4(b)(2)(E) of the act addresses the need

for states to preserve the confidentiality of child protection agency records from unauthorized release. In 1974 only 5 states had such confidentiality provisions in their laws; by 1986 all states had enacted such provisions. The issues of privacy of these sensitive records and better controls on their release continues to be a major concern. This is a particular concern for parents who feel that they have been wronged by unwarranted intrusions into their family's privacy, and who have become vocal about the need for systemic reform in this area.

2) The federal act and its regulations, by defining child maltreatment broadly, have had a major impact on getting the states to act in a similar fashion. In 1974 when the federal act took effect, there were 9 states that did not require the reporting of suspected child neglect, as distinguished from abuse. Only 10 states in 1974 specifically included sexual abuse of children in their mandatory reporting laws, and only 6 included the concepts of emotional maltreatment or mental injury. By the late 1970s, all states required that neglected children, as well as abused children, be reported. By 1986, 45 states had included sexual abuse within their child abuse reporting law definitions, and 41 had included emotional or mental injury inflicted on children within those definitions.

3) Subsection 4(b)(2)(F) of the act requires that eligible states provide for the cooperation of law enforcement officials, courts, and human service agencies in handling child abuse and neglect cases. In 1974 only 8 states had legislation directing such cooperation. By 1986 all but 3 states had specific laws addressing the issue of coordination of various agency efforts to serve maltreated children. However, only 27 states had laws which specifically dealt with the relationship between protective agencies and the police in the child abuse investigative process. This area has been a growing concern over the past few years, and therefore it is fortunate that the cooperative involvement of law enforcement and child protective service agencies has also been addressed in the recent federal Children's Justice and Assistance Act (Public Law 99-401), which will be covered shortly in this testimony.

4) Some of the most important new state legislation related to child abuse which has resulted from the 1974 federal act has been in the area of court-appointed independent legal representation of children (also referred to as the appointment of "guardians ad litem"). In 1967, the U.S. Supreme Court ruled in the In re Gault case that a juvenile

charged with acts of delinquency has a constitutional right to a court-appointed lawyer. All 50 states quickly changed their laws to comply with this mandate. Yet, since the Gault case did not address cases involving children alleged to be abused or neglected, there was no federal incentive for states to act on their behalf. That is, until the 1974 federal child abuse act, in Subsection 4(b)(2)(G), made state eligibility for grants conditioned upon the state providing by law that: "in every case involving an abused or neglected child which results in a judicial proceeding, a guardian ad litem shall be appointed to represent the child." In 1974, only 3 states provided for such mandatory representation. By 1986, 47 states provided a right to representation for allegedly abused children under the law, either by attorneys or citizen volunteers (frequently called "court appointed special advocates" or C.A.S.A.).

Despite these essential changes in state laws, for which the federal act has been instrumental, there are many areas of legislative and court reform where continued federal leadership remains essential. For example, in August, 1986, the Congress passed the Children's Justice and Assistance Act which gave the federal National Center on Child Abuse and Neglect increased research and information dissemination responsibilities under Sections 2 and 4 of the Child Abuse Prevention and Treatment

Act in the areas of investigation, prosecution, and judicial handling of child abuse cases.

In late 1984, a decade after passage of the original federal act, it was further amended to expand the scope of the term "child abuse" to include abuse committed by employees of residential homes or facilities and persons providing other forms of "out-of-home" care. On February 6, 1987, federal rules to guide the states in their implementation of these provisions were finally published. State legislators and child protective agency policymakers will now need considerable federal guidance in dealing with the case investigation and confidentiality implications of these modifications in the federal law.

In addition, many states have recently passed, or are now considering, legislation which changes the evidentary rules and testimonial procedures affecting young child victims of sexual abuse. However, without federal efforts to help evaluate these widely promoted systemic reforms, and to circulate information nationally on proven methods of effectively implementing these laws, many states will continue to enact and implement laws in a haphazard manner. The ABA is supporting a number of the most carefully considered of these reforms through its 1985 Guidelines for the Fair Treatment of Child Witnesses in Cases Where Child Abuse is Alleged, developed by the Association's Criminal Justice Section.

Many of the most difficult child abuse and neglect cases go into the judicial system, either as: a) civil, juvenile court child protection proceedings; b) domestic relations court custody, guardianship, or visitation disputes; or c) criminal prosecutions of alleged abusers. In some situations the same family may be involved in all three types of proceedings simultaneously. The federal act has made it possible for the government's National Center on Child Abuse and Neglect to target some of the demonstration project funds available under Section 4 of the act for innovative, potentially replicable local projects which promise to improve the coordination of such multiple proceedings, while minimizing trauma to the affected child and family.

But this is only the beginning. In 1980 the ABA Child Advocacy Center, in conjunction with the National Center for State Courts, developed the first comprehensive national desk book for judges handling child abuse cases. In that year, about 13.7% of all child abuse cases serviced by child protection agencies led to court action. By 1984, principally because of the dramatic increase of sexual abuse cases, this figure rose to 30.2%. Problems with the ways in which some courts continue to handle child abuse cases need significant attention. For example, in a current report on child abuse developed by the U.S. House of Representatives Select Committee on Children, Youth, and Families, it was noted that in one

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jurisdiction "the sometimes cumbersome and/or slow moving court proceedings can impede timely resolution of neglect or abuse cases, and timely placement of children in permanent homes." Unfortunately, we believe that this malaise is more widespread than in this single example.

Another area requiring new federal attention through this act is the subject of court-related statistics. Although the government has contracted with the American Humane Association since the mid-1970s to compile annual data on child abuse and neglect, there has never been any data collected directly from the courts on the total volume of civil and criminal petitions or indictments related to child maltreatment. Nor do we have any data from the American Humane Association on the temporary and final dispositions in any of the court cases known to child protective service agencies.

To be specific, we don't know:

a) the proportion of cases which lead to courts issuing emergency orders to temporarily place maltreated children in foster care;

b) the proportion of cases which ultimately result in children being placed in the permanent custody of the state child welfare agency (and where parental rights are permanently terminated);

c) the proportion of civil court petitions filed by child protective agencies which are dismissed as unproven, as well as adjudicated based on sufficient proof;

d) the proportion of intrafamilial physical and sexual abuse in juvenile court cases which are also referred for criminal prosecution;

e) the proportion of criminal cases which lead to an acquittal, a plea of guilty, and a conviction after trial; and

f) any nationally-collected data on the ultimate sentences given to convicted child abusers.

In short, we lack vital statistical information which would help us to better understand whether, over time, we are improving the way in which juvenile and criminal courts are handling child abuse cases, whether the courts are taking actions truly consistent with the best interests of children, and whether offending parents are being appropriately dealt with. Of particular concern to us is the need to collect adequate data so that we can determine how the increasing involvement of the criminal justice system in child abuse cases can lead to outcomes which best reflect the needs of the child victims.

When the Children's Justice and Assistance Act was signed by the President on August 27, 1986, the states were given an important vehicle to help encourage local judicial system reforms in the handling of child abuse cases. The act specifies that the federal government will play a more active role in the identification and evaluation of effective legal procedures in the handling of child abuse cases. And new federal funds derived from a portion of fines and other penalties assessed in federal criminal trials, estimated at $2.8 million from Fiscal Year 1986 collections and $3.6 million from contemplated Fiscal Year 1987 collections, should be made available to eligible states to help finance systemic improvements.

Yet, to date the two federal agencies responsible for implementing this legislation, the U. S. Departments of Justice and Health and Human Services, have not completed the necessary administrative steps to either notify states of the process which must be followed for applying for these funds, or to distribute any of this money. The eligibility criteria for state receipt of a share of what are referred to as "Children's Justice Act" funds will be a barrier in a fair number of states, and many states will require advice and information from federal agency staff and other legal reform experts in order to come into compliance with the new act's requirements. Implementation of the Children's Justice and Assistance Act is

clearly tied to the Child Abuse Prevention and Treatment Act. We hope that this Subcommittee will help assure that both laws are carried out effectively.

In conclusion, our Association views as essential the extension of the Child Abuse Prevention and Treatment Act and enhanced support for the National Center on Child Abuse and Neglect, the only federal program specifically targeted at the prevention, identification, and treatment of child abuse. More than ever, legislators, judges, prosecutors, and other legal system professionals concerned with child maltreatment need the continued assistance and resources made possible by this important legislation.

We thank the subcommittee members and staff for inviting us to present this testimony, and we will be pleased to assist in any further explorations of how the law can improve the ways in which we respond to the needs of abused and neglected children.

APPENDIX

Programs and Activities of the American Bar Association Related to Child Abuse and Neglect

- Development, in the 1970s, of a comprehensive set of Juvenile Justice Standards designed to improve the process of legal system intervention in all types of cases related to the custodial care of children

- Establishment, in October, 1978, of the National Legal Resource Center for Child Advocacy and Protection, a program of the ABA Young Lawyers Division, to serve as a focal point for th Association's activities related to child abuse and neglect

- Publication of over twenty-five Resource Center books, manuals, periodicals, and monographs related to the legal aspects of child abuse and neglect

- Creation of several Resource Center training videotapes designed to improve legal and judicial system practices in child abuse and neglect cases

- Funding of child abuse legal education related activities of over 40 state or local bar associations

- Sponsorship of 7 ABA national conference and four invitational policy conferences related to the legal protection of children

- Adoption by the ABA House of Delegates of a number of policy resolutions concerning children, including: support for the federal Child Abuse Prevention and Treatment Act and the Adoption Assistance and Child Child Welfare Act; encouragement of state and local bar association efforts to create special committees on children; and endorsement of a set of Guidelines for the Fair Treatment of Child Witnesses in Cases Where Child Abuse is Alleged

- Support of a number of research and technical assistance projects on such topics as: state and local legal system reforms in the handling of child sexual abuse cases; screening and substantiation of child abuse and neglect reports; investigation of cases involving the abuse of children in out-of-home care; analysis of criminal sentences in child molestation cases; responses to cases of alleged withholding of medical treatment to severely disabled newborn children; development of a law school curriculum on child abuse; and the resolution of allegations of child sexual abuse in child custody and visitation disputes.

Mr. OWENS. I have no questions. I would like to have you submit, if you don't have it included in your testimony, some of the statistics you gave about the State and local situation.

Mr. KOPIT. I have that and I will do that. Thank you, Mr. Chairman.

Mr. OWENS. Thank you.

[Material follows:]

GUARDIAN AD LITEM APPOINTMENTS
Child Abuse, Neglect, Dependency
Cuyahoga County

1979	215
1980	738 (approx. First ten months = 615)
1981	504 (approx. Five months (Aug.-Dec.) = 210)
1981	476
1983	492 (approx. First six months = 246)
1984	696 (approx. Eight months = 464)
1985	546

Increased 2.5 times between 1979 and 1985.

Table 1

COUNTY BREAKDOWN OF CA/N REPORTS

County	1978	1979	1980	1981
Adams	9	13	59	97
Allen	16	22	16	312
Ashland	65	102	103	100
Ashtabula	119	137	147	90
Athens	29	39	54	140
Auglaize	13	17	38	67
Belmont	181	181	134	95
Brown	15	89	104	75
Butler	367	499	526	582
Carroll	0	8	10	11
Champaign	54	72	63	49
Clark	372	262	98	110
Clermont	122	276	345	441
Clinton	6	1	7	84
Columbiana	102	25	138	289
Coshocton	4	20	33	125
Crawford	81	63	27	37
Cuyahoga	1,665	2,430	2,431	1,467
Darke	47	110	44	146
Defiance	2	7	4	18
Delaware	23	22	2	7
Erie	33	25	21	20
Fairfield	15	15	93	238
Fayette	99	82	67	144
Franklin	1,691	1,859	1,233	1,089
Fulton	59	92	162	97
Gallia	1	2	1	11
Geauga	10	39	41	74
Greene	124	362	398	349
Guernsey	98	139	125	62
Hamilton	760	1,137	1,489	1,744
Hancock	57	10	11	149
Harding	5	105	95	68
Harrison	11	18	9	14
Henry	2	0	3	8
Highland	7	5	16	8
Hocking	8	15	7	15
Holmes	8	22	56	32
Huron	8	4	9	8
Jackson	4	9	46	129
Jefferson	13	59	123	72
Knox	16	35	21	33
Lake	8	23	24	112
Lawrence	9	7	4	7

County	1978	1979	1980	1981
Licking	10	27	54	47
Logan	8	14	4	67
Lorain	30	69	87	187
Lucas	539	535	922	513
Madison	10	7	16	70
Mahoning	371	345	308	322
Marion	28	22	27	97
Medina	9	46	89	31
Meigs	17	9	10	5
Mercer	20	16	74	56
Miami	11	2	4	27
Monroe	3	10	11	5
Montgomery	497	620	626	483
Morgan	1	2	2	1
Morrow	16	4	2	6
Muskingum	52	61	162	22
Noble	2	2	8	2
Ottawa	5	38	44	75
Paulding	36	47	27	54
Perry	14	38	199	205
Pickaway	0	5	24	26
Pike	5	6	6	34
Portage	221	226	223	272
Preble	9	1	7	5
Putnam	2	3	23	85
Richland	67	66	105	175
Ross	12	118	194	193
Sandusky	30	28	19	9
Scioto	3	3	1	7
Seneca	6	11	16	43
Shelby	54	169	249	258
Stark	235	940	1,201	1,230
Summit	1,136	1,165	1,035	886
Trumbull	17	26	32	28
Tuscarawas	113	141	246	315
Union	4	19	18	62
Van Wert	65	81	112	122
Vinton	0	3	12	0
Warren	11	3	14	109
Washington	165	147	76	57
Wayne	1	43	115	7
Williams	134	82	48	55
Wood	5	10	6	13
Wyandot	0	14	28	45

TOTAL REPORTS OF ABUSE/NEGLECT

1978	1979	1980	1981
10,435 reports	13,839 reports	15,114 reports	16,514 reports
123 missing observations*	156 missing observations*	191 missing observations*	1319 missing observations*

*Reports which were received, but not compiled because of technical error (e.g., incomplete forms, illegible writing, contradictory responses, inability to identify county, "indicated")

ABUSE AND NEGLECT STATISTICS
Reports Received By
Children Services Agencies
(Substantiated and Unsubstantiated)

OHIO

	Total	Percent Increase From Previous Year
1976	6,861	
1977	9,537	39%
1978	10,435	9%
1979	13,839	33%
1980	15,114	9%
1981	16,514	9%
1982	15,880	(4%)
1983	28,276	78%
1984	47,007	66%
1985	70,923	51%

Increase almost 10.33 times since 1976.

CUYAHOGA COUNTY

1978	1,665	
1979	2,430	46%
1980	2,431	-0-
1981	1,467	(40%)
1985	8,727	495%

Increase almost 5.25% since 1978.

Mr. OWENS. Toni Oliver?

STATEMENT OF TONI OLIVER, CONSULTANT AND ADOPTION SPECIALIST, NATIONAL CENTER FOR NEIGHBORHOOD ENTERPRISE, ON BEHALF OF THE NORTH AMERICAN COUNCIL ON ADOPTABLE CHILDREN

Ms. OLIVER. My name is Toni Oliver, and my testimony today will look at the Adoption Opportunities Act and the impact that it has had specifically, and how it can have future impact on Black, Hispanic and American Indian Children.

As a board member with the North American Council of Adoptable Children, I chair a task force that focuses on the issues of Black, Hispanic and American Indian children. The reasons that we have looked at this group as a specific population is that, although Public Law 96-272 and the Adoption Opportunities and Reform Act have sought to come up with a number of reforms in the child welfare system, these reforms have not necessarily had a positive effect on these populations of children.

As an example, in 1977 when we first began to look at national statistics for children in out-of-home placement, there were about 500,000 children in care and about 38 percent of those children at that time were minorities. However, after the legislation and the reforms that it sought, we find now that there are about 275,000 children in care and nearly 50 percent of those are Black, Hispanic and American Indian.

If we look at urban centers, the plight for minority children is even more grim, in that 80 to 90 percent of these children in foster care in urban centers are Black and Hispanic, predominantly. For a specific example, in New York City over the past 3 years the percentage of Black and Hispanic children in foster care has increased from 75 percent to 90 percent currently.

Although the Adoption Reform Act has been instrumental in funding a lot of activities, I feel that there were many demonstration projects that had a limited period of existence, many of which have been very successful. One of the major problems is that those successes have not been institutionalized in the traditional practices of adoption services.

The major focus of the demonstration projects has been on recruitment of minority families, with the thought being that once the families were recruited, then of course the children would receive placements. However, what has happened is that we look at the fact that recruitment projects, when they are offered in a culturally relevant manner, are very successful in identifying minority families, but there is a problem and a gap in the numbers of families that are recruited and the numbers who actually get through the system.

For example, in Indiana there was a one church/one child project that was instituted in the State because the State had identified 197 children, Black children in care, for whom there were no families. During a period of 1 year and 2 months, that project had identified 150 Black families who were interested in adoption. Currently, about a year and 4 or 5 months after the inception of that project, only 20 of those families have received a home study, and

of that 20, only 7 have received placements, which equals 8 children.

In California over the past 4 years the State has funded recruitment projects for four separate minority organizations at the tune of about $600,000, and less than 5 percent of the families who have been recruited over that period of time have received placements of children.

Successes in the area of adoption for minority children have been confirmed through a study of adoption services for waiting minority and non-minority children that was submitted to the Department of Health and Human Services by Westat, Inc., in April of 1986. In all instances, success was measured by the increase in the pool of adoptive families, a decrease in the time families and children wait for placement, and an increase in the actual number of placements.

In reauthorizing the Adoption Opportunities Program, particular attention must be given to the fact that successful recruitment efforts alone do not ensure the placement of minority children. States receiving funding should demonstrate how they will involve various segments of the minority community in outreach and in the development of eligibility assessment and placement criteria that is culturally relevant. This could be done by using members and staff from projects that have previously demonstrated success in recruiting families, to review and monitor agency practices.

Recruitment programs that happen to be independent of agencies should be funded under the conditions that there exist timetables to respond to inquiries; timetables to follow up with families and agencies regarding referrals; a system to resolve disagreements regarding the appropriateness of prospective families; and agreements from specific agencies holding the custody of children, stipulating the ways in which they will respond and cooperate with recruitment efforts; and, last but not least, mechanisms for accountability and sanctions for noncompliance. This would avoid situations like the one in which the Homes for Black Children agency in Detroit received funding to replicate——

Mr. OWENS. Could you take one minute to sum up?

Ms. OLIVER [continuing]. Its success in seven sites throughout the country. However, during the 3 years of the demonstration project, not one site identified 100 children, although at that time there were 50,000 children legally free for adoption and 42 percent of those were Black.

In conclusion I would like to say that minority children represent 14 percent of the Nation's population, yet they are nearly 50 percent of the foster care population. Minority recruitment programs have demonstrated effectiveness, yet the families have been screened out rather than screened in. There must be coordinated efforts between community groups and adoption agencies and exchanges, so that proven, successful activities can be institutionalized and that the quality of life can be improved for children in a relevant and timely fashion.

Thank you.

[The prepared statement of Toni Oliver follows:]

Testimony before
the

Committee on Education and Labor
Subcommittee on Select Education

U.S. House of Representatives

April 29, 1987

Hearing on:

Reauthorization of the Child Abuse Prevention and Treatment Act and Adoption Reform Act of 1978

Testimony Presented by:
Toni Oliver, Board Member
North American Council on
Adoptable Children

Consultant and Adoption Specialist
National Center for Neighborhood Enterprise

Mr. Chairman and members of the Subcommittee, my name is Toni Oliver and the views I express today are not necessarily those of the National Center for Neighborhood Enterprise. I am testifying this morning on behalf of and as a board member of the North American Council of Adoptable Children (NACAC's), an organization which represents over 800 adoptive parent groups. NACAC major purpose is to advocate for the rights of every child to a permanent family, specifically children in need of adoption. As a national organization, we hold an annual conference which draws approximately 1,000 adoptive parents and professionals and publish a quarterly newsletter that focuses on legislative, practice, and parenting issues related to adoption.

As a member of the Board, I chair a task force on Black, Hispanic and American Indian adoptions. We have focused particular attention on these populations not only because they are disproportionally represented in foster care, but the reforms sought through Public Law 96.272 and the Adoption Reform Act of 1978 for the foster care industry has not been very positive for minority children. In fact, their ranks have continued to swell.

To illustrate this point, in 1977 when the foster care population reached a high of 500,000 children, minority children comprised 38 percent of the total. However, of the 275,000 children currently in foster care nearly 50 percent are members of minority groups. In urban centers the situation is even more grim in that as many as 80-90 percent of the foster care population are minority children. In New York, for example, the

population of Black and Hispanic children in foster care has increased from 75 to 90 percent over the past three years.

The Adoption Reform Act has been instrumental in funding activities to identify barriers to the adoption of minority children and programs targeted toward improving adoption opportunities for them. To this end, training curriculum has been developed and training sessions have been conducted for adoption workers in public and private agencies; funding for minority parent groups was made available for a one-year demonstration period; demonstration programs were implemented for recruitment efforts targeted toward prospective minority parents; and, a national exchange and various regional exchanges were funded to give children within and across state lines greater visibility to prospective parents interested in adopting children with special needs.

These programs have demonstrated that targeted recruitment efforts are highly successful in identifying minority families interested in adoption and that when culturally relevant and flexible eligibility criteria are applied, the adoption rates for minority children increased significantly. Why, then, do Black, Hispanic and American Indian children continue to be over represented in the group of children waiting to be adopted and to wait a disproportionally longer time for adoptive placements? The answer to this question is very simple. The ingredients for success have generally been limited to the scope and term of the demonstration projects and there has been little cooperation be-

tween those who recruit and those who have the authority to make placements.

In every instance, successful projects were those in which minority communities not only targeted for determining interest in adoption but they were integrally involved in all aspects of local adoption programs on an on-going basis. From this collaboration there developed trust and positive attitudes on the part of minority communities regarding agency adoption efforts that replaced previous skepticism and reticence. Agencies simultaneously broadened their recruitment efforts and designed more flexible eligibility criteria that served to screen in rather than screen out single parents, fixed and lower income families, families with children and non-professional persons. All of these factors seen as contributors of success have been confirmed in a study of Adoption Services for Waiting Minority and Non-Minority Children submitted to the Department of Health and Human Services by Westat, Inc., in April of 1986. Success in these instances is measured by the increase in the pool of minority families, decrease in the time families and children wait for placement and increases in the actual number of placements.

In reauthorizing the Adoption Opportunities Program, particular attention must be given to the fact that successful recruitment efforts alone do not ensure the placement of minority children. Activities funded under this program must be tied to placement outcomes. States receiving funding must demonstrate how they will involve various segments of the minority com-

munities in outreach and in the development of eligibility, assessment and placement criteria that is culturally relevant. This could be done by using as members of advisory boards, staff and volunteers who have demonstrated success in recruiting families to review and monitor agency practices and progress in improving adoption opportunities for minority children.

Recruitment programs that are independent of agencies should be funded under the conditions that there exist timetables to respond to inquiries; timetables to follow-up with families and agencies regarding referrals; a system to resolve disagreements regarding the appropriateness of prospective families; and agreements from specific agencies holding the custody of children stipulating the ways in which they will respond and cooperate with recruitment efforts and last but not least, mechanisms for accountability and sanctions.

Minority adoptive parent groups should be funded to monitor agency adoption activity; to assist in the development of relevant criteria; to identify barriers to adoption; to recruit and prepare families for adoption; and to support families through the adoption process and beyond. Programs should be funded that increase the visibility of children waiting and demonstrate a decrease in the length of time they wait.

Children who have the goal of adoption but are not yet legally free should be among those receiving increased viability and for whom adoptive families are actively sought.

For many children, years elapse between the time adoption becomes the goals and an actual placement is effected. Last year in Maryland, for example, a state task force found that it takes five years from the time adoption is identified as a goal for an actual placement to occur. In Baltimore City, seven years elapsed between the goal and the placement. Professionals in the field of adoption attest to the fact that the longer children are denied a permanent family, the greater the likelihood they will experience social adjustment, academic, behavioral and emotional problems.

Legal risk adoptive placements, that is pre-adoptive placements for children whose parental rights have been terminated, should be pursued for these children. Such placements can insure that children are residing and bonding with families who intend to make permanent commitments to them while the legal process moves at its' own rate of speed. For 5-7 years in the life of children in foster care equals at least half of their lifetime. Efforts to redress this specific atrocity against children must be coordinated with judicial systems.

Conclusion

Minority children represent approximately 14 percent of the nation's population under 19 year old, yet they represent nearly 50 percent of the foster care system. They are younger and healthier than non-minority children yet they wait longer for adoptive placements.

Minority recruitment programs have demonstrated that

minority families respond in significant numbers to the cry for adoptive parents yet they are screened out by irrelevant criteria or wait for inordinately long periods before receiving placements.

Coordinated efforts between community groups and adoption agencies and exchanges have proven to be successful in increasing adoptions for minority children activities funded under the Adoption Opportunities Program must be directed at insuring that placement, not process, is the only measure of success, and that these activities become institutionalized as standard practice rather than time limited demonstrations.

I thank you for the opportunity to testify on this issue and I hope the information and suggestions given will enable you to direct policy and resources toward improving the quality of life for children in desperate need of permanence.

Mr. OWENS. Thank you, Ms. Oliver.
Kay Donley?

STATEMENT OF KAY DONLEY, EXECUTIVE DIRECTOR, NEW YORK SPAULDING FOR CHILDREN, ON BEHALF OF THE CHILD WELFARE LEAGUE OF AMERICA

Ms. DONLEY. Thank you, Mr. Chairman, members of the subcommittee. My name is Kay Donley. I am executive director of an adoption agency called New York Spaulding for Children in New York City, and you have my written statement. I am just going to supplement that a little bit, if I may.

I really would like to speak to the reauthorization of the Adoption Reform Act of 1978 and an expansion of that act. I think it is time that we include post-legal adoption service in our purview of those things that are necessary to put into motion if we are in fact going to successfully recruit families, place children, and sustain those placements.

It boils down to kind of two basic reasons, I think, that this is a necessary piece of the process. Increasingly, the children who are being placed for adoption, especially that special needs population of this country, tend to be very complicated youngsters. They tend to have very complex family histories, very extensive multiple placement histories, as they come into their new families. They also tend to be children who ofttimes have to be placed with brothers and sisters, not just isolated children but whole groups, family groups of children coming into new families.

I think it important that we understand that all of that means that the children are very complex, and that we need to be able to sustain them in those placements that we make. We are demonstrating over and over again across the Nation our ability to identify the kids, to try to place the children. What we now have to demonstrate is our ability to help those placements survive over time.

I think the second reason that this is a timely sort of a venture on our part, the expansion of that particular program, is because it is very clear that we understand a lot more now about separation trauma and what it does to those children who are coming to us in these programs. These children have been highly traumatized by what life has dealt them, and it is naive of us to believe that we can resolve their future simply by virtue of offering them a new family, a new family relationship.

The upshot of it is, unless we face this fact head on now, I believe, and begin putting post-legal services into place for these families, we are going to see significant numbers reentering our service system. Especially in group care services, they are beginning to emerge in different parts of the country. I have some data on that that is included in the written statement that is available to you.

We did a survey in late 1985, for example, and discovered that some 10 percent of children in group care services were in fact children with previous adoption experience, so you have to ask yourself the question, "Why are those children there?" Largely because there are not sufficient community-based services to be of assistance to those families who find themselves in difficulty with a separation-traumatized child who is now moving through adolescent

years. It is a very difficult time for these youngsters and for those families.

If you have any questions, I will be glad to respond to them.

[The prepared statement of Kay Donley follows:]

CHILD WELFARE LEAGUE OF AMERICA, INC.

TESTIMONY OF

KAY DONLEY
EXECUTIVE DIRECTOR,
NEW YORK SPAULDING FOR CHILDREN

ON BEHALF OF

THE CHILD WELFARE LEAGUE OF AMERICA

BEFORE

COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON SELECT EDUCATION

U.S. HOUSE OF REPRESENTATIVES

April 29, 1987

Hearing On:

Reauthorization of the

Child Abuse Prevention and Treatment Act and
Adoption Reform Act of 1978

Mr. Chairman and Members of the Subcommittee, my name is Kay Donley and I am testifying this morning on behalf of and as a member of the Child Welfare League of America. I am the Executive Director of New York Spaulding for Children, a member agency of the Child Welfare League, which is a specialized adoption agency dealing with older and handicapped children, often referred to as children with special needs.

The Child Welfare League of America, established in 1920, is the only national voluntary organization and standard-setting agency in the child welfare field. The League is comprised of 475 public and private voluntary not-for-profit member agencies and 1600 affiliates who provide various child welfare services to children and their families throughout North America. Such services include adoption, foster family care, residential treatment, group homes, home-based social services, day treatment and child day care. Examples of League member agencies include, the New York City Department of Social Services, Special Services for Children Division; New York State Council of Voluntary Family and Child Care Agencies, Inc.; the Texas Department of Human Services; Juliette Fowler Homes, Inc., located in Dallas, Texas; the Vermont Children's Aid Society; the Montana Department of Social and Rehabilitation Services; and, the California Association of Services for Children.

We appreciate the invitation and opportunity to appear before the Subcommittee this morning to share with you our views on issues related to the programs which are presently before the Subcommittee for purposes of reauthorization — The Child Abuse Prevention and Treatment Act, The Adoption Reform Act of 1978 and the Family Violence Prevention and Services Act. We would like to focus our remarks particularly on the Adoption Reform Act of 1978 (hereinafter referred to as the "Adoption Opportunities Program") and comment

briefly on the Child Abuse Prevention and Treatment Act as well as the Family Violence Program. Specifically, we would like to address our remarks to the following recommendations which we believe, if enacted, would greatly strengthen these programs by addressing the current needs in both the fields of adoption and child abuse.

With respect to the Child Abuse Prevention and Treatment Act:

- CWLA urges that the National Center on Child Abuse and Neglect (NCCAN) be required to compile and analyze case data related to the nature and extent of officially reported child maltreatment in the United States.
- CWLA urges that the authorized funding level for FY 1988 be increased to $50 million.

With respect to the Adoption Opportunities Program:

- CWLA urges that the authorized funding level for FY 1988 be increased from the current fully funded level of $5 million to $10 million, and, that within this increased level, $3 million be set-aside for targeted efforts aimed at the recruitment of and placement in permanent homes for minority children who are defined as "special needs" and who are legally free for adoption and awaiting placement in a permanent home.
- CWLA urges a new legislative authority, funded at $10 million, for post-legal adoption services.

Child Abuse Prevention and Treatment Act: In our opinion, this program should remain basically as is. We believe that this program, as currently written, provides states with a great deal of flexibility in administering their child protective service systems while insuring adequate and needed protections for children who are reported as abused and neglected.

However, we would like to recommend one slight legislative change related to NCCAN's collection of data from the field. As you know, since 1976, NCCAN has funded a national reporting study for the purpose of gathering data from the states regarding the number of reports received over the previous year related to abuse, neglect and child sexual abuse. In 1984, the latest year for which this study was published, all 50 states, the District of Columbia, Guam, Puerto Rico, the Virgin Islands and Marianas Islands, contributed data on the total numbers of child abuse and neglect reports received in that year. This data is what produces information regarding the total number of reports of abuse and neglect each year, allowing us to chart national trends with regard to whether reports are increasing or decreasing from one year to the next.

In combination with the collection of data related to the number of reports, NCCAN has also funded a more detailed analysis, utilizing "case data" in the form of computer generated files from the states wherever such information is available. In 1984, 30 states and territories representing 61 percent of the total U.S. child population provided such data. In 1984, the type of information generated from such an analysis included:[1/]

- "Type of Report ... neglect, alone or in combination with abuse, is the most frequently reported type being reported in approximately 58 percent of all cases of child abuse and neglect. Abuse is reported in approximately 50 percent of all

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1/ Highlights of Official Child Neglect and Abuse Reporting 1984, The American Humane Association

cases, where abuse generally included reports of both physical and sexual maltreatment ..."

- "Source of Report ... the types of individuals who report suspected maltreatment to child protective services agencies are evenly divided between professional sources and nonprofessionals. It is interesting to note that it is the victim's own friends, neighbors and relatives who constitute the single largest group of reporters..."
- "Substantiation Status .. Based on data from 19 states, a national estimate of 727 thousand reported children were considered substantiated for child abuse and neglect by CPS systems. This represents approximately 42 percent of the 1.7 million children who were reported in 1984..."
- "Summary Profile of Reported Families ... average age of involved child was 7.2 years... 48% were males, 52% were females...67% were White, 21% were Black, 10% were Hispanic and 3% were categorized as Other."

This type of information goes on and on — Perpetrator Descriptors (for example, the average age is 31.5 years); Type of Maltreatment Associated with Fatalities (for example, major physical injury is indicated for 47% of fatalities, deprivation of necessities or neglect is indicated in 44% of fatalities and minor physical injury accounts for 21%); Profile of Families, Characteristics by Substantiation Status; Characteristics for Emotionally Maltreated Children, etc.

Funding for the 1985 study was the first year in which NCCAN did not fully fund this type of analysis. In fact, the funds made available were sufficient only to study data from five states. It would appear that NCCAN's commitment to this type of data gathering is waning and it is our opinion that the collection of same should not be left to the discretion of any Administration but rather mandated in order to insure the continuing and consistent collection of such information.

The collection of such data is critical to the field of child abuse and neglect for the following reasons:

(1) There is a developing continuity of reporting data over the past ten years. The depth of data is sufficient to begin utilizing it for time series studies which, when coupled with other information about the child protective service system, have the potential to reveal a great deal about the forces that interact with and drive the system. This then would allow for the development of training programs for protective service workers as well as shore-up state systems based on information about "what-we-know"" relative to the national profiles of maltreatment, descriptions of involved children, caretakers, perpetrator, source of report, etc.

(2) Data collection for a revised National Incidence study occurred in 1986 and is in the process of finalization. Because of important revisions in the incidence study methodology, more appropriate comparisons with reporting data will be possible than was the case with the 1979 incidence study. This has several important benefits having to do with more precise calibration of incidence study data (which is sampled) to the case specific data from the reporting study (which is not sampled.)

Calibration of data will provide us with an ability to adjust the reporting data if necessary for "representativeness." This means that we can have more confidence in our national estimates based on reporting data; however, this cannot occur until there is more complete case data in 1986.

Accordingly, CWLA urges that that NCCAN be required to compile and analyze case data related to the nature and extent of officially reported child maltreatment in the United States, to include case data from the maximum number of states possible and not less than the level of effort with regard to the case data analysis in 1984.

With regard to the overall funding level of the Child Abuse Prevention and Treatment Act, CWLA urges an increase in the authorization levels for each year and specifically, for FY 1988, we would suggest the figure of $50 million. This, as you know, compares with the current authorization level of $43.1 million and we believe could be used by the states in shoring-up their systems in whatever way they considered necessary (i.e., training, public education, establishment of multi-disciplinary teams, etc.)

Adoption Opportunities Program: Since its inception in 1978, the primary purpose of this program has been to support activities which serve to increase adoption opportunities for children in need of permanent, adoptive families and to ensure the adoption of children with special needs by eliminating barriers which might prevent such adoptions from occurring. Tremendous strides have been made in the advancement of such goals through the funding of state and regional-wide training conferences; the development of curriculum materials for state adoption workers and supervisors; funding of the national and various regional adoption exchanges which help to match a family in one state who is interested in adopting a child located in another state; the funding of specific targeted efforts to recruit permanent adoptive homes for waiting children -- all of which have contributed to forcing systemic changes around the notion that "no child is unadoptable."

CWLA believes that such activities should not only continue but be expanded by increasing the authorized funding level by $5 million, resulting in a total authorized level of $10 million for FY 1988.

Within this increased level, CWLA urges that $3 million be set-aside for targeted efforts aimed at the recruitment of and placement in permanent homes for minority children who are defined as "special needs" and who are legally free for adoption and awaiting placement in a permanent home.

We believe that such a targeted effort on behalf of minority children is necessary since the placement of these children in permanent homes has been one of the more problematic issues in the field of "special needs" adoption for the last several years. According to the most recent figures from the U.S. Department of Health and Human Services (HHS) approximately 36,000 children with special needs are awaiting to be placed in adoptive homes. Of this number, 42% are minority, 37% are handicapped, the median age is 12 and 68% have been in foster care for 2 years or more. There is much evidence that where targeted, comprehensive efforts

are made, homes for minority children are found, surprisingly, often without great difficulty. The next hurdle in the process seems to come after families have been identified in terms of the actual placement of the child. Once a family is identified, adoption agencies, either state or private agencies, are charged with insuring that the potential family is the best one suited for and in the best interest of the child. The breakdown in the process seems to occur at this point — in actually moving the families through the system to the point at which children are actually placed with them. For example, the New York Council on Adoptable Children (COAC) recently testified before the House Select Committee on Children, Youth and Families that they currently have an average of 424 families (383 of whom are Black and Hispanic) waiting an average of 2 years and 3 months before the process is complete; that is, before the child is actually placed with the family. These families have been recruited by COAC for purposes of placing some of the 3800 children currently waiting in New York City's foster care system who have the goal of adoption. Ninety (90%) of these children are Black or Hispanic and just this one agency has been able to locate 424 homes in which to place these waiting children yet, because of the delays experienced in actually completing the process, COAC reports that up to 25 percent of the families drop-out. The obvious affect of this is that some of these children who might otherwise have been able to grow-up in a permanent adoptive home, continue to wait and grow-up in the foster care system.

What CWLA believes is needed is a comprehensive and specifically directed effort that begins at the "front-end" of the process, with outreach and recruitment activities aimed at identifying prospective families and continues all the way through the process, to the placement of the child with a family. A precedent exists for such a targeted effort under the Child Abuse and Treatment Act, with regard to the so-called "Baby Doe"

amendments of 1984. Such amendments authorized additional grants to the states for the purpose of developing, establishing, operating and implementing procedures for programs aimed at disabled infants born with life-threatening conditions. These grants encouraged states to develop programs of education and training of professional and paraprofessional staff as well as coordinated existing and necessary services related to such infants. Today, just over 2 years following the implementation of these requirements, virtually every state agency has in place a procedure, system and program for addressing the needs of these infants.

CWLA is suggesting that a similar type of focused effort be developed, one which is targeted specifically to the population of waiting, minority children with special needs. Similar to the "Baby-Doe" programs, such an effort should include programs of education and training of professional and paraprofessional staff, whose only responsibility would be the recruitment of permanent homes and the placement of minority children into those homes. This, to insure that waiting minority children with special needs do not continue to wait a disproportionately longer period of time than other children with special needs.

In addition, CWLA urges new legislative authority, under the Adoption Opportunities Program, for a demonstration program for post-legal adoption services. We strongly believe that this is a critically necessary adjunct to the Adoption Opportunities Program and entirely consistent with its purpose as defined in the Findings and Declaration of Purpose, as follows:2/

> "...It is, therefore, the purpose of this title to facilitate the elimination of barriers to adoption and to provide permanent and loving home environments for children who benefit by adoption, particularly children with special needs..."

2/ From Title II, "Adoption Opportunities," P.L. 95-266, "The Child Abuse Prevention and Treatment and Adoption Reform Act" of 1978.

CWLA submits that the responsibility of this program to insure "permanent and loving home environments for children who would benefit by adoption," does not end with the finalization of the adoption. The fact that a court decrees an adoption to be final does not also decree that this new family will automatically become the "loving home environment" envisioned by this law. If we have learned anything over the last 10 years of the operation of this highly successful program it is that the families that "we" have formed through the workings of this program and other federal efforts, do not stop needing "the system" once the adoption has been finalized. Indeed, their needs are just beginning while the needs of the system as presently established are ending, with placing the child in a so-called "permanent and loving home environment." The present system then tends to view the adoption as a solution unto itself, a solution which is ended at the courthouse steps, with the signing of the papers.

However, we now know that the system as presently constructed is not in step with reality; that is, the needs of adoptive families. And, as a result, as we become more successful in placing children in permanent, loving home environments, the more families are returning to the system in crisis and in need of post-legal adoption services. Unfortunately, there are only a handful of agencies and a few private therapists with any kind of specialized adoption counseling programs. Many families report having encountered counselors and therapists who lacked knowledge, familiarity or understanding of adoption. Sometimes parents struggling to maintain a family with a troubled adopted child were asked why they adopted and were advised to "send the child back."

In the interest then of keeping these families together, CWLA believes that the necessary and appropriate support services must be provided to adoptive families.

CWLA further submits that such services should be available to every adoptive family inasmuch as current data indicate a growing incidence of families having adopted children as infants, turning to the child welfare system for help and finding none, place the child in foster care.

As previously indicated, CWLA has within its membership, agencies providing the total range of out-of-home care services and for the past several years, many of these agencies have been reporting that more and more children who were adopted as infants, often now at the age of puberty or adolescence, are being placed in their care. Approximately 2 years ago, an effort to quantify this was undertaken by an 11 year-old project within CWLA, known as the Family Builders Network, a group of non-profit adoption agencies dedicated to serving older, handicapped, minority children. Under the auspices of this project, a survey was conducted of 107 group care facilities located in 11 states[3/] representing 4100 children. This survey found that approximately 10 percent of children in care were adopted. Of this number, 38 percent had been adopted as infants and 62 percent had been adopted as older, possibly "special needs" children. Around the same time, a similar survey was undertaken by the American Association of Children's Residential Centers (AACRC) in conjunction with the National Association of Pychiatric Treatment Centers for Children (NAPTCC), both national organizations whose members provide interdisciplinary mental health treatment for emotionally disturbed children and their families. Although the AACRC/NAPTCC survey was smaller, based on responses from 51 facilities, the results were somewhat similar: 14 percent of children in care were adopted; 51 percent of this number had been adopted as infants and 49 percent were adopted after infancy. What is perhaps most striking about this

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3/ These states include: Florida, Georgia, Illinois, Kansas, Massachusetts, Michigan, New Jersey, New York, South Carolina, Texas and Washington.

data is the fact that of the total U.S. child population under age 18, adopted children comprise only 2 percent. Therefore, the percentages indicated by these two surveys point up a disproportionate number of adoptive children going into out-of-home care. Moreover, as substantiated by our member agencies, at the base of the family crisis giving rise to the child's out-of-home placement, are issues related to adoption.

For the child, such issues may relate to never having resolved the loss of their birthparent(s) or never fully believing that their adoptive parents are their "real" parents. Society can be inadvertently cruel to children who are adopted by giving insidious messages that being adopted means never really belonging to any family. In the process of becoming fully functioning adults, with strong egos and realistic self-concepts and images, we all search for our identity and go through the process of understanding "who we are." It is a process made all the more difficult for children who are adopted, given such messages. And, adoptive parents, in order to help their children through these issues, need to believe that they are "real" parents and that their children are their "real" children. Before such issues, which are uniquely related to adoption, are dealt with, the "normal" process of development for children, for parents and for families, will not occur.

For children who are adopted as "special needs" or who come from other countries, these issues are even more compounded. Children with special needs are typically children who have been adopted often after a prolonged period of time spent in foster care — 5 or 10 years is not unusual for some of these children. Many of these children come into the "system" at young ages, having been abused or neglected by their parents, whose legal rights to their children are subsequently terminated, a process which is itself often prolonged and extremely traumatizing to the child. Many of these children come into the "system" after having been born with severe physical handicaps and,

because their parents may be unable to adequately provide for their care, the state becomes their legal custodian. It is for these children that efforts under the Adoption Opportunties Program and other federal initiatives are primarily focused. However, it is a focus that is one-sided -- related only to recruiting a family and placing the child. Once this occurs, we shut the door in their faces and beyond wishing them "a nice day" effectively wish them "a nice life." When they return to the system seeking support and counseling, 6 months or 6 years later, we respond as though we have fulfilled our obligation by placing the child and now have no further responsibility. But, we do. We must do more for these families -- we have helped to create them and we must help them stay together.

What CWLA proposes is:

- A demonstration program of post-legal adoption services with an authorization of 4 years, beginning FY 1988, funded at $10 million for each year.
- Grants would go to state social services agencies to develop a program of post-legal adoption services. States would design and direct their programs to the adoptive families having the greatest need as determined through consultation with appropriate adoption and community groups having an interest in the field of adoption, including parent groups, private non-profit adoption agencies and other appropriate state agencies.
- A report to Congress by the Secretary of the U.S. Department of Health and Human Services would be provided demonstrating the needs of adoptive families and the effectiveness of meeting such needs.

The Child Welfare League of America believes that a program of post-legal adoption services authorized and funded under the Adoption Opportunities Program is absolutely critical if we are to fully realize the purposes embodied in the law aimed at providing "permanent and loving home environments for children who would benefit by adoption." We have, for several years now, referred to the efforts to date under this law, as having placed children in permanent homes only now to learn that true permanency requires another step -- ongoing support after finalization. We urge this Subcommittee to provide for this next step by authorizing a new program of post-legal adoption services so that adoptive families can be maintained in homes that are truly permanent and loving.

Family Violence Prevention Services Act: CWLA strongly urges this Subcommittee to reauthorize this program for 4 years, with incremental increases in the authorized funding level for each year, beginning with FY 1988. Specifically, for FY 1988, we would recommend an authorization level of $30 million which, as you know, would provide for needed increases over the present authorized level of $26 million.

We believe this is a necessary program and critical adjunct to the Child Abuse Act because of its specific emphasis on the problem of family violence which so often affects children. The grants which are provided under this program to states and non-profit community organizations for shelter and related services to the victims of family violence help to maintain children with at least part of their family during such situations. Critical too is the program of law enforcement training and technical assistance.

According to the Center for Women Policy Studies, nationally, 20% of the visits to emergency rooms are made by women who are victims of spousal abuse and 2 million women per year are reported as battered due to family violence. Given these alarming statistics, CWLA submits that a system of emergency shelters, prevention and counseling services, all which are provided for under this program, are clearly needed.

CWLA, therefore, strongly urges this Subcommittee to reauthorize this program, as currently enacted, including the present formula for the distribution of grants, for a 4 year period, beginning FY 1988.

Mr. OWENS. Thank you very much, Ms. Donley.
Mr. Arcara?

STATEMENT OF RICHARD J. ARCARA, ESQ., PRESIDENT, NATIONAL DISTRICT ATTORNEYS ASSOCIATION

Mr. ARCARA. Mr. Chairman, my name is Richard Arcara. I am a former United States Attorney for the Western District of New York, the present District Attorney for Erie County, Buffalo, New York, and as its president, I speak to you today on behalf of the National District Attorneys Association. The National District Attorneys Associatior is the professional association of America's local prosecutors, fo nded in 1950, with approximately 7,000 active and associate members.

I will focus my remarks, with the chairman's indulgence, on the 1986 amendments to the Child Abuse Prevention and Treatment Act, commonly cited as the Children's Justice Assistance Act of 1986. As a prosecutor whose office handles hundreds of such cases yearly, I can attest to the critical need for improvement in the criminal justice system response to child sexual abuse victims.

Though my office policies have changed, too often we have seen children needlessly subject to an array of bewildering interviews with often untrained professionals. Too often we have seen law enforcement, child protection and mental health personnel working at cross-purposes to the detriment of the victim. Too often we have seen archaic courtroom practices used to bar the testimony of young victims we should be protecting. This is changing slowly across our country today. I believe an effectively implemented Children's Justice Act can provide an important impetus for speeding that change.

However, there are times when effective implementation of worthwhile programs is often hampered by convoluted and complex plans, at the expense of simple solutions and a good measure of common sense. America's district attorneys are concerned that this not happen with the implementation and the execution of this legislation. One tool that we can use to prevent such unnecessary distortion is to begin to formulate a simple and clear vision of how the Children's Justice Act can be used to achieve the dual goals of, one, improved investigation and prosecution of child abuse cases and, two, reduced trauma to the child victim.

There are two main points I want to make this morning about the effective implementation of the Children's Justice Act. Point number one, the act will have the greatest impact if it is used as an opportunity to train local law enforcement in the state-of-the-art techniques of investigation and prosecution of child abuse cases. Point number two, this training should be designed and carried out by prosecutors with expert skills and lengthy experience in child abuse prosecution.

We suggest that the delay in implementing the Children's Justice Act and the great concern it causes both you as an oversight committee and us as prosecutors can be easily remedied by NCCAN's utilization of the mechanisms already in place and actively functioning under the auspices of the National District Attorneys Association. The NDAA, through its research affiliate, the

American Prosecutors Research Institute, has created our National Center for the Prosecution of Child Abuse, which will within the next 30 days distribute to the field what we believe to be a landmark publication in the legal system's response to child abuse, entitled "Investigation and Prosecution of Child Abuse."

For the first time, a comprehensive manual by and for investigators and prosecutors on effective ways to handle child abuse cases will be available. It contains authoritative guidance on trial strategies, legal reforms, child development issues, medical advances, treatment options, and service resources affecting child abuse prosecution. It contains step-by-step procedures for investigating child abuse reports, coordinating law enforcement with child protection and treatment efforts, protecting victims throughout the criminal justice process, and responding to and preparing child victims, including the very young, adolescents, and multiple victims. This manual represents the collective experience and expertise of many of America's finest child abuse prosecutors, literally from all over the United States.

I see that I am running out of time, and I will just rely upon my written report.

Just in conclusion, Congressman Miller indicated that the name of the game here is money. I think he said it very forthrightly, and I think he is very accurate in this.

Three years ago I implemented a program in my office called the CARE unit, a Comprehensive Abuse, Assault and Rape Unit. The purpose of that unit was to deal with the fragile victims in the domestic violence area and rape. The funding for that program came from the private sector. I went to the government for funding in this program and I was turned down every which way. I thought the importance of this type of approach dealing with these kinds of crimes was paramount.

Fortunately, in Buffalo I was able to go to a local foundation and they provided the funding for that program. I think the program that we have is a model program. It has been very effective. It has brought together all the various agencies, private and government, that deal with this problem.

I can say that when I first initiated this program, I met with all these various agencies, the social groups, the various agencies that were involved, and there was much suspicion: "What is this district attorney going to do? He wants our help. What is his real angle on this thing? Is he really sincere? Is he really addressing the problem or is he trying to build a little fiefdom for himself?"

Many of these groups I found were suspicious of each other because they were all funded from many of the same sources, and they were all concerned about whether or not this program that we were initiating would in some way at all have some adverse effect on their programs. Well, I am very happy to say that it did not. After a few months, they recognized where we were coming from and that we really had a common purpose here. Even though our interests were different, the common purpose was to protect children from being abused, and to make sure that when these children—and battered wives—go through the criminal justice system, that they go through the system with the least amount of trauma as possible.

Thank you very much.
[The prepared statement of Richard J. Arcara follows:]

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STATEMENT

OF

RICHARD J. ARCARA
PRESIDENT
NATIONAL DISTRICT ATTORNEYS ASSOCIATION

BEFORE

THE

COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON SELECT EDUCATION
UNITED STATES HOUSE OF REPRESENTATIVES

CONCERNING

REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT

ON

APRIL 29, 1987

Mr. Chairman and members of the House Subcommittee on Select Education:

My name is Richard J. Arcara. I am a former United States Attorney for the Western District of New York; the present District Attorney for Erie County, Buffalo, New York; and, as its President, I speak to you today on behalf of the National District Attorneys Association. The National District Attorneys Association (NDAA) is the professional association of America's local prosecutors. Founded in 1950 with an initial membership of sixteen, the Association today has nearly 7,000 active and associate members representing virtually every community in the country. The Association is currently governed by a board of directors with representation from every state. In this way, a consensus of opinion on widely divergent topics can be achieved.

I appreciate the opportunity to offer testimony on the reauthorization of the Child Abuse Prevention and Treatment Act. I will focus my remarks, with the Chairman's indulgence, on the 1986 amendments to the Child Abuse Prevention and Treatment Act, commonly cited as the "Children's Justice Assistance Act of 1986." I appreciate that there are many issues of importance to the work of this Committee. However, I believe that this Committee will be interested in the specific recommendations for implementation that I will make.

Title I of the Children's Justice Act authorizes the National Center on Child Abuse and Neglect (NCCAN), operating under the Department of Health and Human Services, to award grants to states for programs which improve the investigation and prosecution of child abuse cases and the handling of those

cases in a manner which limits additional trauma to the child victim. The emphasis is on cases of child sexual abuse.

As this Committee is aware, in order to qualify for Children's Justice Grants, states must meet the existing eligibility criteria in the Act (P.L. 93-247). A state must also have established a multi-disciplinary task force on children's justice to review current state investigative, administrative and judicial handling of child abuse cases and recommend improvements.

The recommendations of the task force must include: 1) reforms to reduce the trauma to the child victim and ensure procedural fairness to the accused; 2) programs for testing innovative approaches to improving judicial action in child abuse cases; and 3) reform of state laws and procedures for providing protection for children.

The Act also requires NCCAN to develop and disseminate model training procedures for professionals working in child abuse investigative, administrative, and judicial proceedings, and to conduct research on appropriate procedures in child abuse cases.

These are worthy and important goals. They deserve our support and appreciation for those who worked to pass this potentially far-reaching legislation.

As a prosecutor whose office handles hundreds of cases yearly, I can attest to the critical need for improvement in the criminal justice system's response to child sexual abuse victims. Though my office policies have changed, too often we have seen children needlessly subjected to an array of bewildering interviews with often untrained professionals. Too often we have seen law enforcement, child protection, and mental health personnel working at cross purposes to the detriment of the victim. Too often we have seen archaic courtroom practices used to bar the testimony of young victims we should be protecting. This is changing slowly across our country. I believe an effectively implemented Children's Justice Act can provide an important impetus for speeding that change.

However, there are times when effective implementation of worthwhile programs are hampered by convoluted and complex plans, at the expense of simple solutions and a good measure of common sense. America's district attorneys are concerned that this not happen with the implementation and execution of this legislation. One tool that we can use to prevent such an unnecessary distortion is to begin this morning to formulate a simple and clear vision of how the Children's Justice Act can be used to achieve the dual goals of improved investigation and prosecution of child abuse cases and reduced trauma to the child victim.

There are two main points I want to make this morning about the effective implementation of the Children's Justice Act. Point number one: the Act will have the greatest impact if used as an opportunity to train

prosecutors in state-of-the-art techniques of investigation and prosecution of child abuse cases. Point number two: this training should be designed and carried out by prosecutors with expert skills and lengthy experience in child abuse prosecution.

We suggest that the delay in implementing the Children's Justice Act, and the great concern that it causes both you as the oversight committee and us as prosecutors, can be easily remedied by NCCAN's utilization of the mechanisms already in place and actively functioning under the auspices of the National District Attorneys Association.

The NDAA, through its research affiliate, the American Prosecutors Research Institute, has created our own National Center for the Prosecution of Child Abuse which will, within the next 30 days, distribute to the field a landmark publication in the legal system's response to child abuse entitled INVESTIGATION AND PROSECUTION OF CHILD ABUSE. For the first time, a comprehensive manual by and for prosecutors on effective ways to handle child abuse cases will be available. It contains authoritative guidance on trial strategies, legal reforms, child development issues, medical advances, treatment options, and services resources affecting child abuse prosecution. It contains step-by-step procedures for investigating child abuse reports; coordinating law enforcement with child protection and treatment efforts; protecting victims throughout the criminal justice process; responding to and preparing child victims, including the very young, adolescents, and multiple victims. Practical checklists, sample transcripts, interview guidelines,

supplemental resources, state statutes and caselaw references are also included.

This manual represents the collective experience and expertise of many of America's finest child abuse prosecutors. In addition to the manual, our Center is using a variety of other resources to bolster the efforts of district attorneys interested in improving the investigation and prosecution of these cases. These include the publication of monographs on such topics as "Special Hearsay Exceptions", "Competency of Child Witnesses", "Videotaping Child Victim Interviews or Statements", and "Videotaped Depositions and Closed Circuit Television Testimony," and in the provision of technical assistance in response to a wide range of requests from local prosecutors. The technical assistance provided to date has consisted of legal research, advice on trial techniques, recommendations about investigative approaches, and information about how to handle child victim witnesses.

Our Center is also assisting local prosecutors and state associations in the development and presentation of training events and local conferences to meet the needs of prosecutors and involve professionals from other disciplines in a coordinated approach to child abuse on the local level.

At the state level, district attorneys are members of state district attorneys associations. In many states, these associations are supported by expert professional staffs headed by prosecutor coordinators who plan and conduct training for prosecutors, produce manuals and handbooks, provide

research assistance and help local offices to improve their operations and practices. It would be a natural and logical extension of the services already offered by these prosecutor coordinators to address the training needs of local prosecutors under the Children's Justice Act and as members of the state multi-disciplinary task forces called for in the Act.

NDAA feels strongly that the expertise represented by the state prosecutor associations and the work of our National Center are invaluable resources to aide in the implementation of the Children's Justice Act. We note the language in the Act that calls upon the Secretary of Health and Human Services to carry out the Act through NCCAN "in consultation with the Attorney General." The Department of Justice has a day-to-day familiarity with the work of local prosecutors and for that reason we believe that active consultation with Justice will improve both the quality and the speed with which the Act is implemented.

We can be of assistance in the following areas:

First, the Act calls on NCCAN to develop and disseminate model training procedures to improve the investigation and prosecution of child abuse. Our manual INVESTIGATION AND PROSECUTION OF CHILD ABUSE is the most comprehensive manual ever produced on the subject. It provides a complete practice tool for working prosecutors, and a starting point for the task force recommendations called for under the legislation.

Through the Children's Justice Act resources could be made available for development of state-specific supplements, rather than each state devoting resources to develop material already contained in the manual.

Second, the governor of each state is required to appoint a task force to develop a plan to implement the Act on the local level. In this process, the NDAA, our National Center and prosecutor coordinators can play a useful role by providing support to the local prosecutor members of these task forces.

Third, our National Center can work closely with NCCAN to identify the concerns and needs of prosecutors in improving the handling of child sexual abuse cases. It can also serve as a conduit for disseminating information about NCCAN's activities and priorities affecting child abuse prosecution to a nationwide network of practitioners facing these cases on a daily basis.

Rarely is legislation enacted with the potential for having great impact for little money. Because Washington is conditioned to equate great impact with great appropriations, there is the danger that a small program like the Children's Justice Act will not receive the attention it deserves because it represents such a small amount of money. Indeed, we are convinced that if this money is diluted into a fund for broad general purposes at the state level and blended into the vast social services budgets of the states that it will have no appreciable impact. We feel it is essential to allocate these funds so that their benefits flow directly to prosecutors.

NDAA feels strongly that the expertise represented by the state prosecutor associations and the work of our own National Center are invaluable resources for the implementation of the Children's Justice Act. We urge NCCAN to consult with NDAA and our National Center in the process of developing their guidelines. State associations should be actively involved in developing state plans and providing services to local prosecutors to accomplish the goals of the Act.

We are determined to work with the states to improve responses to child sexual abuse. We urge NCCAN to take advantage of our expertise and membership network. This hearing is, we hope, a start in that direction. We appreciate the opportunity to testify on behalf of the reauthorization of the Child Abuse Prevention and Treatment Act and commend your concern for child abuse victims in this country.

Mr. OWENS. Thank you very much, all of you, for your testimony.

I would just like to first ask the lawyers who are present, the district attorney and the two gentlemen from the Bar Association, are you—in addition to what you have recommended in your written testimony—are you saying also that if not in this act, then somewhere there should be some mandates on the way the criminal justice system operates or the way the law schools train lawyers? The kind of thing you were talking about in the manual and the new procedures, et cetera, should that not be a routine part of the training of lawyers on the district attorney staff?

Mr. ARCARA. Is that directed at me, Mr. Chairman?

Mr. OWENS. Either one of you. Feel free.

Mr. DAVIDSON. Well, first of all, the National Center on Child Abuse and Neglect has the ability to fund demonstration programs in a variety of areas related to your question, such as to fund innovative law school programs that involve law students, social work students, and other graduate students, criminal justice graduate students as well, in the child abuse area. Those types of programs are very important, and without the Federal involvement in supporting those kinds of demonstration models and then disseminating information about those demonstration models, I don't think they are going to happen, because it is hard to raise private funds for those kinds of very special, very unusual projects.

I mentioned in our testimony that we are developing a standardized curriculum for law schools so that students who are taking family law or juvenile justice in law school can get part of a course directly devoted to the issue of child abuse, and hopefully some of those law students will have the incentive to go on and practice law in this field.

Mr. OWENS. Mr. Bartlett?

Mr. BARTLETT. Thank you, Mr. Chairman.

I was just notified that my amendment in the Housing Subcommittee is up right now, so I am going to have to go over there for the markup, but I did want to inquire of Ms. Oliver some of the things that you said in your testimony.

Could you tell us, do you have any data to quantify the—on page 6 you say that adoptive parents are being screened out by irrelevant criteria or wait inordinately long periods of time—do you have any data that you can provide for this committee as to the number of adoptive parents?

Ms. OLIVER. There are a number of recruitment programs across the country that are documenting, now, the numbers of families that are recruited and comparing that with the numbers that get through and some of the isolated reasons for rejection, yes.

Mr. BARTLETT. Well, if the chairman would hold the record open, I think that would be very useful information for this subcommittee to know, as far as the number of adoptive minority parents that are being screened out.

Could you give us some examples of the irrelevant criteria that are used in that screening process?

Ms. OLIVER. Well, several come to mind immediately. Let me take Indiana. A two-parent family who are interested in adopting a child, the home study has been put on hold because they live in a two-bedroom house, and the agency feels as though they need to

live in larger quarters before an adoption could be effected. A woman who has raised three children and is in a wheelchair, raised them while she was in a wheelchair, was rejected because the agency felt as though because she was in a wheelchair, she could not raise children. A minister who had said that he was interested in adopting a sibling group has been approved since January of 1986, and even though there are 197 children in Indiana, the "right" child has not come for him and so he is still waiting, and it just goes on and on, if you want to hear others.

Mr. BARTLETT. Well, it does seem to me that that is a productive inquiry for this subcommittee in terms of reauthorizing the law. I would suggest that in the last reauthorization of Public Law 98-457, we had thought that we had started the agencies and the Federal agency on the right road. We added language that struck out the words "parent groups" and inserted the words "adoptive family groups" and "minority groups," and we thought we had given the agencies at least some guidance, but you might be able to help us on some ways to improve that guidance out of the Federal law, and perhaps we can be of some assistance.

Ms. Donley, the problem you talked about of post-placement services with regard to health care, is it a problem that the health insurance companies are treating adopted children differently from——

Ms. DONLEY. Well, it is twofold. In the first instance, a lot of these are considered preexisting conditions and so they are not covered under existing insurance coverage, but in many instances we are not talking about things that could be covered by health insurance. We are talking about the kind of assistance—for example, I call this, when I am teaching social workers how to do this kind of work, I call this remedial service.

You are working with a family who came through the system some time ago, and at that point someone didn't properly prepare this child for placement. It may have been an older, school-age child who really wasn't informed on their antecedents and their family connections, and so the child has come on into the new family, and he is now older and he is questioning and he is puzzling over these things.

Well, now, that is not the kind of thing that you need to have health insurance coverage to handle. You need somebody who is skilled in providing good, quality, basic child welfare services, who can reenter the scene. But in most States, you see, if in fact your adoption was legally completed last year or whatever, there is no service money left for you now. You are just going to have to go whistling or hope that you stumble into the hands of a helpful social worker.

Mr. BARTLETT. Would it be productive to approach it as a coverage gap in Medicaid, for example, with regard to the special children, the handicapped children? Is there a gap?

Ms. DONLEY. With those children it could be, but I am more concerned, to be honest about it, in terms of the kind of handicapping condition that doesn't fall into that category, specifically those children who have some measurable emotional disturbance. See, I happen to believe, and many of us practitioners do, that every child who is placed for adoption really suffers some degree of sepa-

ration trauma. They have to cope with that as they move through life, and it is those pieces of assistance that we have to put into place. Otherwise, we are going to see increasing numbers of these children at adolescence who are coming back into our child care system at much greater cost to us as a community.

Mr. BARTLETT. Thank you.

Thank you, Mr. Chairman.

Mr. OWENS. Thank you, Mr. Bartlett.

Did I hear you say, Ms. Oliver, that the recruitment effort has reached its peak? It is doing the job. We don't need to push that much more. It is far head of the effort to place——

Ms. OLIVER. Where they exist. I think that there is a need to have recruitment efforts across the country. Every agency that has custody of children and has an adoption arm should have some way in which they recruit families for the populations of kids that just wait in the system, but the ones that have been implemented have been extremely successful—the one church/one child projects, the Homes for Black Children projects. There are exchanges that do recruitment programs and they are able to identify thousands of families who are interested in adopting, but it doesn't equal action placements. In fact, the percentage of those recruited and those placed with are miles apart.

Mr. OWENS. You mentioned Detroit before. At one time, didn't they have a model program for adoption and almost no children were——

Ms. OLIVER. Federally funded. Yes, that was the one I was talking about. It was seven sites that were to replicate the Homes for Black Children project out of Detroit and in each of the sites, what the agencies—the State agencies or local public agencies—were supposed to do was to identify 100 children that they could recruit for and prepare families to adopt, but in none of those seven sites were 100 children identified. In fact, in some of the sites no children were ever identified in a 3-year period, so although Federal money supported the implementation of that replication of a successful project, there was no coordination between the federally funded project and those who had the custody of the children.

Mr. OWENS. Thank you.

To return to the representatives of the Bar Association and the district attorney, I still am distressed by the fact that on such a basic issue, with so many problems mushrooming related to child abuse and family violence, that the call here appears to be for Federal funding or nothing will be done. I mean, it is being treated by the criminal justice system at the local level as an auxiliary problem, a supplementary kind of problem, when it seems to me the numbers show that it is a basic problem.

We usually have, I think, domestic courts that handle large numbers of cases. Large numbers of family problems related to foster care children, adoptions, and family violence, end up in court. All of it must occupy a large part of the judicial system, not only the courts but the district attorney as well, and more and more the police, and yet I hear the statement being repeated over and over again that if the Federal Government doesn't continue to play a major role in this, nothing significant is going to be done.

Could you just comment on how we can get the local systems to pick up their responsibilities for a basic problem that is there in the population that they serve?

Mr. ARCARA. I think we have recognized this problem more in the last 5 years than we ever have, ever. The local governments are recognizing it. I have done it in my office, and there are many other district attorney's offices throughout the United States.

However, we think that because of the complexity in this area, that more has to be done and that this problem, as I heard earlier today, is a national problem, that we are becoming more aware of it, the numbers are increasing every year, and that the Federal Government really should not walk away from this problem and say, "Well, it is strictly a local matter."

We feel that it is a local matter but we need help. When I have to go to a private foundation for funding for what basically would be a government interest, it is quite embarrassing as an elected official, where the money was not available in the first instance after we put the program in place when the State of New York recognized the importance of it.

What I am suggesting here is that because of the complexities of this, the training that is necessary—in this area as prosecutors, investigators, we are learning new techniques every day and it costs money to train. Most prosecutors that are in this area have a real high burnout problem, so new prosecutors need more training.

The National District Attorneys Association, through the American Prosecutors Research Institute, on our own came up with this manual which will be released next month, which was an effort that we made independent of the Federal Government. We would like to do more with this but we are limited in the funds that we can have. We recognize it as a major problem in the United States today, and I hope that as a result of these hearings, that there is a new sense of urgency that can come out of this.

This child abuse area, the domestic violence, it was in vogue 2 years ago and now it all of a sudden seems to have lost its popularity. Well, the problem isn't getting any smaller. I can tell you that. The numbers in my office are increasing every day, and it is very difficult, and you have to have—you just can't put a prosecutor or a policeman to investigate these kinds of cases. There is the requirement of an interrelationship between the other various agencies that are necessary here, that requires cooperation on all parts and the Government.

The Federal Government, as Congressman Miller said today very accurately, cannot run away from this problem. The best way to deal with it is to set up programs, and we certainly can help you in that area because we are working in that area, but it is going to require funding. To say we are just going to leave it to the locals, it is a local problem, it is not just a local problem. It crisscrosses all throughout the United States.

Mr. DAVIDSON. If I could comment, as we indicated in our testimony, in 1980 it is estimated that about 13.7 percent of child abuse cases went into the court system. By 1984 that figure had risen to 30.2 percent, and there is reason to believe that that figure is still rising. The courts need help. Judges need help. Lawyers who represent child welfare and child protective service agencies need help.

The Children's Justice and Assistance Act, which uses not appropriated funds but money collected from criminals in Federal criminal cases, under the Children's Justice and Assistance Act the Government has already collected in the last fiscal year about $2.8 million that should be distributed to eligible States to help them on the road to implementing some of these reforms, and we don't see a lot of forward movement on that legislation. This year it is projected that $3.6 million will be available for distribution to the States.

The concept of giving the States some small amount of money and saying, "Target some attention to this area of reform of the way the legal and judicial process handles abused children," it is the legal and judicial process, Congressman, that gets the most criticism in the child protective community. It is what happens when cases go to court, that we hear the most criticism. We are all trying to do a lot about it but it is an issue that really needs Federal attention and Federal incentives to supplement the interest of the private sector and the local and State governments.

Mr. OWENS. Thank you very much. I thank all of the witnesses for their testimony. In the cases where we asked for additional information, the record will be open for 10 days for the additional information to be submitted, and we would appreciate your submission of it.

The next panel is the child abuse panel: Ms. Ann Cohn; Leslie Roberts has already testified; David Chadwick; Victoria Young; Rick Ventura; Tom Nerney; and James Bopp.

I understand, Mr. Bopp, you have a time problem, and we will let you testify first. Mr. Bopp.

STATEMENT OF JAMES BOPP, JR., PRESIDENT, NATIONAL LEGAL CENTER FOR THE MEDICALLY DEPENDENT AND DISABLED, INC.

Mr. BOPP. Thank you very much, Mr. Chairman.

Mr. OWENS. You know your written testimony will be entered into the record, and you are free to make some comments for 5 minutes.

Mr. BOPP. Thank you, Mr. Chairman, and if the record may be held open for the footnotes which were not available at the time the testimony was printed, I would appreciate that as well.

Mr. Chairman, I am testifying as president of the National Legal Center for the Medically Dependent and Disabled, located in Indianapolis, Indiana, which is a national support center for the Legal Services Corporation. We have a special interest in the "Baby Doe" provisions of the Child Abuse Prevention and Treatment Act, inasmuch as our responsibility as a national support center is to defend the rights to medical treatment of medically dependent and disabled persons.

I think you correctly read in your opening remarks, Mr. Chairman, from Dr. Vincent Fontana, who in his book, "Somewhere A Child Is Crying," in exposing the nature and extent of the child abuse problem, also correctly discussed the problem of what has become to be known as the "Baby Doe" situation which was existent at that time—widespread infanticide of particularly disabled newborns—which has continued to the present day.

The "Baby Doe" problem is best represented as the discriminatory denial of available beneficial medical care from an infant, due to nonmedical social and economic criteria. Said another way, it is the problem of denying medical treatment because of a quality of life standard where the value of the child's life is measured, rather than whether or not the available medical treatment can assist in ameliorating a problem that the child has.

We represent, along with the American Civil Liberties Union, Carlton and Sharon Johnson of Oklahoma City, Oklahoma. Carlton Johnson is a 4-year-old black child who was born with spina bifida and denied beneficial medical care at Oklahoma Children's Memorial Hospital. Sharon Johnson is a single parent on AFDC, and the hospital published an article in "Pediatrics" describing the quality of life criteria that they utilized to deny Carlton Johnson necessary surgery because of nonmedical social and economic criteria, or the application of the quality of life standard.

Children who are poor, who are disabled, who are racial minorities, are the most vulnerable when these criteria are used. It is our fear that despite the Child Abuse Amendments of 1984 and their clear rejection of the quality of life standard in this area, that this problem persists. We have cited in our testimony the extensive record of physicians and medical organizations who are continuing to advocate the use of quality of life criteria which make the poor and the racial minorities the most vulnerable.

We believe that the child abuse amendments as they existed in 1984, in terms of their standards, ought to be reauthorized; that they provide appropriate protection for the at-risk population. I do think we have a legitimate concern, though, about the implementation of this congressional standard within hospitals and the medical care setting.

The preliminary analysis of the Inspector General of HHS is really quite troubling in terms of the data which has so far been accumulated, and that data is, I submit, insufficient, and additional data needs to be accumulated. However, there are inferences that can be drawn from what has been done so far.

First, they report that 21 cases were reported to child protective service agencies within the 50 States, and that of those cases, 30 percent involved situations where the treatment decisions were changed due to child protective service intervention. That is 30 percent of the cases, which is a rather large number of cases in which there was not the application of the appropriate congressional standards for medical treatment for these children.

But, second, they also looked at 10 hospitals and found some 20 to 36 cases in which hospital ethics committees looked at "Baby Doe" cases, and found that only three of those cases were referred to child protective service agencies. What is troubling about this data are two things.

Number one is, the only thing that the Inspector General looked at was to determine whether or not these 20 to 36 cases were "resolved." "Resolved" meant that everybody agreed to whatever the decision was. What we do not know is whether or not that decision comported with congressional standards in terms of treatment and care for those infants. Secondly, if there were 20 to 36 cases in 10 hospitals and suspected cases of child abuse are required under the

act to be reported, we could have a very large under-reporting problem.

Therefore, my recommendation to this subcommittee is that they urge the Inspector General's office, in completing its final report on this matter, to go back to these hospitals, to examine in a confidential way the records, to summarize the circumstances of each of these cases and determine, number one, whether or not the appropriate congressional standards were complied with once these cases were "resolved" internally within the hospital; and, secondly, whether or not when these cases were determined to be suspected cases of child abuse, they were properly reported as the law requires.

There are people who advocate hospital ethics committees to be the mechanism by which this matter may be resolved. We have no data on whether or not these cases are being resolved within hospital ethics committees in conformation with the standards adopted by Congress. We urge that this committee help and urge the Inspector General's office to accumulate that data, so that we may determine whether or not the standards are being implemented.

Thank you, Mr. Chairman.

[The prepared statement of James Bopp, Jr., follows:]

STATEMENT BY:

JAMES BOPP, JR.
PRESIDENT
NATIONAL LEGAL CENTER
FOR THE MEDICALLY DEPENDENT
AND DISABLED, INC.

BEFORE

SUBCOMMITTEE ON SELECT EDUCATION
COMMMITTEE ON EDUCATION AND LABOR
U.S. HOUSE OF REPRESENTATIVES
APRIL 29, 1987

Chairman Owens and Members of the Subcommittee, I am pleased to testify in my capacity as President of the National Legal Center for the Medically Dependent and Disabled.

As the Program Director of a national support center for the Legal Services Corporation that concentrates on discriminatory denial of lifesaving medical treatment to indigent people with disabilities, I am naturally most concerned with the impact of reauthorization of the Child Abuse Prevention and Treatment Act on poor people.

I want to focus on that part of the Child Abuse Amendments of 1984 commonly known as the "Baby Doe" section. It addresses a problem of particular relevance to poor people, and especially to those who are members of racial minorities. Together with the American Civil Liberties Union's Children's Rights Project, our legal services program is currently representing Carlton Johnson, a black child to whom Oklahoma Children's Memorial Hospital doctors denied lifesaving surgery for his spina bifida.[1] We are also representing his mother, Sharon Johnson, who is an AFDC recipient.

There is every indication that the doctors at the Oklahoma state hospital left Carlton to die untreated precisely because of their prejudice and stereotypes about the child of a single black welfare mother. These doctors published a medical journal article in which they described how they had decided to let die 24 out of 69 babies with spina bifida they saw over a five year period.[2] The article said they used a formula, "QL=NE x (H+S)," in deciding whether to recommend that children live or die.[3] "In this formula, ... QL is quality of life, NE represents the patient's natural endowment, both physical and intellectual, H is the contribution from home

and family, and S is the contribution from society."[4] As Martin Gerry, former Director of the Department of Health and Human Services (HHS) Office for Civil Rights, has written, there is an "obvious potential of the highly selective 'contribution from home and society' criterion ... for introducing race, sex and socio-economic bias into the decisionmaking process...."[5] The doctors themselves admit that its use means that fo. two children with an identical degree of disability, the recommendation may be for one to live and the other to die "depending on the contribution from home and society."[6] A black welfare mother whose "contribution" was apparently judged unacceptably low, Sharon Johnson was manipulated into giving uninformed consent to the death of her child. To induce that consent to let her son die, she was told clear untruths about her son's condition--that he was blind, that even with surgery, he would die within a year, that, as she put it, "Everything was negative, no positive, no hopes, nothing. ... He was going to die. That was the bottom line."[7] In fact, due largely to the courageous intervention of a nurse at the Children's Shelter where he was sent to die, Carlton's plight was publicized by a national news documentary, and he was--very belatedly--given the surgery needed to survive. Today, as one journalist reported, he "careen[s] around ... in a small red wheelchair."[8]

The ACLU and our legal services program will be seeking class certification in this case to obtain justice and recompense on behalf of the many other indigent victims of the Oklahoma hospital's discriminatory practices.

Such discrimination against those with disabilities who are the children of poor people is hardly restricted to Oklahoma. In a recent American Medical Association Journal article whose analysis logically applies to

children with disabilities, H. Tristum Engelhardt, Jr., and Michael Rice argue that, while anyone who is rich enough to afford comprehensive access to intensive care should be allowed it, those who are poor should face rationing under which they are denied treatment if their "quality of life" is judged to be too low. "[L]osing at the natural and social lottery does not per se vest any individual with a claim on innocent others for care," they write. "[I]f the goods sought [--the intensive care units in hospital--] are privately owned, then the fact that individuals in need do not find resources for treatment may be an unfortunate circumstance, not an unfair circumstance."[9]

A survey by Adams confirms that whether physicians refer children with disabilities for treatment is influenced by their parents' socioeconomic status.[10] Pediatrician John Britton of the University of Arizona Health Services insists that "economic implications for the family and society must be weighed in the decision-making process" concerning provision or denial of treatment to children with disabilities.[11] In the context of advocating that treatment be provided only to those with an adequate quality of life, the Chairman of the Ethics Committee of the American Pediatric Surgical Association, Dr. Anthony Shaw, has given as the example of one with a poor quality of life "a child born normally formed but ... in an urban ghetto to an unwed teenage drug addict." According to Shaw, even with a "respectable quantity" of natural endowments, such a child's quality of life would be low because nothing would be contributed to the child's welfare by his or her home.[12] Dr. Joel Frader, a pediatrician at Pittsburgh Children's Hospital, has written, "Why shouldn't non-medical considerations, like family and community resources ... become important to the decisions? Good reasons for permitting death may exist."[13]

Those we represent and whose lives we defend frequently have three strikes against them: The health care system discriminates against them because of their disability, the health care system discriminates against them because of their poverty, and--because racial minorities are disproportionately represented among poor people--the health care system discriminates against them because they are black or Hispanic.

Given this context of prejudice and discrimination--discrimination that results in death--the Child Abuse Amendments of 1984 must be evaluated by asking how good are the tools they create to attack the discrimination, and their implementation must be judged by measuring how well and how frequently these tools are being used.

The standard of care embodied in the legislation is a largely sound and protective one. It establishes that "disabled infants with life-threatening conditions" must always receive "appropriate nutrition, hydration and medication."[14] With three exceptions, they must also receive "treatment ... which, in the treating physician's (or physicians') reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions."[15] Following the expressed intent of the Congressional sponsors, Health and Human Services regulations define a "reasonable medical judgment" as one "that would be made by a reasonably prudent physician knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved."[16]

The three exceptions--circumstances in which the most effective treatment may legally be omitted, although food, fluids, and medication must still be given--apply when the child is "chronically and irreversibly comatose," when treatment would be futile in doing more than prolonging dying, and when "provision of such treatment would be virtually futile in

terms of the survival of the infant and the treatment itself under such circumstances would be inhumane."[17]

These standards are obviously incompatible with discrimination based on socioeconomic status, and they go far in barring discrimination based on degree of disability. In its "Interpretative Guidelines" concerning the statute and its implementing regulations, the Department of Health and Human Services appropriately emphasized that "consideration of the infant's future 'quality of life' ... would be inconsistent with the statute."[18]

Because they set forth relatively clear and workable policies that carefully cabin the discretion of physicians and others who may wish selectively to deny lifesaving health care to the disabled children of poor people and members of racial minorities, these provisions are essentially sound from a civil rights point of view. Therefore, we are pleased with the standard of care set forth in the Child Abuse Amendments of 1984, and we believe these standards should be reauthorized without change.

There is cause for concern, however, in an effort to distort these standards, reinterpreting them in a manner that is significantly less protective.

There have been suggestions in publications and by the medical defendants in a Minnesota "Baby Doe" case that the plain meaning of the language of the first exception, "chronically and irreversibly comatose," should be be ignored and that this exception should be interpreted to exclude from protection those in a "persistent vegetative state."

Those who seek to reinterpret the statute maintain that the real meaning of the exception is to exclude those who are permanently unconscious, and that this includes those who are not comatose but in a persistent vegetative state.[19] But, as Martin Gerry, one of the principal negotiators of the

compromise that became the Child Abuse Amendments, writes in the current number of Issues in Law and Medicine,

> [I]n the negotiations leading up to the consensus language formed in the Child Abuse Amendments, the term unconscious was explicitly rejected. ... The term "coma" was, in fact, adopted because it was substantially more restrictive and was applicable to few children. Thus, the consensus language was plainly intended to have narrow application, not the expansive application suggested by some.[20]

In the Minnesota case of In re Steinhaus, Judge George Harrelson properly rejected the medical defendants' contrary position. The court held, "It's clear that the statute that's applicable does make an exception to a chronic and irreversible coma. It does not make an exception to a persistent vegetative state so that the court would have to find that the child is in a chronic and irreversibel coma in order for heroic measures beyond food, water and appropriate medications [to be withheld]."[21]

The record should be unmistakeable that this statute means what it says, and that this effort at reinterpretaton is an abuse inconsistent with the spirit and letter of the law.

Beyond the adequacy of the standards of care and the appropriateness of their interpretation, legal advocates for health care rights of poor people are of course concerned with the adequacy and effectiveness of their implementation and enforcement.

Unfortunately, there is presently insufficent data to make a comprehensive judgment about this. We are eager to work both with this Subcommittee and with other appropriate sectors in conducting the sort of surveys and other inquiries that are necessary to evaluate properly the effectiveness with which the "Baby Doe" provisions of the Child Abuse Amendments of 1984 are being implemented.

What information we do now have suggests two conclusions.

The first is that when Baby Doe incidents are reported and the Amendments are faithfully applied, they appear to be doing their intended job.

In the one case in which, to my knowledge, a Baby Doe case has reached the courts since the effective date of the Amendments, the judge carefully analyzed the statute and regulations and meticulously applied them to the facts of the case before him. This is the Steinhaus case, which I mentioned a moment ago. The judge ordered that antibiotics that were being denied the child be provided and, until the evidence was clear that he was in fact chronically and irreversibly comatose, required that resuscitation and other lifesaving treatment be made available.[22]

On April 20, 1987, the HHS Inspector General submitted a preliminary report on a "Baby Doe National Inspection."[23] It found that, of the 21 Baby Doe reports since the effective date of the Amendments, Child Protective Service "intervention is credited with changing treatment decisions in approximately six cases."[24] This means that in nearly 30% of reported cases, the existence of the Child Abuse Amendments prevented or reversed discriminatory denial of lifesaving health care, presumably saving the lives of children who otherwise would have died.

The second conclusion that may be drawn from the indirect evidence that we presently have, however, is more disturbing. It suggests that instances in which the requirements of the Child Abuse Amendments are being flouted or simply ignored may be widespread.

Initially, it should be understood that, although the Child Abuse Amendments of 1984 are an important and progressive contribution to the civil rights of children with disabilities, especially the children of poor

people and those who belong to racial minorities, they nevertheless suffer from three inherent limitations.

First, the Amendments are not necessarily binding on the states. They apply only to those states that choose to accept funding from a comparatively minor federal program of grants under the Child Abuse Prevention and Treatment Act. Three states, California--which has the largest population in the United States--Indiana, and Pennsylvania, do not receive funding under this Act. Thus, poor children in those states receive no protection from the Amendments.

Second, the Amendments commit the principal responsibility for enforcement to child abuse and neglect agencies in each state. There are indications that, as a general rule, workers in these agencies are not those most sympathetic to or equipped for enforcement of the Amendments. They often face a conflict of interest, since their primary sources for reports of traditional child abuse cases--the beating or neglect of nondisabled, typically older children--are physicians. Yet physicians are commonly the subjects of investigation in Baby Doe cases. State child neglect and abuse workers do not usually have experience working with children who have disabilities, and they may well share in the often pervasive devaluation of persons with diabilities all too common in the general population. Indeed, when the Child Abuse Amendments were first proposed, their national organization, the National Council of State Public Welfare Administrators of the American Public Welfare Association, opposed them, describing "denial of health care for handicapped infants" as "most often the result of difficult medical/ethical judgments ..., and not instances of willful abuse or neglect ...."[25] Furthermore, the public records of state child abuse and neglect agencies in well-publicized "Baby Doe" cases in Indiana, Illinois, New York

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and Oklahoma has been far from exemplary: In these cases, they supported denial of treatment, acted only under extreme federal pressure, or failed to act at all.[26] All of these factors combine to create reservations in one's confidence about the vigor with which these state agencies enforce the Child Abuse Amendments.

Third, standing alone, the Amendments lack the strong federal role and encouragement of private action that experience has proven vital in other areas of civil rights law. All the precedents in the fields of racial and sex discrimination demonstrate that reliance on state and local authorities alone--people often beholden to powerful local institutions (such as major hospitals) and likely to share the common mindset in areas where discrimination is pervasive--is inadequate to root out well-entrenched and longstanding discriminatory practices.

There is, I said, indirect evidence that suggests that implementation of the Child Abuse Amendments has in fact been less than universal. Some of this comes from the HHS Inspector General's Preliminary Report. It describes the results of visits to 10 hospitals in 8 major cities, all of which have "committees in place to review and advise on the handling of neonatal cases, including treatment of severely disabled infants."[27] These committees, the Inspector General reported, "estimated that they had reviewed between 20 and 36 potential Baby Doe cases since the Baby Doe Regulations went into effect. Only 3 cases were reported to CPS units because they could not be resolved by the committee."[28] The term "potential Baby Doe cases" is not defined. However, it is a reasonable inference that these were cases in which it was at least suspected that medically indicated treatment was being or would be withheld from disabled infants with life-threatening conditions. If so, then it is disturbing that only 3 of

those cases were reported, and those only when the committees could not "resolve" them.

The Amendments and their implementing regulations require "prompt notification by individuals designated by and within appropriate health care facilities" not just of instance when an internal review mechanism such as a hospital committee has determined that withholding in violation of the standards has occurred, but whenever such withholding is "suspected."[29] Still less is it justifiable to hold back on reporting until a committee has decided whether it can "resolve" the situation internally.

Apart from the apparent failure to abide by the reporting requirements that is so far documented by the Inspector General's Preliminary Report, it would be desirable to learn precisely how the committees "resolved" the 17 to 23 cases that they did not report. Was the treatment provided to each of these children in fact in strict accordance with the standards of care specified by the Child Abuse Amendments?

The Inspector General's Report suggests further grounds for concern. As it notes, "The volume of cases reported to CPS units remains small"--21 in the entire nation since October 1985 when the Amendments went into effect.[30] We have seen that the number of "potential Baby Doe cases" reviewed by committees in 10 hospitals alone was 20 to 36. Yet the likelihood seems large that these are a distinct subset of cases of withholding of treatment even in those hospitals. As the Inspector General explains,

> Specific criteria for reviewing cases vary from hospital to hospital. Most committees review cases involving disagreement between the treating physician and parents regarding appropriate treatment. All committees serve as a consultant when the treating physician is uncertain as to the appropriateness of treatment. Only one committee requires mandatory review of any case where withdrawal of life-support is being proposed.[31]

In general, therefore, a "potential Baby Doe case" does not get reported

to a hospital review committee--let alone a state agency--unless there is a dispute among health care personnel and parents, or unless a physician is sufficiently self-questioning to seek review committee involvement. When those concerned are in agreement to withhold treatment in a manner that may violate the standards of the Act, there is no indication that there is any review or check on the process at all.

While, again, there is insufficient information at present to say for sure, these data suggest that there may be significant underreporting and underenforcement. This suspicion is reinforced by the profusion of medical, legal, and ethical publications since the adoption of the Child Abuse Amendments that strongly advocate denial of treatment required by the Amendments. Indeed, one article openly calls for what amounts to a conspiracy between hospital review committees and local child protection agencies to ensure that there is no interference when such committees "ocasionally condone nontreatment in circumstances not contemplated" by the Act and its implementing regulations. The authors even suggest that the committees "educate" local child protection agency personnel so that they "come to appreciate all of the morally relevant factors involved and will, accordingly, defer to the decisions made by parents, doctors and committees, except in cases where the child's best interests are clearly being threatened." This approach, they say, "if put into practice, would easily compensate for the shortcomings" they find in the treatment mandates contained in the Child Abuse Amendments.[32]

H. Rutherford Turnbull, II, President of the American Association on Mental Deficiency and himself the parent of a child with a disability for whom physicians once recommended denial of treatment, recently surveyed the medical literature and found that "the recent commentary on the issue is

overwhelmingly in favor of denying treatment to those deemed to lack a sufficient 'quality of life.'"[33] The results of his survey, embodied in testimony before the U.S. Civil Rights Commission, are appended to this testimony. I shall quote only two of the many physicians' opinions he excerpts.

In an article published after the passage of the Child Abuse Amendments, widely reprinted in medical newspapers and in USA Today, Dr. George Crile, former head of the Department of General Surgery of the Cleveland Clinic, denounced the Amendents for forcing society to support what he called "the growing numbers of hopelessly disabled, often unconscious people whose costly existence is consuming so much of the gross national product." "No child with Down's Syndrome ever grew up to be self-sustaining," he proclaimed. "If the parents still want to rear their child, that should be their decision, but there should be no support from the community or the state."[34]

In less vivid language, a New England Journal of Medicine editorial in Spring of 1986 protesting requirements for treating children with disabilities stated, "Quality of life is an important consideration as the weight of our ethical, medical and legal traditions suggests."[35]

It would be comforting to think that the passage of the Amendments itself played so great an educational and deterrent role that the only "Baby Doe" cases that required state agency intervention to enforce the standards of care they mandate were those six cases reported by the HHS Inspector General. However, given the very widespread and often deeply felt opposition to the principles embodied in the Amendments, particularly among members of the medical community, it seems far more likely that those cases represent only the tip of the iceberg. The handing down of Brown v. Board

of Education and the passage of the Civil Rights Act of 1984 did not immediately abolish racial prejudice or result in the sudden cessation of discriminatory practices. They required--and, indeed, still require--vigorous and unfailing enforcement on a federal as well as a state level. There is no reason to suppose that any less effort will be required to enforce the rights of children with disabilities, especially those who are poor and/or members of racial minorities, to equal treatment.

In sum, then, I want to emphasize the importance of the Baby Doe provisions of the Child Abuse Amendments to the civil rights of poor people with disabilities. The standard of care in those provisions is protective and powerful, and I call for no change in it. The record should be clear, however, that weakening interpretations are inconsistent with the statute and unacceptable. We currently have insufficient information fully to judge the effectiveness of implementation of the Amendments. Where they are being applied faithfully, they appear to be effective, but there are significant grounds for concern that they are not being consistently and vigorously enforced. Our center is eager and willing to cooperate in appropriate efforts to evaluate more fully the degree to which the Amendments are being enforced.

Thank you very much.

Mr. OWENS. Thank you very much. You have stated your case quite forcefully, with quite a bit of documentation.

Mr. BOPP. Thank you.

Mr. OWENS. Ms. Anne Cohn?

STATEMENT OF ANN COHN, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR THE PREVENTION OF CHILD ABUSE

Ms. COHN. Congressman Owens, the Federal child abuse program is not a big one, averaging $24 to $25 million a year, but its accomplishments in the last 13 years have been quite substantial. In contrast to 1974, today we have a good sense of the size of the problem, we know a lot about the underlying causes, we are beginning to understand how to treat the problem and certainly how to prevent it, and there are literally thousands of professionals from a wide variety of disciplines now working in the field, but we haven't accomplished enough.

Our knowledge still remains inadequate, particularly with respect to the long-term consequences of treatment and prevention. There are no standards or generally accepted principles of practice in the field. There is no standardized method of data collection, particularly with respect to child abuse deaths. The Children's Protective Service System is literally on the verge of collapse, but to me most important when you look in relation to 13 years ago, it is not clear to me that we have seen any reduction in the size of the child abuse problem. In fact, there appears to be an increase in the number of child abuse deaths.

Given this, I believe that as we continue the Federal child abuse program, which I hope we will do, we need to expand our emphasis on prevention as opposed to treatment or after-the-fact intervention. There are several reasons why I think we ought to do this. The first is a humane one. It shouldn't hurt to be a child, and when we wait until abuse has occurred, we are letting children be hurt. But, second, there are very significant economic reasons which two Congressmen this morning already alluded to.

We know that abused children suffer a wide variety of different kinds of emotional and developmental problems, and those problems may well lead to them having difficulties with the law as juveniles, running away from home, problems with alcohol and drugs, even attempting, and sometimes successfully, to take their own lives; and then later on in life when they become parents themselves, getting involved not only in abuse of their children but possibly abuse of their spouses.

I believe the only way we will see a reduction in the amount of child abuse is to focus on prevention. We have learned a lot about prevention in the last 13 years. We have learned a little bit about some of the kinds of interventions, but there is still a tremendous amount we need to know.

We need to know about the relative effectiveness of different kinds of prevention strategies. We need to understand better what kinds of prevention strategies we ought to be putting into place for different kinds and types of child abuse. And, most significantly, we need some long-term studies that allow us to follow up people who have been in prevention programs for 5 years or longer, to

really measure whether or not these programs are making a difference.

To do this, we need more money. To do this, we need the Federal challenge grant program for the Children's Trust Funds to continue, so that those Children's Trust Funds can grow stronger and can grow larger, and we also need a substantially larger proportion of the NCCAN dollars to go directly into the funding of prevention research and demonstration programs.

In addition to more money, which I think is quite important, we also need more leadership. We need more leadership from the National Center on Child Abuse and Neglect. There are a number of specific areas where I think this leadership can be tended to, and I have outlined them in my testimony. There are three that I would like to mention right now.

First, I think that the National Center on Child Abuse and Neglect now needs to begin to do some long-range planning. We know a tremendous amount more about this problem today than we did 13 years ago, and it is time to stop funding programs from one year to the next, sprinkling money in various areas of interest, but to do so with a focus and to do so with a purpose and to do so with a direction, so we can move toward a day when we will actually see a reduction in the amount of child abuse.

Second, I believe as the National Center sets about a course of long-range planning, I believe that they need now to seek more input from the field. Child abuse is a very complex problem. There are many different professionals, many different agencies involved. I think the National Center needs not only to rely on its Federal Advisory Board, which sadly at the moment only meets twice a year, but needs to look out at the other agencies and other programs in the field and to seek their input early on, before priorities have been established, before this long-range plan has been put into place.

Then, finally, I think that the National Center needs greater visibility within the Government. To accomplish any plan to reduce child abuse, there is need for some power, some clout, some influence. NCCAN is buried, as you might well know, well into the bureaucracy. It needs to be elevated. It needs a full-time director. It needs a well-qualified staff. It needs a chance to make a difference.

In closing, let me just say that the National Child Abuse Coalition, made up of 25 different national organizations, has outlined four specific recommendations for the continuation of the Federal Child Abuse Act. One is to extend the act for at least 4 or possibly 5 years and, second, to make sure that the authorization level is increased to $50 million.

Thank you.

[The prepared statement of Anne H. Cohn follows:]

Presented Before The
House Subcommittee on Select Education
April 29, 1987

By Anne H. Cohn, D.P.H.
National Committee for Prevention of Child Abuse

I am pleased to present testimony which I hope will lead to the reauthorization of the Child Abuse Prevention and Treatment Act of 1974 and to the strengthening of the National Center on Child Abuse and Neglect (NCCAN). When the Act was first passed in 1974, little was known about the child abuse problem. In fact, at Congressional hearings leading to the enactment of the Child Abuse Act, the late Dr. C. Henry Kempe testified that there could be as many as 60,000 cases of child abuse. We now know the number of cases annually -- even at that time -- to be closer to one million. At that time an estimated 1 out of 10 adults had heard of the child abuse and neglect problem. Today, essentially all adults have heard of the problem; most are concerned and want to do something about it. In the short 13 years since the federal government shone a spotlight on the child abuse problem much has happened:

- a cadre of thousands of professionals from law enforcement, social work, medicine, public health, psychology and other fields have become actively involved
- state children's protective service agencies have developed systems for identification, diagnosis and treatment of cases.
- we have a better idea of the size of the problem

- we know a lot about the underlying causes of the different types of maltreatment
- we have a developing knowledge base about treatment
- we have a sense of promising prevention programs
- prevention activities have exploded -- support programs for new parents, prevention education for elementary school children and the like can be found in every community
- 40 states now have Children's Trust Funds, spurred on by the national matching grant program
- the public have become aware of the problem and the private sector has become involved
- child abuse is recognized as a top social problem: 66% of the public say they as individuals can do things to prevent it; 23% say they did something in the last year.

Much of this progress can be attributed directly to the existence of a federal child abuse program. However, despite all this progress, we face a number of significant problems:

- the Child Protection Service (CPS) system in many locations is in a state of what I would call collapse -- significant numbers of cases diagnosed as child abuse, for example, are opened up for treatment and never receive any and serious reabuse occurs
- there are no standards or generally accepted principles of practice; as a result investigative, diagnostic and treatment practices across the country are quite inconsistent

- we still know very little about the long term effects of treatment and prevention strategies
- the child abuse field remains relatively isolated from other social problem areas -- such as family violence -- with which there are clear connections
- and most important, there does not appear to be any reduction in the amount of child abuse and indeed, the number of deaths due to child abuse appear to be increasing. (See Appendix)

Today I would like to address these concerns and why I think the reauthorization of the federal Child Abuse and Neglect Treatment Act is vital, and how I think the federal program can be strengthened so that, in turn, our efforts in the field can be more effective.

Child abuse is an extremely complex problem. Not only are the causes and consequences many, but so too are the types of agencies and professionals involved -- law enforcement, medicine, psychiatry and psychology, social work, public health and the list goes on. For well over a decade now a growing movement nationwide has addressed the issue. And, a growing consensus appears to be:

1) Child abuse is a problem which is not going away: We have no reason to believe that the child abuse problem has gotten any smaller during the last decade, even though one study suggests that violence toward children in certain segments of the population (namely two-parent households) has diminished. Reports of child abuse continue to rise -- at a national average rate of

6% last year. And sadly, deaths due to child abuse and neglect seem to have increased 23% nationwide last year. It would appear that one million children are seriously abused and/or neglected each year and that at least 1,200 die as a result.

2) Our efforts must increasingly be on prevention: Prevention is worthy of our primary focus for several reasons. First, it is humane. It does not make sense to wait until a child is hurt to do something. Second, it is cost-effective. When we do wait until abuse has occurred and then intervene our success rates are low (less than 50%); the abuse continues as nationally we spend over $2 billion. Dollars are saved by intervening early so that children do not suffer severe emotional and developmental difficulties which can -- and often do -- lead to teenage runaways, school problems, juvenile delinquency, drug and alcohol abuse, teenage prostitution and tragically, abusive behavior as a parent. The costs of these social problems are enormous and they could be avoided.

Recent analyses of the CPS system suggest that prevention is crucial to cut down on the number of cases coming into the system so that those cases which are reported can receive quality diagnoses and treatment. Recent analyses of deaths due to child abuse suggest that prevention efforts beginning in the community are crucial to curbing the numbers.

3) We have much to learn about how to effectively prevent abuse: As we study the prevention literature and look for research that will survive close scientific scrutiny, we find few

studies which prove we can prevent child abuse (such as that by Dr. David Olds). There is a lot we know about the underlying causes of child abuse that points toward promising preventive strategies. Indeed, there are literally hundreds of different types of child abuse preventive programs now in place in communities across the country. We need well designed, long-term evaluative studies of the various approaches to improve our knowledge base so that our preventive efforts can be focused on those strategies which are most effective.

4) We have to focus our prevention efforts more: Most prevention approaches to date, with the exception of sexual abuse prevention education for children, have been relatively generic, e.g., have focused on the "child maltreatment problem" without specific attention to one type of abuse or another. Given the differences in the underlying causes of different types of abuse and neglect, prevention strategies should also differ. For example, given that physical abusers so often lack parenting skills and know very little about child development, prevention should include parenting education and support programs for new parents. With emotional or verbal abuse, parents seem to need to be made aware of the impact of their words, whereas with neglect, parents too often need changes in their environment -- better housing, jobs, more stable income. There is a need to test and measure different prevention strategies for different types of abuse.

5) We need more and longer term research on prevention: The only way to expand our knowledge about prevention is to commit more funds to prevention research. And, that research must be of such length (5 years) to allow for sufficient follow up on program interventions to determine what their impacts truly are. With the exception of the Olds study, prevention research has typically been 1-3 years in length.

6) We need more funding for prevention: A total of 41 states have created Children's Trust Funds. Another two have state-level prevention funding mechanisms. These are currently the only institutionalized funding sources for prevention and few of them are stable or significant in size. Last year, total funding nationwide from the mechanisms amounted to approximately $25 million. Slightly over $4 million was available through the federal challenge grant program and an additional slight amount through NCCAN grants. In contrast to the $2 billion plus spent on treatment, it is clear what a meager commitment we have made to prevention. The public now seems to understand the importance of prevention. Most who work in the field acknowledge that the way to stop the problem is by focusing on prevention. It is time that the dollars followed suit; and most important dollars from that authorized for spending by NCCAN. In fact, perhaps the majority of NCCAN funds in the next 4-5 years should be used for prevention activities to assure significant breakthroughs in this area.

7) We need more leadership from the federal government: NCCAN is the only opportunity the federal government has to

address the issue of child abuse directly. Happily, the legislation creating NCCAN is currently crafted in such a way to allow NCCAN the flexibility to address the range of issues of high importance which arise in this field from year to year. Given the importance of the issue of child abuse and the relatively small amount of funds NCCAN has at its disposal, NCCAN must operate as effectively as possible, building on and working with other resources which exist in the field.

It seems to me that, given the complexity of the problem and the variety of professions, agencies and interests involved, NCCAN should play a leadership role, it should be a catalyst, a beacon for action in this field. It is not that NCCAN should be making decisions for the field or even necessarily espousing specific positions on issues. Rather, NCCAN as a leader should facilitate decision making and discussion of issues and should help set directions for the field. And NCCAN should be an active partner with the field in a variety of critical activities. As examples of how NCCAN could serve as a leader over the next five years, the federal program would be strengthened if there were:

a) More use of research findings: Since 1974, NCCAN has funded several hundred demonstration treatment programs and research programs which have resulted in useful information. For example, over 80 of them have been subject to extensive evaluative research. The findings across studies are consistent and useful. This is just one example of research findings gathered by NCCAN. And, as with most research findings, they haven't been used as

extensively as they might be. The findings from these studies are logical leads for subsequent studies in the field. And states and local treatment facilities would benefit from knowing the conclusions of this work which NCCAN spent over $40 million on. They also offer unique methodologies which can be improved upon and used elsewhere. If NCCAN made the findings from these and other research and evaluation projects funded by NCCAN readily and regularly available to the field, we would make more progress.

b) More publicity of NCCAN's Clearinghouse: NCCAN has put literally millions of dollars into the development and maintenance of a clearinghouse on child abuse and neglect. The Clearinghouse features a computerized data base on key literature in the field and other important information. The only problem is few professionals working in the field know of the existence or capacity of the Clearinghouse because there has been little publicity about it. If professionals in the field do not know about the Clearinghouse, not only do they fail to use it, but they also do not let it know about their own work, which makes the Clearinghouse incomplete. Efforts should be made to publicize the Clearinghouse capability.

c) More collaboration with other social problem fields: Family violence, drug abuse, alcoholism, juvenile delinquency all have strong connections with child abuse. In fact, one often cannot address the child abuse problem without addressing some of these other issues. While NCCAN has, over the past 13 years, been involved in a variety of cooperative projects with groups such as

the National Institutes of Mental Health, more can be done. NCCAN's cooperative ventures could serve as a model for state and local efforts to do the same. Certainly in areas such as family violence, where the overlap of client families is substa..tial, much collaborative work needs to be done.

d) More attention to the development of standards in the field: Currently several different national organizations are setting about to develop standards of practice for their particular constituency in the field. Even the U.S. Surgeon General is working on the development of protocols for the field. The field has much to gain if these efforts were coordinated. If NCCAN helped to do so, the field would benefit greatly.

e) More attention to the collapse of CPS: As reports of child abuse have climbed during the last decade, funding for Children's Protective Services has not increased at the same rate. Consequently, CPS systems, particularly those in urban areas, appear overburdened, overwhelmed and essentially on the verge of collapse. Many states have established task forces to respond to this problem. Some national organizations, such as the American Public Welfare Association, has gotten involved as well. If NCCAN helped to lead these efforts, minimally facilitating communication among the various groups struggling with this problem, NCCAN would be seen as a resource the states can draw on and progress would be hastened.

f) More gathering of national data including full funding of the only national data base: For a decade now, NCCAN has funded a

national reporting data study which gathers information on child abuse reports from all 50 states. This is the only national data base in the field. Although not a perfect data base, it does provide important trend information on the types of child abuse cases being handled nationwide. In the past year, NCCAN cut the funding of this national data gathering effort substantially. The result? The study may now only analyze data in depth from a maximum of five states. Such analyses have little utility. If anything, this is a study which should receive more funding so that it can work on perfecting its weaknesses and it could, for example, gather data nationally on child abuse-related deaths. The federal government in other areas has long played a role in measuring society's economic, social and health well being. So too must it be the case with child abuse. A million dollar incidence study funded by NCCAN every 5-10 years is important, too. But, it must not take the place of this trends data particularly since this trends data provides crucial insight into what is happening with CPS across the country. The solution, clearly, is to reinstate full funding for this study and put energy behind making this study as useful as possible.

g) More support of staff: The people who work within NCCAN have not been allowed to become professionals in the field. They are not allowed to travel, to go to conferences, to educate themselves about what's going on. This is a fast moving, rapidly changing field. Its hard to be isolated or removed from the field and provide any guidance or leadership to the field. A priority

for NCCAN should be for its staff to be fully up-to-date on developments in the field, to be, in fact, experts to whom the field would turn.

Addressing these areas of concern should result in a National Center which well serves the field. But more could be done to enhance NCCAN's leadership role, including:

- Improve the visibility of NCCAN not only within the federal government but nationally as well: NCCAN not only needs its own full time director, it needs a clear and distinct position within the federal government so it is not overshadowed by or melded in with other equally important programs.
- Expand opportunities for the field to advise NCCAN on the directions it should take and to work in partnership with NCCAN: NCCAN needs an active partnership with its Advisory Committee as well as with liaisons from the states and the many other organizations working in the field -- such as the members of the National Child Abuse Coalition --to assure that as new issues emerge in the field, NCCAN can and does address them.
- Do some long range planning to set an agenda for itself and in turn for the field: NCCAN's programs and priorities from year to year should be related to a long range plan. Rather than develop annual research and program priorities in a vacuum, they could be related to longer term concerns.

Research activities, drawn from such a plan, could lead to demonstration programs -- so we can try out the ideas we learn from research. The public's opportunity to comment on annual priorities is very important. As NCCAN does long range planning, the field should be able to comment n these plans as well.

The problem of child maltreatment will not be solved by laws alone. State governmental programs will not be enough to reduce the numbers of children who are abused and neglected. Private agencies at the local, state and national level have important roles to play. So, too, does the federal government. Through the vehicle of the National Center on Child Abuse and Neglect, it makes good sense to work toward a federal program which is as effective as possible.

Reauthorization Issues

Beyond these opportunities for strengthening NCCAN's leadership position, there are some issues basic to the legislation itself which we hope will be addressed during the reauthorization process. The following basic positions have been adopted by the National Child Abuse Coalition, an informal coalition of 25 major national organizations concerned with child abuse. Those positions include:

(1) Extend P.L. 93-247 for an additional five years. (This program has proven its importance; the child abuse problem will not diminish in the near term. With longer term

certainty, the program could do separately needed long range planning.)

(2) Increase authorized funding to $50 million for FY 88. (Authorization for FY 87 is at $43.1 and appropriations are at $25.898 million.) Not only should the authorization be increased to reflect the importance of this problem, but the appropriations must be at the full authorization levels.

(3) Amend the grant years limit from three years to five years to promote long-term research. (We remain handicapped by our lack of knowledge about the long term effects of both treatment and prevention programs. Longer term research is essential.)

(4) Do not expand the responsibilities of NCCAN more than the definitions of child abuse currently in the law. (NCCAN's responsibilities are already extensive. Successes with the charges NCCAN has will only be possible if NCCAN can remain focused.)

In sum the National Center on Child Abuse and Neglect should be a leader for the field, providing guidance and coordination on issues which emerge in the field while pursuing a thoughtful plan of research and demonstration. The issue of child abuse is too important for the federal government to do anything but give this program prominence and priority. In reauthorizing the Child Abuse Prevention and Treatment Act I hope it will be possible to identify ways to strengthen this essential program.

Thank you.

APPENDIX

Increase in Child Abuse Deaths

Since 1982, the National Committee for Prevention of Child Abuse (NCPCA) has conducted a semi-annual fifty state survey in order to monitor trends in the number and characteristics of child abuse reports nationwide and in the funding and scope of child welfare services. Twice a year, the federal government's liaison officer for child abuse and neglect in each state is contacted by telephone and asked a series of questions with respect to child abuse reports as well as other issues of concern to the field. In our most recent round of telephone calls to the states, we gathered, among other things, information on reports of child abuse-related deaths during 1986.

By March, 1987, 34 states were able to provide actual comparable figures for 1985 and 1986 with respect to reports of child abuse-related deaths. Overall, for these 34 states, 727 children were reported dead as a result of child abuse; this represents a 23% increase between 1985 and 1986. (A report released by NCPCA earlier this year cited an increase of 29% based on 24 states.) We now project at least 1,200 children died last year as a result of maltreatment. The actual number could exceed this projection, given that (a) a number of states only count those deaths which occur in cases being handled by the Child Protective Service agency and, (b) a number of child abuse-

related deaths are not reported as such but are labeled as sudden infant death syndrome (SIDS) or some other category.

Approximately half of the fatalities involved physical abuse. In some instances, death was the cumulative result of repeated, severe beatings while in other cases death resulted from a single violent episode. The other half of the victims died as a result of child neglect, most often because parents failed to provide adequate supervision. While we do not have detailed data on those children who died in 1986, studies suggest at most 75% of the victims of child abuse deaths are one year or younger, and they are more likely children of younger caretakers.

Although only an estimate, we felt that the magnitude of this increase was striking enough to warrant serious attention. Of course, of initial concern was whether this increase may reflect a more accurate reporting system. While the increase is consistent with current trends in infant mortality rates and levels of serious family violence and violent crimes, we felt it would be important to know what the states felt the cause of the increase was -- better record keeping or other social or systems problems. To this end, on March 19, 1987 we held a meeting in Washington, D.C. to discuss the reported increase in the number of child abuse fatalities. Representatives from all fifty states were invited to attend.[1] According to the individuals present at the meeting,

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1. States and organizations sending representatives included: California, Connecticut, Delaware, Georgia, Illinois, Maryland, Massachusetts, Minnesota, Missouri, Montana, New Jersey, Pennsylvania, South Carolina, Texas, Utah, West Virginia, American Humane Association, Child Welfare League of America, National

(and the states with the most significant increases were present) the increase cannot be attributed solely to more accurate identification systems. Most of the states reported that their statutes pertaining to the identification of fatalities have been in place for a number of years. And the numbers remain under counts of child abuse deaths in part because some unknown number of child abuse deaths get labeled as SIDS cases. Therefore, with a few notable exceptions, these numbers regrettably reflect an actual increase in the number of children dying as a result of maltreatment.

With a consensus on the reality of this statistic, the group identified some of the underlying causes contributing to the increase in child fatalities. Three major themes were evident among the reasons for the increase: (1) growing social problems, (2) problems within the current child protective service structure, and (3) the lack of a coordinated effort among the other systems dealing with children.

Several of the state representatives, particularly those from the nation's largest urban areas, indicated that growing drug problems, higher rates of teenage pregnancy, and poverty in general appear to have contributed to an increase in child deaths due to maltreatment. States reported seeing a higher number of very severe cases, particularly among families involved in child

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Association of Public Child Welfare Administrators (APWA), National Association of Social Workers, Parents Anonymous, National Child Abuse Coalition and National Committee for Prevention of Child Abuse.

neglect. While not all states identified teenage parents as being more likely than older parents to harm their children, the limited resources in single parent, female headed households appear to contribute to a higher risk that the child may experience serious harm. Also, households which have a number of adults moving in and out present more volatile and potentially dangerous situations for children.

Outside of these social issues, the shortcomings within the child protective service agencies may also contribute to an increase in certain deaths.[2] Participants cited an inadequate level of available resources, resulting in the number of child protection workers being too small to handle the volume of reported cases. Overburdened with heavy caseloads, the workers devote so much time to the initial investigations that they are unable to adequately follow-up and monitor families once they are on the caseload. When families are identified and labeled as abusive and do not receive direct services, the children become even more vulnerable. Because of the unusually high turnover rate among child protective service workers, caseworkers are responding to reports without having been given sufficient training in crisis intervention. Neither schools of social work nor CPS agencies have taken the initiative to provide the workers with the skills necessary to be effective child protective service workers. It is also important to point out that some number of the child abuse

2. It is important to note that between 25% to 50% of child abuse deaths involve children reported to local children's protective service agencies prior to their death.

information they need and all the service support their caseloads require. The failure to interpret child protection as a community problem and a shared responsibility was another problem discussed at the meeting. The lack of a coordinated effort among law enforcement, juvenile court judges, medical professionals, coroners, and other public health officials necessitates CPS workers having to make decisions without all the facts. By failing to respond or offer help initially, these professionals as well as members of the community do not leave time for the protective service agency to adequately deal with their cases.

A number of crucial issues emerged from the discussion which must be addressed by individual states and the field in general:

- How to achieve better, more coordinated nation-wide data collection which reflects the total number of deaths including those now counted as SIDS deaths or those not counted at all.
- How to facilitate obtaining and monitoring the details surrounding a child's death so we can learn more about prevention.
- How to educate the public on the severity and impact of child neglect as well as physical abuse as triggers of child abuse deaths.
- How to provide better training and working conditions for CPS workers to avert child abuse deaths.
- How to put into place an improved diagnosis and screening system to assure that families at risk do get support.

- How to encourage and train social work students to go into the field of child abuse prevention and treatment.
- How to best apply permanency planning guidelines in reducing a child's risk for serious abuse.
- How to plan and implement an expanded child protection system which involves the community in preventive activities.

Consensus at this meeting was that we need a national gathering soon of all 50 states and those studying child abuse deaths to spend more time pooling our knowledge and identifying solutions to the above. The National Committee for Prevention of Child Abuse along with other members of the National Child Abuse Coalition will hold such a meeting within the next four months.

There is tremendous enthusiasm from the states and a number of private agencies for the action now being taken with respect to child abuse deaths. Collectively, I believe that there is a sense of relief that we are finally addressing this issue as both a state and a national concern.

Mr. OWENS. Thank you.
Dr. David Chadwick?

STATEMENT OF DR. DAVID CHADWICK ON BEHALF OF THE AMERICAN ACADEMY OF PEDIATRICS AND THE WESTERN ASSOCIATION OF CHILDREN'S HOSPITALS

Dr. CHADWICK. I am David Chadwick. I am a pediatrician. I am the director of the Center for Child Protection, which is a part of the Children's Hospital in San Diego. I am here representing the American Academy of Pediatrics and the Western Association of Children's Hospitals, and our written statement has been submitted.

I do child abuse work. I have been a pediatrician all my life, and for the last 2 years I have done child abuse work full time. I have always seen abused children. I document their abuse. I confirm it. I go to court about it. On Friday I will go to court on an infanticide case in a nearby county, and I do that about every month. I have been to court about 250 times on child abuse cases, and perhaps 20 of those have been fatal cases.

At this point I want to say that dealing with child abuse and the criminal justice system is a lot like treating heart disease using CPR. It is late. It is a late approach. You have to do it. You can't refrain from doing it. You can't stop doing it, but you have to recognize that you are coming in at a terrible stage of the game. It is ineffective, inhumane, and it is certainly not cost-effective.

A similar thing is true of putting children out of their homes in order to interrupt abuse. That is not quite as late as dealing with a death or dealing with a criminal situation but it is also late in the game, typically, by the time a child has to go out of home, and earlier interventions must be sought.

Ann has told you that we do know something about prevention. We know quite a lot about it. We don't really know how to prevent child abuse across the board but we have a handle on that. We have a beginning. Our efforts thus far have been micro efforts. We have demonstrated the preventability of abuse on a tiny scale. We need to begin to enlarge that. When I say that, we have done that for physical abuse and neglect and we are beginning to do it for sexual abuse with the school-based prevention programs and the early treatment of victim perpetrators. We need some carefully designed, medium-scale field trials of these early methods that have worked.

We need some long-term projects. You are dealing with something that is generational, that goes on and on. It is ingrained. To deal with it in short-term projects tends to be frustrating because you never really learn what the outcomes are for the people that you are looking at.

I think the heart disease analogy is pretty good. I think child abuse tends to be a cataclysmic event, superimposed on a chronic and visible dysfunctional process that is going on and on and on. Unless you can understand how that process works and intervene before the abusive event occurs, you are never going to be effective.

I do believe that we need more of a health science approach. I guess that's natural. I am a doctor. I don't think you can throw out

justice and social services. We couldn't possibly deal with child abuse in any other way than what we are right at the moment, because the cases are upon us and they must be dealt with, but I do think we need more of a health science approach. I would like to see a health science present in the National Center for Child Abuse and Neglect.

Last year Dr. Koop reached out and said that violence is a public health problem. He is absolutely right. All kinds of violence, including child abuse and other forms of family violence, are included in that statement.

I am going to get done and leave an extra minute for somebody.

I strongly urge you to reauthorize the NCCAN at the $50 million level suggested. Let me just say that if you talk about the thing that we are all most interested in, which is money, the out-of-home placement budget for the State of California is pushing toward $500 million a year. California is about a tenth of the United States, so it is $5 billion or so for all of the United States, so the NCCAN budget is 1 percent of that, but we are talking about authorization. We are not talking about real money because they will get 60 percent of that, so that puts things in perspective for you in terms of the money that we might be spending. Reauthorize it, push it up, increase the health component, increase prevention, increase long-term projects. Or, if you like spending money ineffectively, we can just keep doing what we are doing.

I would like to conclude by inviting any Californians on your committee, none of whom are present, or any of you for that matter, to come and see us, see how we work, visit us in the field to get a better idea of how this works.

Thank you.

[The prepared statement of Dr. David L. Chadwick follows:]

T E S T I M O N Y

BEFORE THE

SELECT EDUCATION SUBCOMMITTEE

EDUCATION AND LABOR COMMITTEE

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

ON

REAUTHORIZATION OF THE CHILD ABUSE PREVENTION AND TREATMENT ACT

PRESENTED BY

DAVID L. CHADWICK, M.D., F.A.A.P.

ON BEHALF OF THE

American Academy of Pediatrics

and

Western Association of Children's Hospitals

April 29, 1987

Mr. Chairman, I am David Chadwick, Director of the Center for Child Protection, San Diego Children's Hospital and Health Center and a member of the American Academy of Pediatrics Task Force on Child Abuse and Neglect. I am here today on behalf of the Academy and the Western Association of Children's Hospitals.

At the outset I want to commend you, Mr. Chairman, for convening this hearing today. Child maltreatment is clearly one of the most difficult issues facing our children and our society. Despite the public debate and rhetoric about child abuse, it appears too few truly appreciate the ramifications of the abuse and neglect of our children. Child abuse pervades many of our major societal problems. A high proportion of delinquents, substance abusers and suicide victims are the victims of abuse. Moreover, the problem is self perpetuating. Without treatment and attention, abused children are more likely to abuse their offspring, and so the cycle continues. On the positive side, we know much more about how to treat children and how to prevent certain forms of abuse. Tragically, we have just begun to implement what we know, so that abused children still are never identified; others are never treated -- we fear that many die.

My testimony today will review 1) the nature and scope of the problem of child abuse and neglect; 2) problems and developments in child abuse and neglect within the past five years; 3) the role and effectiveness of the National Center on Child Abuse and Neglect (NCCAN); 4) the import of the "Baby Doe" language; and 5) recommendations for reauthorization.

I. CHILD ABUSE AND NEGLECT: NATURE AND SCOPE OF THE PROBLEM

Child abuse and neglect is not a single entity. It therefore demands a multidisciplinary strategy. The problem includes physical abuse, sexual abuse, emotional abuse, physical neglect, emotional neglect, and medical neglect as well as other entities such as poisoning, sexual exploitation and homicide. Child abuse and neglect is an international problem; it crosses all socio-economic lines. Although physical abuse seems to be more prevalent among those in lower socio-economic strata, sexual and emotional abuse seem to be equally prevalent in all groups.

Last year approximately 2 million cases of child abuse and neglect were reported. This figure does not include the 2,000 - 5,000 deaths which were probably the result of abuse and neglect. Unfortunately, as I will discuss later in my testimony, exact figures on child abuse and neglect are impossible to obtain for we do not have a good reliable incidence study on the problem. Nevertheless, these numbers are a good benchmark as to the scope of the problem and the resulting crisis in terms of unmet needs and demands on child protective service workers.

II. POSITIVE TRENDS 1981-1986

In the past five years we have witnessed a dramatic change in public, private and professional awareness of child abuse and neglect. As the House Select Committee on Children, Youth and Families recently published report concludes, we expect much of this increased attention is due to "rediscovery" of child sexual abuse. I emphasize "rediscovery" since the first report in the medical literature on sexual abuse was in an 1868 paper by a French physician, Ambroise Tardieu, who described his findings after evaluating 616 sexually abused children under age 11 in Paris.

On the positive side, as noted, there clearly is an increased public awareness of the problem of child abuse and neglect. All fifty states have passed reporting laws and protections for families against abuse of their rights and privacy. Many states have provisions for guardians ad litem for children including protective court cases and support for identifiable child protective services at the local level. We have advanced our knowledge about child maltreatment and developed effective programs, approaches and practices. Notably, our research and evaluation efforts have become more sophisticated and confirm that we do know how to prevent and to treat the most prevalent forms of abuse. Federal efforts, particularly during the past two years, have dramatically improved also. While inadequate authorities and fundings continue, the new direction taken by the Children's Bureau and the National Center on Child Abuse and Neglect is excellent. New program initiatives in interdisciplinary training, national resource centers, better coordination between state child protective services (CPS) agencies and mental health and law enforcement systems are commendable. Indeed with the help of the National Committee for the Prevention of Child Abuse, the National Child Abuse Coalition and many state and local groups, 38 states have now enacted children's trust funds to focus additional resources on prevention. We are confident these efforts will begin to yield positive results in the next decade.

Concomitant with the increase in public awareness, there has been a healthy surge in professional awareness. The AAP, AMA, American Psychological Association, American Academy of Child Psychiatry, National Association of Social Workers, Child Welfare League, NAPCWA and many others have formed task forces or committees to plan how to contribute to the solutions to our problems. Further, an increasing number of our students are taking electives and doing their doctoral training in the field of child abuse and neglect. These men and women have grown up in a time when abuse and neglect were regular media fare. Unlike their older mentors, they do not have to redo their basic education and overcome a long history of denial of the existence of the problem.

III. ADVERSE TRENDS 1981-1986

Nevertheless, there is still cause for great concern. Although we have made progress in our knowledge about the causes, consequences and treatment needs of abused children and their families, further progress in actual prevention and treatment has been stalled.

1. Reporting

Overall reports of child abuse and neglect have increased by 55 percent within the last five years; although for the first time last year, the rate of increase in sexual abuse cases declined. The National Center on Child Abuse survey concludes that the 2 million reports of child maltreatment in 1986 represent a 6 percent increase from 1985. This increase is well below the 10 percent increase between 1984 and 1985 as reported by the American Association for Protecting Children, a division of the American Humane Association. The Center cautions that this apparent decline in the rate needs to be interpreted cautiously since these numbers were based on projections for 33 states during the initial six months of the year.

Nevertheless, the overall increase in reports comes at a time when the State Child Protective Service Agencies are struggling to survive against budget reductions and a manpower shortage. Consequently, as the CPS system's ability to keep pace has lagged, the number of "unsubstantiated" reports has increased. Some have wrongly equated "unsubstantiated" with "false". Thus, it has been said that 60-65 percent of all reports to CPS agencies are false, when, in fact, many of these cases are inadequately evaluated because of staff shortages or insufficient time. We should no more label these cases as "false" than we should label them "true". They should be labelled "insufficient information".

As reports have increased, so too have false allegations of abuse, especially in the area of sexual abuse, involving custody disputes. Careful studies have shown that while false allegations exist they are more commonly instigated by adults (6.5 percent of reported cases) than children (1.5 percent of reported cases). It is, in fact, not true to say "children never lie" -- they do, but more commonly they lie when they have been questioned and say they have not been sexually abused, but were (4 percent), than when they say they were sexually abused, and were not (1.5 percent). It is even more common for children never to reveal sexual abuse.

2. Child Treatment Issues

Nor have government agencies mandated to provide services and treat abused children and their families been able to keep pace with the surge in reported cases. The current child protective services system, although required by state law to provide "treatment plans" to families, falls far short of its goals. For example, recent surveys show that mental health services for abused children barely exist in many places. The treatment plans for abusive families consist of a series of 5-10 "parenting classes," a weekly phone call and a monthly visit from a CPS worker. Those families whose children have been molested in day care, school or other institutional settings receive even less help.

Additionally, community mental health and private community centers are full due to the deinstitutionalization of the chronically mentally ill. Our failure to meet the needs of these children and their families will

dramatically impact on present as well as future generations. For despite other efforts, the best way to break the cycle of abuse and neglect is to treat its current victims.

3. Child Fatalities

An extremely alarming trend has been the recent increase in child abuse fatalities. The National Committee for the Prevention of Child Abuse found a 29 percent increase in the number of confirmed or suspected deaths due to maltreatment between 1985 and 1986 for the 24 states able to provide such numbers. Between 1984 and 1985 the number of child deaths declined by 2 percent. The Committee found for many of these children, death occurred after the child was reported to local child protective services agencies. In some cases, the children died in protective custody as a result of abuse or neglect by their foster parents or emergency care providers.

It is not clear what has caused this increase. At least 3 possibilities exist:

1) We know there is a relationship between unemployment and serious physical abuse of children. At a 1983 Congressional hearing in Salt Lake City, data was presented from the Child Protection Team in Denver which demonstrated that physical abuse cases rose and fell in parallel with the Colorado unemployment rate over a 14 year period. The data from the past three years extends and confirms the earlier association.

2) The diagnosis of a child abuse fatality requires a careful investigation and an autopsy. In many parts of the United States, children die, they are buried, no one examines the body, and the death certificate is labelled "unexplained", "natural causes" or SIDS (Sudden Infant Death Syndrome). This practice is, happily, decreasing as more cities and counties pull together multidisciplinary child death review committees. The increase in child abuse fatalities may be a component of better recognition. Unfortunately no one tracks these data.

3) The changing demography of the American family has led to more children being left in unsafe settings by teenage or working mothers. Many child abuse deaths are now caused by boyfriends or other caretakers in contrast to the situation 20 years ago.

This lack of certainty in knowing why child abuse fatalities are rising points toward another disturbing problem: the fact that data collection in this field is terrible. Indeed, efforts to monitor trends for research or policy purposes are severely hampered by the continuing lack of reliable data in this field. While our government carefully tracks our labor force, agricultural and industrial production, imports and exports with great care, no one tracks our children.

4. Children with Disabilities

There are 2 issues of great concern regarding abuse and children with disabilities: 1) the degree to which children with disabilities are being abused; and 2) the number of children who have acquired disabilities because of abuse.

Research has acknowledged that children with disabilities represent a disproportionate number of child abuse victims (Chotiner and Lehr, 1976; Friedrick amd Boreskine, 1976; National Center on Child Abuse and Neglect, 1975; Sandgrund, et al, 1974.) Other isolated studies have indicated a relationship between child abuse, mental retardation, emotional, behavioral and physical disabilities. In a recent study, Diamond and Jaudes (1983) examined the occurrence of child abuse among 86 children with cerebral palsy. Of 18 children with postnatal onset of cerebral palsy, eight resulted from child abuse, five from infection, and three from accidents. Nine other children were abused after the onset of cerebral palsy, and one child was abused after the onset of cerebral palsy which resulted from prior abuse. Thus, in this study, 20% of the children with cerebral palsy were abused. Another 14% were considered at risk for abuse.

Despite these findings, it is difficult to determine accurately the incidence of abuse among children with disabilities because of the lack of specificity in state reporting requirements. Camblin (1982) found that seven out of 51 state child protection agencies do not have standard reporting forms which would facilitate data collection in child characteristics. Of the 44 states that do have standard reporting forms, 18 do not identify pre-existing handicaps of abused children. Further, Camblin found that in those states requiring this information, 43% of the state agencies regarded the information as inaccurate.

It is important to note, as the PACER group concluded, that children with disabilities are at high risk for child abuse for a number of reasons. These children are generally less able to defend themselves physically. Some children with disabilities may be unaware that they are being abused as they are unable to differentiate between appropriate and inappropriate behavior. Some of these children may be less able to articulate the instance of abuse.

In conclusion, it appears some children with disabilities are at high risk for abuse. Emphasis should be placed on collecting reliable nationwide data on the incidence and needs of children with disabilities who are abused, as well as training programs for parents and all personnel who deal with these children to prevent and to treat such abuse.

[Material for this section was excerpted from the Council on Exceptional Children briefing paper on Incidence of Child Abuse Among Children With Disabilities.]

IV. THE NATIONAL CENTER ON CHILD ABUSE AND NEGLECT (NCCAN)

The National Center on Child Abuse and Neglect was founded in 1974. The original law called for NCCAN to: 1) compile, analyze and publish a summary annually of recently and currently conducted research on child abuse and neglect; 2) develop and maintain an information clearinghouse on all programs, including private programs, showing promise of success for the prevention, identification and treatment of child abuse and neglect; 3) compile and publish training materials for personnel who are engaged or intend to engage in the prevention, identification and treatment of child abuse and neglect; 4) provide technical assistance (directly or through grant or contract) to public and non-profit private agencies and organizations to assist them in planning, improving, developing and carrying out programs and activities relating to the prevention, identification and treatment of child abuse and neglect; 5) conduct research into the causes of child abuse and neglect and into the prevention, identification and treatment thereof; and 6) make a complete and full study and investigation of the national incidence of child abuse and neglect, including a determination of the extent to which incidents of child abuse and neglect are increasing in number or severity.

As you are aware, the Center's responsibilities have been expanded since that time to include an emphasis on sexual abuse, family violence prevention and services, and promotion of children's trust funds. As you are also well aware, funding for this agency has never approached needed levels.

The Academy and WATCH believes that the Center is extremely important if we are to build a strong federal presence in the field of child abuse and neglect. Indeed there is no question that compared with years prior to 1973, there is more of a federal effort in child abuse and neglect. Although we have been critical of the Center in the past, we are very pleased with the directions currently being pursued by the NCCAN and the Children's Bureau. Nevertheless, there is an urgent need for a stronger, federal effort in the area of child maltreatment. Several of these issues demand Congressional support and attention:

1. National Incidence Study

The first national incidence study mandated by law was poorly conceived. Rather than utilize the expertise of other federal agencies, such as the National Center for Health Statistics, the Census Bureau and the national Centers for Disease Control, the study done under contract to NCCAN used figures voluntarily submitted by the states -- a notoriously poor method of data collection. The study, therefore, has led to the impression that child abuse and neglect is primarily a problem of the poor and tends to understate the severity of the problem. Sexual abuse also has been grossly underreported in this study.

2. Research Efforts

Despite the fact that research on prevention and demonstration programs is one of the NCCAN's primary aims, in a 1983 review article in Child Abuse and Neglect: The International Journal, Ray Helfer was able only to cite three studies that were adequately controlled in the research area in the last 10 years. One of these was privately supported, and the other two were supported by the NCCAN.

Nor has the research effort funded by NCCAN reflected the multidisciplinary nature of the field. Rather it has focused primarily on the social aspects of the problem with little attention focused on the pediatric, psychiatric or epidemiologic aspects of child abuse and neglect. The Center has failed to develop interagency efforts with NIMH, NICHD or CDC which would have served to multiply the impact of research efforts. Unfortunately, these other agencies involved with child abuse and neglect systematically decided not to fund related projects, assuming the NCCAN's leadership. As a result we are years behind in our research, prevention and treatment efforts.

It is perhaps our greatest concern that the most important research question -- what is the natural history of abused children -- has never been addressed adequately. We do not know how many of these children grow up and abuse or neglect their own children, or how many are appropriately treated and continue on to lead non-abusing lives. The Center has been curtailed in its ability to pursue this. Obviously, the results of such a study would dramatically affect, if not alter, our prevention and treatment efforts. However, to be done well such a study will demand a collaborative and multidisciplinary approach.

3. Manpower

There is a great need for increased federal leadership in the development of programs to help meet the desperate need of state and local child protective services agencies as they stagger under the weight of enormous increases in the reporting of cases of child abuse and neglect by an increasingly aware public. Our perception is that there is an even greater crisis in child protective service professionals than existed 20 years ago with the lack of primary care physicians. At that time the government recognized the need to develop incentives and training programs for family physicians, pediatricians and other primary care specialties to meet an unmet and growing need. The crisis today for child protective service workers is even greater. Schools of social work do little to train people in child protective services; thus most of these workers are trained on the job. There is also an enormous shortage in mental health professionals and child therapists. It is interesting to note that the Department of Justice has recognized this problem and is encouraging district attorneys to work collaboratively with social work and mental health.

4. Administrative Standing

As you know, the National Center on Child Abuse and Neglect is buried within the enormous bureaucracy of the Department of Health and Human Services. The NCCAN's present position beneath the Office of Human Development Services, Administration on Child Youth and Families and the Children's Bureau, severely inhibits the Center's ability to develop appropriate collaboration with other federal agencies, e.g. NIMH, NICHD, Office of Maternal and Child Health, Head Start, Run Away Youth and Social Services and the CDC. Further, the Center's lack of authority seems to have decreased over the past several years as the Office of Assistant Secretary has assumed even greater responsibility for this area and has attempted to merge the Center's activities into the overall agenda for the Office of Human Development Services. This continued layering of bureaucracy and authority has exacerbated the Center's inability to achieve its goals, as each decision must be cleared and approved by three offices.

V. "BABY DOE"

As you are well aware, the 1984 reauthorization of the federal child abuse law was dominated by debate surrounding treatment issues for seriously ill newborns, the so-called "Baby Doe" issue. After two years of intense controversy and debate, nearly twenty organizations, representing health, disability and anti-abortion issues, and 7 key Senators agreed to language in the child abuse law pertaining to treatment for disabled infants. Specifically the law expanded the definition of medical neglect to include a new category entitled the withholding of medically indicated treatment from disabled infants. The definition described the parameters within which the withholding of treatment, other than appropriate nutrition, hydration and medication, was appropriate, as defined by reasonable medical judgements. The law required states to establish procedures to respond to this category of medical neglect, including identification of a key contact person in the hospitals, and legal authority to pursue these issues as necessary. Compliance with these requirements is necessary for states to receive their share of federal child abuse funds.

A review of state procedures shows that with the exception of California, Pennsylvania and Indiana (the latter two have not taken the federal monies for several years due to legislative issues) all the states enacted procedures which call for immediate or high priority response to such calls. The special monies to help states establish these procedures were used primarily for parent and CPS worker education courses and to pay for medical consultants. Of note, not all the states used, or needed the monies to respond to the new requirements. It must be recalled that the language was intended to build onto existing state procedures and not establish a new CPS system. Thus for some states monies were not required. This does not mean these states were not interested in the issue or failed to comply.

The law also encouraged the creation of hospital review committees to help parents with these difficult decisions. Although such committees were not mandated, it is significant that according to a recent survey which the Academy pursued with the Connecticut Research and Training Center for Pediatric Rehabilitation, University of Connecticut Health Center, most hospitals have or are in the process of establishing such committees. Hospitals surveyed were those with neonatal intensive care units or over 1500 live births annually. The survey reveals two other significant points: 1) committees have been used actively by hospitals; and 2) many of the hospitals which do not have committees use some form of multidisciplinary decisionmaking or refer these cases to a more sophisticated center. The details of the report will be shared with you shortly.

These figures indicate that a significant number of hospitals, within a relatively short period of time, have instituted review committees. Clearly this percentage represents a dramatic change in the way decisions are being made regarding disabled newborns. The Academy and WATCH have long supported -- and continues to advocate -- the creation of such committees to assist with the decisionmaking process in difficult cases. To this end, the Academy has developed a set of guidelines to facilitate the establishment of such committees. Additionally, the Academy has convened a number of seminars, workshops and education courses at Academy meetings to help members with this issue. We believe additional and ongoing education is required in this area.

Despite the difficult path to compromise, you should be pleased to know that the law appears to be working. As such, the Academy and WATCH along with the National Coalition on Child Abuse and other organizations does not recommend any changes or modifications to this section of the law. We will continue to devote our energies to the successful implementation of this law and to helping physicians, health care professionals and families deal with the ever increasingly difficult biomedical ethical issues.

VI. RECOMMENDATIONS

There is no one "solution" to the problem of child abuse and neglect. Rather, a problem of this complexity and magnitude demands an array of approaches and strategies, involving:

1. IMPROVED COORDINATION BETWEEN THE NCCAN, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION, DEPARTMENT OF EDUCATION AND THE OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES, THE DIVISION OF MATERNAL AND CHILD HEALTH, DEPARTMENT OF JUSTICE, NATIONAL INSTITUTE ON MENTAL HEALTH, AND BUREAU OF INDIAN AFFAIRS.

   Unfortunately, recommendations such as this for increased cooperation between federal agencies often result in token interagency agreements which are confined to the paper on which they are written. I can not overstate the need for such cooperation. Indeed this theme runs through most of our individual recommendations -- the need for identification, prevention, research and treatment to involve all those agencies and programs which deal with these children and their families. No one agency can deal effectively with this problem --particularly one as underfunded and seemingly undervalued as the National Center on Child Abuse and Neglect. Rather the Center should serve as the lead agency to direct and coordinate the efforts of all programs in this area.

   This reauthorization bill should look to promoting a "total approach" to child abuse -- emphasizing early identification, intervention through home visits, support services and case management of the families' needs. Hawaii is one example of where such collaboration is working beautifully. In 1984 some clever, progressive thinkers obtained funds for a demonstration project to fund the Hawaii Family Stress Center and Child Health Plan. After being funded for 2 years (at $400,000) the results of Project Healthy Start were dramatic -- a 100 percent reduction in abuse and 87.5 percent reduction in neglect among infants from birth to age one. Notably, this occurred in the county in Hawaii which had previously reported the highest incidence of abuse and neglect. (See attached materials for details.)

   The point is that prevention can be accomplished. But it involves the support of an array of professionals and agencies. The Hawaii

model relies upon the concept of a "medical home" and a reinstatement of the community health system that will provide comprehensive primary health services which address all the child's needs. The essentials of an adequate "medical home" include: (1) geographic and financial accessiblity; (2) continuity of care from the prenatal period through early childhood and adolescence; (3) coordination through identification of needs and linkage of the family to services needed by the child; and (4) community orientation of awareness of child health problems and resources within the community. This model also emphasizes the need for a greater emphasis by the NCCAN on health issues as part of their child abuse strategy.

Another related example is the Office of Special Education and Rehabilitative Services (OSERS). The recently enacted P.L. 99-457, Education of the Handicapped Act Amendments, gives states monies to establish systems to provide early intervention services to disabled infants from birth. To date, it appears little attention is being focused on how this program be used to prevent the abuse of these infants -- that is, family and parent support programs to help them better deal with the additional stress of a child with disabilities. Emphasis should be placed on using these programs to help special education teachers identify, and help prevent abuse of these children.

The examples are numerous -- the possibilities endless: efforts with ADAMHA to deal with the substance abusing mothers who neglect their children; the Head Start network to provide a therapeutic environment to three to five year olds, etc.

At a minimum, the reauthorization legislation should require model demonstration programs between the NCCAN and other agencies to facilitate these efforts. Some efforts in this area have already taken place, for example with the OSERS, however these efforts must be expanded. On a broad scale, the legis' tion might call for the NCCAN or a special task force to develop a model for such linkages. What is clear is that these efforts are not taking place to the degree necessary. Nor can the National Advisory Committee as currently constituted or directed fulfill this function. The Center and the Children's Bureau should be commended for their efforts to elevate this committees importance -- however, the effort that is required to implement such agreements exceeds the power and authority of an advisory committee.

2. ELEVATE THE NCCAN

A portion of the above problem is related to the NCCAN's lowly status within the DHHS Bureaucracy as previously explained. The elevation of NCCAN to a position opposite the Assistant Secretary level (either for Health or Human Services) would permit the interagency cooperation necessary to fulfill the Center's goals and objectives. Such cooperation has not occurred with the present alignment for 16 years, and cannot occur unless NCCAN has the status necessary to work with NIMH, NICHD, the CDC and the Office of Maternal and Child Health, Head Start, Run Away Youth and Social Service Research efforts.

3. REDESIGN THE RESEARCH EFFORT

The National Center should: 1) Coordinate and fund a collaborative multi-site longitudinal study -- in cooperation with the NIMH, CDC, NICHD, MCH Office -- into questions regarding the natural history of the abused child, e.g. how many are treated effectively, how many grow up to become abusive parents, etc. As such, the grant period should be extended from 3 to 5 years. The agency should be authorized specifically to conduct a four year longitudinal study on child abuse and authorized to more effectively disseminate this information. 2) Encourage the above agencies to sponsor research on prevention of family dysfunction which leads to physical and emotional harm to children; and 3) Conduct more research into the physical diagnosis of sexual abuse and into sexually transmitted diseases and sexual abuse in this population.

4. DEVELOP AN INTENSIVE MANPOWER TRAINING EFFORT

The need for a quick, "crash" course to train child protective service professionals cannot be overstated. The current child protective services system is on the verge of collapse and, without support, the backlash will be staggering. Clearly there needs to be a federal effort to stimulate schools of medicine, social work and mental health to develop programs in the area of child abuse and neglect. This effort should be coordinated with the NIMH, ADAMH and Bureau of Health Manpower.

5. STIMULATE PROGRAMS FOR CHILD TREATMENT

Both public sector and private sector funds must be used more effectively to improve the treatment of abused and neglected children and their families. By collaborating efforts -- and funds -- with other agencies, the NCCAN can leverage its admittedly scarce dollars. For example, the NCCAN should develop a program with the Department of Education to develop therapeutic programs for abused children which could be delivered through the schools. We think the legislative authority for this already exists in P.L.94-142. Joint efforts could be initiated with the Department of Defense to address the unique needs of abused and neglected children who are military dependents. We also encourage the Center to continue its program of matching funds, whereby programs linked to a match are privately supported within three years.

6. INCREASE FUNDING LEVELS

Although the collaboration of efforts and other recommendations detailed above will leverage the NCCAN's funds, there is no question that this agency is consistently grossly underfunded. Despite the dramatic rise in reports of abuse and neglect in almost every state, and the corresponding increase in demands on social service and mental health agencies, the Reagan administration has failed to recommend an increased federal investment to deal with this crisis.

We agree with the recommendations of The National Committee for the Prevention of Child Abuse that P.L. 93-247 be extended for four years; the authorization level be raised from its current level of $43.1 to $50 million; and appropriated levels accordingly raised. We appreciate the constraints and limitations of a Gramm-Rudman era; yet anything less suggests our government's commitment to this area is nothing more than symbolic.

7. ISSUES SURROUNDING CHILDREN WITH DISABILITIES

The Center should:

1) Conduct an incidence study into the numbers of children with disabilities who are being abused. This will require cooperation with the DMCH and OSERS.

2) Develop training programs to help all personnel who routinely interact with disabled children to identify and prevent abuse and access the child protective services system as necessary.

3) Develop and disseminate programs with the DMCH and OSERS for parents at risk of abusing their children which includes stress management and other parenting techniques.

In conclusion, the Academy and WATCH appreciate the opportunity to testify on this important issue and look forward to working closely with you on this and other issues during the 100th Congress.

CHILD HEALTH CARE PLAN

submitted to the
STATEWIDE HEALTH COORDINATING COUNCIL

prepared by the
HAWAII MEDICAL ASSOCIATION
in cooperation with
HAWAII CHAPTER, AMERICAN ACADEMY OF PEDIATRICS

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May 1979

CHAPTER VI

Summary, Recommendations, and Future Planning

6.100 Analysis and Overall Strategy of the Child Health Care Plan

Introduction - Child health problems are unique and important for several reasons. These are primarily related to the vulnerability of the infant, the rapid growth in all areas of development during childhood, and the fact that development of optimal health in childhood can prevent other conditions of poor health later in life.

The first few hours of life are the most precarious, and more deaths will occur during that short period of time than will occur during the next twenty years. The first year is also quite vulnerable, as attested by the fact that a major indicator of a community or a nation's general level of health is the infant mortality rate.

Due to the extremely rapid physical, emotional, cognitive and social growth rate of the first several years of life, the young child has special needs, which, if not met can result in less than maximal development of permanent damage.

Meeting the special needs of adolescence is also critical to the development of healthy, productive adults. Successful psycho-social development occuring in adolescence is necessary to the establishment of a sense of identity and self-esteem needed to function as an adult.

Thus a major focus upon child health as a special population is worthwhile and rewarding in terms of promoting development of happy, healthy children now and also as a cost-effective investment of a more healthy, less dependent adult population in the future. That is, early remediation or prevention of problems which may be much more costly later in life, or result in dependency upon public institutions, i.e. the mentally retarded, the mentally ill, the

economically dependent and those incarcerated in prisons, is cost effective. All of these dependencies occur at tremendous public expense.

There are particular strengths in the child health services in Hawaii which should be mentioned. Hawaii now has a good immunization program, as evidenced by low incidence of communicable disease among children. The State also has an infant death rate considerably lower than the national rate. The merger of Kapiolani and Children's Hospitals has the potential for strengthening maternal-infant and child health services. A Regional Perinatal Center is already being established. Children's Hospital has several special programs, including a Pediatric Residency Continuity of Care Program, the Child Guidance Clinic and the Hawaii Family Stress Center (a demonstration program for innovative services in child abuse and neglect). The latter program has established a State Council on Child Abuse and Neglect. There is also a Developmental Disabilities Council, which has compiled a comprehensive plan for services to the developmentally disabled. There are Children's Mental Health Teams in each mental health cachement area.

The initial plan will examine child health problems and existing resources, identify gaps in services, establish priorities and make recommendations for a coordinated system of services. The plan will build upon some work already completed or in process in the development of plans for specific problem areas, including developmental disabilities, children's mental health services, maternal infant and child health services, child abuse/neglect services. The plan will advocate for coordination of services, to result in a cohesive system of services from two viewpoints. One of these represents a holistic view of the child, so that all health needs of the individual child can be met in a smooth, unfragmented manner, and the family can utilize services relatively easily. The other viewpoint would reflect a comprehensive system of services on a continuum including early identification and prevention/intervention of health problems, emergency and acute care, follow-up care and rehabilitation services.

6.2

Summary of Problem Statements - The infant mortality rate has declined significantly overall but remains disproportionately high among part-Hawaiian and Filipino ethnic groups and in certain geographic areas of the state, usually associated with low-income neighborhoods. Leading causes of infant mortality include congenital anomalies, prematurity, diarrheal disease, septicemia, pneumonia, and "other causes."

A study correlating the incidence of infant mortality, prematurity, illegitimacy, prenatal visits, standard fetal deaths, families below poverty level and families receiving DSSH benefits for 30 geographic areas indicates the relative need of these areas for improved maternal and infant health care. Areas most in need of improved care include Hanalei, Waikiki, Kauaikau, Waimanalo, Lanai, Kalihi Palama, Koolauoloa, South Kona, Waianae, North Hilo, and Molokai.

Many health problems are common to all socioeconomic levels. However, the needs assessment data shows that there are wide variations in indices of pre- and post-natal well being among infants and young children in different geographic areas and ethnic groups in the state. The geographic areas most needing assistance are defined, and they are low-income, underserved areas. The on-going planning effort should look more closely at the children in these areas to find out who these children and families are and why they are underserved. We know that problems of the underserved are related to inequalities of income and resources which create barriers to access and utilization of services.

Leading causes of death among children 1-4 are accidents, infective and parasitic disease, congenital anomalies, and all other diseases. Age 5-14 showed leading causes of death as accidents, malignancies, congenital anomalies and other diseases.

Major organic illness of childhood have been greatly reduced by application of medical science; however, behavioral and physiosomatic illnesses related to

socioeconomic aspects of the child's environment are increasing. A total of 32,854 children in Hawaii are suffering from some form of emotional disturbance; 2,746 of these are experiencing severe emotional illness. True incidence of child abuse is unknown and is undoubtedly much higher than that which is reported. 506 new cases were confirmed on Oahu alone from January to July, 1977. Child abuse and neglect are causally related to many other problems including mental retardation, emotional and relationship difficulties, school failure and dropout, status offenses and deliquency.

The prevalence of developmental disabilities in Hawaii includes approximately 6,989 mentally retarded, 618 children with cerebral palsy, 1,209 with epilepsy, and 124 autistic children.

Data on morbidity of children is not substantial. Available data indicates that respiratory conditions, infective diseases, injuries and other acute conditions are leading causes of illness among children. Poor children are less likely to receive medical care and are more likely to become ill. A rubella epidemic was the only communicable disease outbreak. Most children are now immunized against the seven preventable diseases. There is an increasing rate of venereal disease among the 15-19 year old group reflecting an 800% increase in the rate since 1967.

Leading health problems of adolescents include teenage pregnancy, emotional disturbances, substance abuse, dropping out of school, status offenses and juvenile delinquency, and developmental disabilities. This suggests a wide range of problems, many of which are preventable early in life. We need to know who these youth are, where they come from and what kind of health care they grew up with, or without. Are they from the same areas and families as the infants and children with poor health indices? What are the situations of their parents, and what practical approaches might be taken to improve their health status within service systems at an acceptable cost? The questions of cost

alone are a critical factor in actual implementation of any plan, as children's services most compete with all other public programs for state and DHEW dollars. We as a society quote such truisms as "children are our most important resource", "children are the future of the nation", but the political reality is that children don't vote. Services for children too often get lost in the political process and become a very low priority for allocation of scarce fiscal resources.

The health status section shows a high correlation between poverty, the health care underserved, and children with health and developmental deficits. The low-income areas evidence the poorest MCH indices, high rates of teenage pregnancies, school dropouts, delinquency and crime etc. While child abuse and substance abuse cut across economic groups, low income families are clearly under greater pressures which precipitate these problems and have less resources with which to cope.

Low income and lack of family resources, which is often linked with race, result in inequality and discrimination in access to health care services. Thus social and economic forces beyond the parent's immediate control create barriers for families who might otherwise care more effectively for their children. Obviously, a health care plan cannot provide social equality and an adequate income for the family, but it can assure access to comprehensive and uninterrupted basic health care for the children of all families, through sliding scale fee mechanisms which provide the same quality serivces to all children regardless of ability to pay. This in the long run will be cost effective because of the many disabilities, physical and social, which can be prevented among the population, which would later become a burden upon the public in costs related to medicaid, public assistance, mental illness, mental retardation and delinquency/crime.

Thus one premise of this plan is that health care resources, particularly primary care, should be developed with priority attention to the underserved who are largely located in low-income areas. A critical related problem which has been identified in under utilization of health services, particularly by low-income, less well-educated and motivated groups. There appear to be at least several reasons for this, including lack of awareness of need for services and use of services on an emergency, episodic basis rather than in a planned way which permits continuity of case. Also, services are often not readily accessible or acceptable to families. One way to effect attitude changes across large segments of the population will be through a broader family life education program in the schools, which begins in elementary grades and focuses upon a wide range of subjects related to health, the family, etc. Accessibility of services in terms of geographic distribution is an area of focus for long-range, in-depth planning. Acceptability of services is related to the manner in which services are provided and is addressed under the medical home. Each individual must be able to seek out a medical home which will support them.

Another premise of the plan is that it will emphasize prevention. Health statistics provide information on both physical and emotional developmental problems with roots in infancy and early childhood. Particularly in view of scarce resources, development of a better integrated system of child health services should give priority to maternal-child health services. Within that context, emphasis will be placed upon prevention and positive developmental aspects of infant and child health, beginning in the prenatal period and with a view to early detection and remediation of all developmental problems.

We need to design a system of health care which truly addresses these problems in the most efficient and economical way. The overall approach of this plan will be to facilitate the development and coordination of an integrated

system of services which focus upon the well-being of the child, within the context of the family. This concept will implement the concept that every child will have a "medical home," which provides primary health care services which are comprehensive in a sense of addressing the needs of the whole child. The essential nature of an adequate medical home includes (1) accessibility, both geographical and financial; (2) continuity, i.e. prenatal through early childhood and through adolescence; (3) coordination, which requires identification of needs and linkage of the family to all services needed by the child; and (4) a community orientation, i.e., an awareness of child health problems and resources in the overall community. The "medical home" may be within the context of private practice, maternal-infant care clinics, children and youth clinics, hospital out-patient clinics, and community health centers. All of these modes of service delivery will have to be more comprehensively developed in order to provide a medical home as described above.

A range of preventive health care efforts will be implemented within the framework of the medical home. This will include prenatal screening for all health problems for which high risk is predictable, intensive periodic screening during the first year of life, and annually thereafter until age five. After age five, annual checkups would be conducted for preventive health maintenance.

The Role of the Medical Home in Child Abuse Prevention and Positive Child Development

Calvin C.J. Sia, MD* and Gail F. Breakey, RN, MPH**

The Hawaii Medical Association and the Hawaii Chapter of the American Academy of Pediatrics adopted a Child Health Plan in 1978, which recognized that child health problems are unique and important for several reasons. These are primarily related to the vulnerability of the infant and the rapid growth in the areas of physical, emotional, cognitive, social and language development during this period. Early identification of and intervention with dysfunctions in these areas can prevent later conditions of general poor health, learning disabilities, mental retardation, juvenile delinquency, school dropout and suicides, and behavioral dysfunctions of later life. Because of extremely rapid growth in the first two years of life, the infant has special needs which, if not met, can result in less than optimal development and sometimes in the child's becoming a burden to his or her family and society.

The Child Health Plan stresses prevention in early life, through development of a better-integrated system of child health services. This system of services focuses on the well-being of the child within the context of the family. It centers on the concept that every infant born will have a "medical home" that provides primary health care services, comprehensive in nature, which address the needs of the whole child. The essentials of an adequate "medical home" include (1) geographic and financial *accessibility*, (2) *continuity* of care from the prenatal period through early childhood and adolescence, (3) *coordination* through identification of needs and linkage of the family to services needed by the child, and (4) *community orientation* of awareness of child health problems and resources within the community.

Health care is rendered, for the most part, by an unstructured system that lacks the coordination to provide information, training and direction. The busy practicing physician is often unable to "link" the family successfully to all of the services needed by the child in the critical early infancy period. Perhaps this is due to lack of orientation to community resources, but commonly it is due to a lack of adequate communication and working relationships between public and private agencies and the physician and family. Episodic, fragmented services do not contribute to the successful development of the individual infant and child.

The 1985 Hawaii State Legislature provided funds for a demonstration program that can provide a framework for linking infants at high psycho-social risk with a "medical home," and to support the physician in referring the family to other service resources as needed. This program was funded as part of the state's initiative in prevention of child abuse and neglect.

All children should have a medical home, but for children born to dysfunctional families, the need becomes critical. Child abuse and neglect have long been recognized as significant medical and social problems and recent studies indicate that the consequences of abuse and neglect and the accompanying dysfunctional parenting are of equal or greater concern.

Ray Helfer, MD, co-author of "The Battered Child," has attributed a host of problems of childhood and youth to breakdowns in the parent-child relationship. Highly dysfunctional parenting and chaotic family environments result not only in abuse and neglect but also in problems such as learning disabilities, emotional problems, acting out behaviors, mental illness, some incidence of cerebral palsy or mental retardation related to physical abuse, truancy, substance abuse, runaways, delinquency and crime. These problems hinder youth of our community from becoming productive adults and are also extremely costly in social and financial terms. A vast array of services must be mobilized to correct or deal with these problems, the most costly being the juvenile and adult corrections systems.

Prevention of child abuse and neglect and other forms of dysfunctional parenting becomes most desirable, as often these cause much irreparable damage.

Numerous studies of abusive families have led to the identification of "profiles," or characteristics, of abusive parents. From this information it has been possible to construct screening instruments for use in identifying at-risk families so preventive supportive services can be supplied.

Families are available for widespread, systematic screening only at several points in their lives, including at birth of an infant, when the child enters school and again full cycle at pregnancy.

Data recently analyzed by the director of the Children's Protective Services

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Medical Unit, James Dorbaugh, MD, indicates that about 84% of serious abuse cases and all 14 deaths since 1980 in Hawaii have occurred among children under five years of age. Intervention with at-risk families at birth is essential for this reason, and also because the first few years of life are so critical for healthy child development. Intervention at this time is also probably the most acceptable to the family, as services can be incorporated into routine perinatal services.

The Hawaii Family Stress Center at Kapiolani Women's and Children's Medical Center and Family Support Service projects at hospitals in Hilo, Kona, Maui, Molokai and Kauai have been conducting screening for at-risk families using a checklist developed by E. Henry Kempe, MD. Home visitor services are provided for at-risk families utilizing the lay therapy approach, following Dr. Kempe's model program.

The new demonstration program will be conducted at Kapiolani through the Stress Center.

This project has several goals. The first is to demonstrate effectiveness of early intervention in significantly reducing abuse of infants in one carefully defined geographic area. The second is to "link" the infant and family to a medical home for monitoring of the infant's safety, early and periodic screening in accordance with the HMA and new Medicaid guidelines, referral of the family to needed services, and providing continuity of care during the child's early years of life (i.e. birth to kindergarten).

Following screening, at-risk families will be referred to the project home outreach workers, who will facilitate parent-infant attachment, provide emotional support and assist parents to establish social support systems. Intensive involvement of the worker will continue for the first 12 to 24 months, according to the child's needs, and then taper off to a monitoring function with visits approximately 4 to 6 times a year.

Also, the worker will "link" the family to a "medical home" for the infant. Project professional and paraprofessional staff will maintain contact with the physician to review the child's status and to assist in facilitating needed referrals.

In this way, the physician becomes the case manager for ongoing follow-up; and the project staff provides support as needed, collects data and conducts periodic monitoring until the child enters school.

It is essential that the "medical home" physician develop and maintain awareness of early childhood problems as well as intervention and management skills related to these problems on an ongoing basis.

Project staff also will meet with providers of various services needed by the project families. The purpose of these meetings will be to enhance networking and to define gaps in service. Desired outcomes will be to increase awareness among service providers of the needs of at-risk families and formal documentation of these needs with recommendations on gaps inservices available.

This project will provide an organized system of identifying at-risk families, linking them to the medical home and supporting the physician in carrying out the role of medical management. The project will provide intensive emotional support to the family initially after birth, and then move toward a monitoring function through periodic home visits and contact with the physician.

The overall goal of the project is to demonstrate the effectiveness of the prevention of abuse and the establishment of support networks to promote positive child development for at-risk infants.

If successful, it is hoped that the program will be expanded, as was the pilot School Health Program.

This is a unique opportunity to develop an excellent system of preventive health services for children. Success of the Medical Home concept highlighting early periodic screening and continuity of care for the infant will be key.

AGENCY: Hawaii Family Stress Center
Kapiolani Women's & Children's Medical Center
1319 Punahou Street, Honolulu, Hawaii 96826

PROJECT DIRECTOR: Gail Breakey Area Code: 808 - 947 8225

Contract Date: From 10/1/86 to 10/1/89

PROJECT: FACILITATION OF PRIMARY CARE PHYSICIAN PARTICIPATION IN PREVENTIVE HEALTH CARE OF CHILDREN AGE 0-5 FROM UNDERSERVED, DIVERSE CULTURAL POPULATIONS

Underserved, diverse cultural populations have poorer health characteristics than the general population, and are more at risk for psycho-social and behavioral problems, termed the "new morbidity". These problems are critical for the 0-5 age group who have much greater preventive health care needs than adults and for whom preventive services are most cost-effective. The EPSDT Medicaid program designed to address this problem reaches only 25% of the eligible population for apparently minimal levels of service and attracts limited physician participation.

The health status problem selected includes developmental delays and psychosocial problems of children 0-5 from underserved, culturally diverse populations. Contributing factors to the health status problem are a range of family stresses which result in dysfunctioning parenting. This target group is most at-risk for and most vulnerable to the effects of these conditions. Consequences in terms of impaired functioning in later life and costs are considerable, including substance abuse, school dropout, delinquency, crime, emotional and mental illness which require expensive remedial services.

The project proposes to intervene with this problem by promoting the involvement of the primary care physicians, pediatricians, in early screening and intervention with the target population, based upon the medical home concept and according to American Academy of Pediatrics Health Supervision Guidelines. Contributing factors to present low physician participation in services to this target group include low Medicaid reimbursement, physician experience of Medicaid families being more difficult to work with, a historic pediatric orientation to treating illness rather than providing preventive care, lack of knowledge/awareness re community resources and sense of being part of a community team.

The proposed MCHIP project would be "piggy backed" to Project Healthy Start", which identifies 125 infants/year from low income diverse ethnic families to prevent child abuse and to promote positive child development. The target group will be primarily low income Part-Hawaiian and Filipino children 0-5 of families from an underserved area of : Oahu, Hawaii. The number of children served would be 125-250 in the first project year, 250-375 in the second year and 375-500 in the third year.

A core group of physician leaders who have met with us in planning this MCHIP will assist in a developing baseline data questionnaire related to present physician attitudes and services to the project population; in sponsoring training for physicians related to the "new morbidity", needs of project families, AAP Health Supervision and Guidelines, early screening tools, such as DDST and use of community resources. Healthy Start staff and the core physician group have already successfully lobbied together in obtaining an increase in the Medicaid reimbursement during the 1986 legislative session. MCHIP project health coordinator and two home visitors will conduct quarterly followup with families regarding safety of the home and parent-child interaction, and conduct case conferences with the physician. Small group meeting with physicians, MCHIP staff and core group physicians will focus on project families and issues of preventive care. Evaluation will utilize the same indices used in the baseline data collection, and will be conducted at months at 18 and 30. A dissemination plan is provided. The project should be of national interest and significance in demonstrating a practical approach to services to the 0-5 underserved, culturally diverse children, and as a "missing link" in establishing a comprehensive, integrated system for health care services for this target group.

Mr. OWENS. I don't think we have any California Members on my subcommittee.

Dr. CHADWICK. Congressman Hawkins.

Mr. OWENS. Oh, you mean on the larger committee?

Dr. CHADWICK. Yes.

Mr. OWENS. I'm sure he will follow up and make the visit.

Ms. Victoria Young?

STATEMENT OF VICTORIA YOUNG ON BEHALF OF THE CONSORTIUM FOR CITIZENS WITH DEVELOPMENTAL DISABILITIES

Ms. YOUNG. I am Victoria Young, and I am one of those professionals who is out there in our overwhelmed child protective agencies. I am a supervisor at Montgomery County Child Protective Services in Maryland, and I am here today on behalf of the Consortium for Citizens with Developmental Disabilities. The Consortium represents over 60 national, consumer, professional provider organizations but, more importantly, it represents children with disabilities and other handicaps.

I would like to talk with you a little bit. I have submitted my testimony but I would like to talk with you a little bit about what is going on in our field and also about how I came to be interested in the link between children with handicaps and disabilities and child abuse.

I came to Protective Services from a prior position in an institution for the mentally retarded, and before that I was in early childhood development as director of a child development center, so I have a real sound basis in child development, and when I came to Protective Services I began to notice as I carried cases—first as a social worker, later as a supervisor—that so many of the children that we were seeing, not only victims but the siblings of the children that were being victimized, were disabled in some way.

I didn't see that there was a significant amount of research on this problem, although I began to look around. I began to come to know other professionals who were concerned with this problem, and that's how I happen to be here representing the consortium.

We do have some research but it is scattered, and again it is not national, truly national research relating child abuse to developmental disabilities. We know that there is a correlation, that a disproportionate number of children with disabilities and handicaps are being abused, and we also know that they are being abused for a longer period of time and that they are less likely to be able to report that abuse.

We feel that much more could be known about the link between developmental disability and other handicaps and child abuse, if there were a uniform reporting system throughout the States and uniform definitions of both handicapping conditions as well as the types of abuse that can be suffered by children. We know that there have been studies done with regard to how many States have reporting laws which can enable us to pick up this information, and it simply is not adequate to the need for developing our data in this area.

We believe that disability and we know that disability does not cause abuse, but it clearly makes a child more vulnerable for a

number of reasons. Children who are disabled are less able to defend themselves physically, obviously. They may be unaware that they are being abused. They are often more dependent on others for assistance and for care, and they are fearful of losing this assistance and care. They may be more trusting because of their isolation. They may be and usually are lacking in self-esteem in some way, and so they are fearful about reporting and they hesitate to provoke anger or lose love. Finally, these children may not be able to speak. They may lack the verbalization skills to report abuse and neglect.

I would like to tell you a little bit about some of the cases that I have dealt with. I have seen a lot in the 8 years I have been at Protective Services. One child that we saw, who came into our service when he was about 6, is now 9 or 10. His mother was retarded and alcoholic; his father was alcoholic; and he was forced by his father, his mother and he were forced to commit sexual acts with each other and with the father.

The mother was finally able to report this, and in many ways you would think, "Well, this is the end of the story." The child abuse was disclosed and he was arrested and sent to prison, but that was really just the beginning because she was left alone to care for this child with very few survival skills and very few living skills. Protective Services practically moved in, I must say. I was a social worker, and we provided practically every service and we tried to coordinate practically every service that this family would need in order to remain in the community.

These are the kinds of things we are dealing with. We have a cerebral palsy child who we have had five reports on, this child, because she comes into school with bruises all over her and she doesn't really—she has very little speech and she always says, "Mommy did it." No matter what you ask her, she says, "Mommy did it." The school is mandated to report, we are mandated to go out and investigate, but it is very hard to determine with a child like this exactly what has happened.

There are other cases. There are a lot of cases that I could tell you about, but I would like to close with letting you know what our recommendations are.

We would like to see more data collected in the area of the link between handicap and child abuse. We would also like to see demonstration projects and training grants so that professionals could be trained, as well as special education teachers, and the children themselves trained to identify abuse and to report it.

We would like to see more research into this area, and we would like to see the implementation and funding of respite care, crisis nurseries, and early intervention programs. We are supporting the continuation of the "Baby Doe" provisions, and we hope that the committee will be able to support all of these recommendations.

Thank you.

[The prepared statement of Victoria Young follows:]

TESTIMONY

BEFORE THE

SELECT EDUCATION SUBCOMMITTEE

EDUCATION AND LABOR COMMITTEE

OF THE

UNITED STATES HOUSE OF REPRESENTATIVES

ON

REAUTHORIZATION OF THE CHILD ABUSE

AND TREATMENT PREVENTION ACT

Presented by

Victoria Young, L.C.S.W.

on behalf of the

Consortium for Citizens with Developmental Disabilities

April 29, 1987

Good morning. I am Victoria Young, Supervisor with Montgomery County, Maryland, Child Protective Services and I am here today on behalf of the Consortium for Citizens with Developmental Disabilities (C.C.D.D.). The C.C.D.D. represents over 60 national, consumer, professional provider organizations -- but more importantly, millions of children with developmental disabilities and other handicaps.

I would like to talk with you about child abuse and neglect and, most especially, about that abuse and neglect which is inflicted upon children with disabilities and handicapping conditions.

Before I review the research and data and present the Consortium's recommendations, I would like to share with you a little bit about our work and how I came to be concerned with this particular area of child protective services work.

When I first came to our agency eight years ago, I was assigned a caseload of 20-25 families which required long-term services to correct conditions which had led to the abuse or neglect of the children. As I became acquainted with these families and began to talk with teachers, counselors and health care professionals who were also providing services, I came to realize that there were, in these abusive and neglectful families, a disproportionate number of children with disabilities and handicapping conditions. This realization was so compelling, that I began to seek out other professionals concerned with this problem and to look to the research for more information.

Indeed, there is research which acknowledges that disabled children represent a disproportionate number of child abuse victims (Chotiner and Lehr, 1976; Friedrick and Boreskine, 1976; National Center on Child Abuse and Neglect, 1975; Sandgrund, et al, 1974.) Other isolated studies have indicated a relationship between child abuse, mental retardation, emotional, behavioral and physical disabilities. In 1970, Morse, Sadler and Friedman found that 42 percent of the children who were abused had an IQ of less than 80. Information available indicated that all but one of the children were diagnosed as retarded prior to abuse. In one of the largest child abuse studies conducted, Gil found that close to 30 percent of the 6,000 abused children studied demonstrated some form of emotional or behavioral disorder prior to being abused. Diamond and Jaudes (1983) examined the occurrence of child abuse among 86 children with cerebral palsy. Of 18 children with postnatal onset of cerebral palsy, eight resulted from child abuse, five from infection, and three from accidents. Nine other children were abused after the onset of cerebral palsy, and one child was abused after the onset of cerebral palsy which resulted from prior abuse. Thus, in this study, 20% of the children with cerebral palsy were abused. Another 14% were considered at risk for abuse.

What research we have has also shown that children with handicaps are more likely than other children to be abused for a longer period of time. In 1979, Glaser and Bentovim found that among 111 abused children, 32 percent of the children with disabilities were abused after the age of 2, compared with 5.2 percent of the children without disabilities. Further, 29 percent of the children with disabilities were abused after age 5, as compared with 9 percent for children without disabilities.

It is encouraging to note these studies have been undertaken which document the increased vulnerability of children with disabilities to child abuse and neglect; however, so much more could be known if all the states had uniform reporting requirements. Camblin (1982) found that seven out of 51 state child

protection agencies do not have standard reporting forms which would facilitate data collection in child characteristics. Of the 44 states that do have standard reporting forms, 18 do not identify pre-existing handicaps of abused children. Further, Camblin found that in those states requiring this information, 43% of the state agencies regarded the information as inaccurate. Surely this reflects on a need for training of child protective professionals so that they become sensitive to the various handicapping conditions and also a need for standardized definitions.

We believe that the Child Abuse and Neglect Prevention and Treatment Act could be substantially strengthened if it required that all states report fully and clearly with regard to pre-existing handicapping conditions in child victims of abuse and neglect and that there be standardized definitions of the various entities throughout the United States.

It is important that the Committee understand some of the reasons that children with disabilities are at high risk for mistreatment and neglect. Disability does not cause abuse, but it clearly makes a child more vulnerable. Children with handicaps are often less able to defend themselves physically. Many of these children may be unaware that they are being abused as they are unable to differentiate between appropriate and inappropriate behavior. Additionally, these children are often more dependent on others for assistance and care and may, therefore, be more trusting or more fearful of the loss of this vital support. Disabled children are frequently lacking in self-esteem and they may fail to report abuse for fear of provoking anger or losing love. Finally, disabled children may be unable to articulate or verbally report abuse.

It is difficult for all children to establish their credibility as valid reporters of abuse and neglect. It is even more difficult for disabled children to do so, due to limitations in speech, cognition or intellectual functioning.

Statistically, families with children with disabilities are 3 times more likely to fall below the federal poverty line. Moreover, women who do not receive prenatal care, and who have drug and alcohol related problems are more apt to have a child with a disability and are thus more likely to be abusive. It is not difficult to understand how volatile combination of these factors places these children at high risk for abuse.

In order to give the Committee some sense of the problems we Protective Services Professionals experience in dealing with these cases, I would like to take a few minutes to describe some children, families, and situations which are typical of our work.

I'd like to tell you about Jim, whom I first met when he was about 6. Jim's IQ is 80 and, when I met him, he was living with his retarded mother at the home of some relatives. Jim's alcoholic father had forced him and his mother to perform sexual acts upon one another and on him. After Jim's mother was able to report this abuse to the authorities, the father was arrested and sent to prison. This precipitated a severe crisis for Jim and his mother. Relatives refused to keep them and, shortly after I met them, they were literally on the street. For over a year, as a Child Protective Services social worker, I provided or coordinated the provision of services which included but were not limited to: housing, basic living skills, psychiatric care and counseling, medical and dental care, parent-aide services, assistance with shopping and budgeting, transportation, crisis intervention, recreation and round-the-clock moral support.

Another case which comes to mind is that of 14-year-old, profoundly retarded and physically disabled Jennifer whose desperate mother brought her child to our offices at 4:55 on a Friday afternoon and told us, "Here! You live with this for a while!"

There is also the case of 5-year-old Suzie. Suzie has cerebral palsy and literally hops on her knees to get from place to place. We have received and investigated 5 abuse referrals on Suzie which have been made by school personnel who are required to report when a child has suspicious looking injuries. Suzie's legs are frequently covered with bruises and, when asked what happened, Suzie invariably replies brightly, "Mommy did it." Due to Suzie's intellectual and speech limitations it is virtually impossible to determine for certain whether Suzie has been abused.

Finally, there are the many cases that Child Protective Agencies receive day in and day out which begin, "Seven-year-old Rick came in to his special education class this morning more agitated and hyperactive than usual. He had a blackened eye and some red marks on his cheek. When asked what happened, Rick stated that he'd taken a note home from his teacher yesterday saying that he hadn't done his class assignment and Dad had beaten him with the belt."

Obviously a major priority must be better programs to prevent the abuse of these children. Attention must be focused on improving support programs for parents at risk of abusing their children. With the advent of P.L. 99-457, infants with disabilities will be identified at birth. This law presents an ideal opportunity to meet with families and to determine whether they are at risk of harming their children. One excellent example of such a program exists in New York State -- the Infant Health Assessment Program. At-risk families are provided stress training courses and other support programs to prevent abuse of their children. Commendably, the National Center on Child Abuse and Neglect has already funded some demonstration programs in this area. However, much more needs to be done.

Recommendations

1. Data Collection

The C.C.D.D. believes it is imperative that the National Center on Child Abuse collect reliable national data on the number of children with disabilities who are abused each year. Currently, data is not collected on a national basis. Reliable, nationwide data on abused handicapped children is needed. Variables in definitions, services criteria, funding, and reporting mechanisms among the states make data collection impossible. At a minimum, these intake forms should be standardized and include information as to whether a child has a disability.

2. Demonstration and Training Grants

We would like to see a national demonstration project developed that would train educators, child welfare workers, the health care providers, child protective workers, and justice system employees on how to address the specific needs of children with disabilities who are abused. Generally, children with handicaps are less able to defend themselves physically, articulate an abusive incident, and comprehend abusive behavior. For example, without training, a social worker may not know how to communicate with a child with cerebral palsy who has no understandable speech. Similarly, children with learning disabilities may pose special difficulties for professionals unable to identify or appreciate the child's disabling condition. Special education professionals must be trained to identify abuse in this population, and to identify high risk families so as to prevent abuse.

We would also like to see a demonstration grant which would provide specialized education and training to disabled children on how to identify, report and protect themselves against abuse.

The National Center on Child Abuse and Neglect has already collected information on model programs in this area. Where information already exists, it must be disseminated effectively to communities all over America.

3. Research

We also believe there is an urgent need to conduct a national study which investigates the correlation between child abuse and developmental disabilities. Obviously we are concerned about children with disabilities who are abused. But, there is new evidence and concern over the growing number of children who become disabled due to abuse. There is no nationwide study that addresses this tragic problem. We need information if we are to be in a position to address this problem.

4. Early Intervention/Respite Care

The NCCAN should also be required to work more closely with the Office of Special Education and Rehabilitative Services on the implementation of P.L. 99-457 so that support programs can be provided to families identified at risk for abusing infants and children with disabilities.

We ask this Committee to work also to ensure that the Children's Justice Act, P.L. 99-401, is funded at the full authorization level of $5 million for respite care demonstration projects and $5 million for crisis nurseries. Respite care is a proven effective strategy to reduce stress and keep families together. Crisis nurseries can ease the burden of caring for a disabled child of potentially abusive parents.

5. Special Protection for Infants with Disabilities

The C.C.D.D. applauds the initiative of the Surgeon General to have the Inspector General study the impact of the "Baby Doe" regulations in each state. The conclusions will be studied carefully by us, and we would welcome the opportunity to make recommendations to you at that time. Nevertheless, we would want to state clearly that "Baby Doe" should remain a part of this bill while maintaining the intent of the original provisions.

With regard to Baby Doe, in the state of Maryland you may be interested to know, the funds provided under P.L. 98-457 have been used to create an outstanding training program for child protective workers and other professionals. This program has not only addressed the Baby Doe issue with thoroughness and sensitivity but it has also served to address other issues important to abused and neglected children. More funding for training of this type in other areas of concern would be extremely valuable.

There are many complex and serious problems to be addressed in this country with regard to the abuse and neglect of children. The recommendations we have submitted today are relatively simple and clear cut. I hope they will receive your full support.

Mr. OWENS. Mr. Ventura, Rick Ventura.

STATEMENT OF RICK VENTURA, DEPUTY DIRECTOR, ACTION

Mr. VENTURA. Mr. Chairman, it is a pleasure to be with you today and to testify on behalf of ACTION, the Federal domestic volunteer agency.

As ACTION's deputy director, I have traveled across the country to meet volunteers and community leaders. I have seen firsthand the encouraging renewal of volunteer spirit and the activity that has come about in the eighties. I have seen a great surge of private sector support for volunteers and private involvement in building local volunteer projects. I can report that we are succeeding in achieving increased growth and effectiveness of our ACTION volunteer programs without greater cost to the taxpayers, and in bolstering the efforts of private volunteer initiatives across the Nation. As President Reagan has said, the spirit of volunteerism is deeply ingrained in us as a Nation.

Currently more than 400,000 citizens serve as ACTION volunteers. They contribute over $350 million in service to our country, a return of some 150 percent on our investment, but the dollar value of their service does not begin to describe the scope of their accomplishment or the benefits gained by both volunteers and those whom they serve.

Since 1964 VISTA—Volunteers In Service To America—has sought to reduce poverty in the United States by bringing Americans from all walks of life, from all age groups, and from all geographic areas to address the problems of poverty. Full-time volunteers address problems affecting low-income youth such as drug abuse, illiteracy, unemployment, hunger and child abuse. Their activities also include support for shelters for the homeless, food banks, economic development, migrant and refugee assistance, and neighborhood revitalization.

As of September 1986, 127 VISTA volunteers were serving on 31 child abuse projects. In Buffalo, New York, Parents Anonymous of Buffalo and Erie County is a community-based organization for abused and troubled minorities living in rural areas. Special focus is placed on preventing child abuse. Four VISTA volunteers assist in recruiting and training community residents to carry out service programs such as the 24-hour Parent Help Line; parent telephone exchange; outreach and crisis intervention; and community education. A major accomplishment of this group is the development of a parent-member volunteer support program.

VISTA volunteers are also instrumental in helping to combat illiteracy. A Notice of Availability of funds for literacy core grants was published April 20 in the Federal Register. Among the emphasis areas being solicited are literacy projects which curb intergenerational transfer of illiteracy within low-income families by providing instruction to parents and their children together. As of September 1986, 474 VISTA's were serving in 108 literacy projects in 40 States.

ACTION's demonstration grant program has enabled communities to test and replicate innovative solutions to chronic social problems through the development of effective volunteer efforts. Since

1982, the demonstration program has awarded over half a million dollars to support projects which raise the literacy level of youths and adults in economically distressed communities. We have worked closely with the recognized leaders in literacy education across the country.

ACTION's three Older American Volunteer Programs offer men and women 60 and over the opportunity to apply their knowledge, maturity and caring where they are most needed. The Foster Grandparent Program has matched low-income seniors with children who have special or exceptional needs. Volunteers are assigned to schools for the mentally retarded, disturbed and learning disabled children, Head Start Programs, juvenile detention centers, foster care programs, and in some cases to a child's home. ACTION's largest program, the Retired Senior Volunteer Program, sponsors 383,000 part-time, nonstipended volunteers who serve in nearly every area of social service, including literacy, crime prevention and child abuse.

In conclusion, Mr. Chairman, as I have traveled across America and met with thousands of volunteers who are working to fight the root causes of poverty, I have seen their power to overcome any obstacle. The American volunteer spirit extends far beyond ACTION's programs. By helping community projects become self-sufficient, we are creating programs that will continue to succeed when Federal funding ends. ACTION's goal is to help community projects get started and to develop the operational excellence that attracts local funding and creates new public/private partnerships. ACTION is committed to expanding the volunteer tradition and to ensuring that every citizen who wishes to contribute will have an opportunity to do so.

Thank you.

[The prepared statement of Rick Ventura follows:]

TESTIMONY
OF
RICK VENTURA
BEFORE
HOUSE COMMITTEE ON EDUCATION AND LABOR
SUBCOMMITTEE ON SELECT EDUCATION
APRIL 29, 1987

Mr. Chairman, members of the Subcommittee, it is a pleasure to be with you today to testify on behalf of ACTION, the Federal Domestic Volunteer Agency.

As ACTION's Deputy Director, I have traveled around the country to meet volunteers and community leaders. I have seen firsthand the great renewal of volunteer spirit and activity that has come about in the eighties. I have seen a great surge of private sector support for volunteers, and private involvement in building local volunteer projects.

I can report that we are succeeding in achieving increased growth and effectiveness of our ACTION volunteer programs without greater cost to the taxpayers, and in bolstering the efforts of private volunteer initiatives around the nation. As President Reagan has said, "The spirit of voluntarism is deeply ingrained in us as a nation. The American people understand that there is no substitute for gifts of service given from the heart."

That belief in citizen initiative is translating into many new community-based efforts aimed at the root causes of poverty. ACTION is proud to be a leader of these efforts. Volunteers are essential to America's social progress and we are working to see that every American who wants to volunteer has an opportunity to do so.

Currently, more than 400,000 citizens serve as ACTION Volunteers. They contribute over $350,000,000 in services to our country, a return of some 150 percent on our investment.

But the dollar value of their service does not begin to describe the scope of their accomplishment or the benefits gained by both volunteers and those they serve.

VOLUNTEERS IN SERVICE TO AMERICA (VISTA)

Since 1964, VISTA, Volunteers in Service to America, has sought to reduce poverty in the United States by bringing Americans from all walks of life, from all age groups, and from all geographic areas to address this problem. Full time volunteers address problems affecting low-income youth, such as drug abuse, illiteracy, unemployment, hunger and child abuse. Their activities also include support for shelters for the homeless, foodbanks, economic development, migrant and refugee assistance, and neighborhood revitalization.

The volunteers, approximately a third of whom are low-income, are assigned to public and private non-profit organizations. VISTA awards funds, assigns volunteers, and shares technical assistance with communities to strengthen their efforts in addressing local problems. When VISTA volunteers help women heading households end welfare dependency and enter the work force, when older volunteers teach illiterate citizens to read or help young people abandon drugs or never use them at all, our society gains in every way. In fiscal year 1986, VISTA volunteers contributed 2,413 service years to over 500 communites. This year we again expect to contribute 2,400 service years.

As of September 1986, 127 VISTA Volunteers were serving on 31 Child Abuse projects.

In Buffalo New York, Parents Anonymous of Buffalo and Erie County, is a community based organization for abused and troubled minorities living in rural areas. Special focus is placed on preventing child abuse. Four VISTA volunteers assist in recruiting and training community residents to carry out service programs, such as the 24-hour Parent Help Line; parent telephone exchange; outreach and crisis intervention, and community education. A major accomplishment of this group is the development of a "Parent-Member Volunteer Support Program."

In Bowling Green, Kentucky, the Barent River Area Safe Space (BRASS) provides emergency shelter and support services for abused women and children. Here, four VISTA volunteers assist in developing programs which explore the cause and effects of family violence on children. The volunteers work to develop activities for children that build self-esteem, communication and socialization skills, and non-violent discipline techniques for parents. BRASS's accomplishments include creating a counseling and child development program for troubled children and youth.

The Montana Chapter of the National Committee for Prevention of Child Abuse encourages the creation of, and provides support to, local communities that work toward the prevention of child abuse. Ten VISTA volunteers working in the communities have increased public awareness and community volunteer involvement and have established an information and support system for preventing child abuse.

ACTION has been at the forefront of the Administration's fight against drug abuse. In addition to supporting community efforts through the award of Demonstration Grants, VISTA volunteers work in alcohol and drug abuse prevention projects throughout the country.

One example of a VISTA project which is now fully funded at the local level is the Altheia House in Birmingham, Alabama, which is a multi-program, drug and alcohol prevention agency that provides alternatives to using drugs. Five VISTA volunteers started and managed a substance abuse and prevention curriculum for young people in kindergarten through third grade. The volunteers took this curriculum into schools and worked with the young. These same VISTA volunteers also set up summer recreational programs and presented these as an alternative to spending the summer on the street.

Similarly, the Drug Enforcement Administration (DEA) and the National High School Athletic Association, in cooperation with the New Hampshire Office of Alcohol and Drug Abuse Prevention, in Concord, New Hampshire, has six VISTA volunteers who assist community groups in developing methods to respond to youth with alcohol and drug abuse problems. Activities include the establishment of a community task force. The task force is an example of community partnership and includes representatives from law enforcement, education, business, health and parent groups.

VISTA volunteers are also instrumental in helping to combat illiteracy. As of September 1986, 474 VISTA's were serving in 108 literacy projects in 40 states.

In Texas, four VISTA volunteers, serving with the Good Samaritan of Garland, are reaching out to support marginally literate low-income students with reading, writing, and comprehension problems.

VISTA has approved the placement of 15 volunteers under the new VISTA Literacy Corps program to the Center for Community Education of Montana State University located in Bozeman, Montana. These volunteers will be placed throughout the State to coordinate the literacy efforts of adult and community education programs. Eight communities and three Indian Reservations will each host a VISTA Literacy Corps volunteer.

Other success stories include the sixteen volunteers assigned to the Mayor's Commission on Literacy in Philadelphia, who have involved the private sector in the development of a city-wide referral outreach system. Six Spanish speaking VISTA volunteers assigned to Heritage College in Toppenish, Washington, succeeded in publishing English lessons in the Yakima Valley Spanish paper "VIVA" and the airing of these lessons twice daily on the local Spanish radio station KDNA.

The ten VISTA volunteers assigned to the Minnesota Literacy Council in St. Paul working with Hmong refugees have, through outreach efforts, secured the donation of nearly 6,000 community volunteer hours. In Arkansas, seven volunteers assigned to the local Arkansas Literacy Councils developed a video literacy public service announcement and established a literacy speakers bureau in all counties.

DEMONSTRATION GRANTS

ACTION's demonstration grant program has enabled communities to test and replicate innovative solutions to chronic social problems through the development of effective volunteer efforts.

Since 1982, the Demonstration Grant Program has awarded over half a million dollars to support projects which raise the literacy level of youths and adults in economically distressed communities. Experience to date demonstrates that trained volunteers are effective. We have worked closely with Laubach Literacy International and Literacy Volunteers of America. Other literacy projects included Big Brothers/Big Sisters of Nassau County in Hempstead, New York, Colonias Del Valle located in Pharr, Texas, and the YWCA of El Paso, and community motivators in New York City.

ACTION is currently funding the Minneapolis Foundation to establish an Urban Literacy Development Fund. The purpose of the fund is to provide grants, communication, training and advocacy in support of literacy efforts in 12 urban metropolitan areas. These test demonstration sites are part of a cooperative plan to increase public, private and volunteer resources. Moreover, they will identify organizations that address urban /literacy issues, to develop alliances and expand resources.

ACTION received $3 million this fiscal year to mobilize and initiate private sector efforts to increase voluntarism in preventing drug abuse through education and public awareness.

The ACTION Drug Alliance is developing initiatives to expand drug abuse prevention and education activities of community-based volunteer groups, with emphasis on long-term self-sufficiency through private sector support.

Our drug abuse prevention and education programs include awarding of demonstration grants to community projects that are models of success and ongoing self-sufficiency; providing technical assistance and information exchange through

workshops for parent, youth, service, religious, school and business groups; and creating a nationwide alliance of community organizations, service groups, businesses and corporations. Our efforts are aimed at helping parent, family, and youth peer groups, become self-sufficient by forming partnerships with service, religious and educational organizations, the business community, and other privarte supporters.

Further, during the past five years, ACTION has committed approximately 40% of its Special Volunteer Demonstration Program funds, approximately $500,000 each year, to assist local volunteer parent groups prevent drug abuse by youth. This money has supported 30 statewide volunteer networking projects which distribute information on the negative consequences to health of drug abuse and by helping volunteer parent groups develop and/or expand their efforts. In addition, ACTION has funded national organizations to provide technical assistance and resource information to individuals and organizations seeking to create a drug free environment for youth.

Compeer in Rochester, New York, addresses the problems of the developmentally disabled. This national technical assistance organization is replicating a program that matches a volunteer with a mentally impaired individual in order to help that person achieve a greater degree of self-sufficiency. Compeer has helped over 100 local projects develop the Compeer Program.

Compeer recently began work with a homeless project in North Dallas to serve as the first Compeer program for the homeless. In addition, Compeer effectively serves as a homeless prevention program by providing a volunteer to keep mentally impaired individuals from slipping into homelessness.

The New York Voluntary Enterprise Commission and the New York State Department of Social Services are jointly sponsoring a foster care independence project that recruits and trains volunteers from business, the trades, and other professions to teach independent living skills to foster care youth in Brooklyn and Syracuse, New York.

Covenant House, in New York City, is operating a long-term residential and job training program for runaway and homeless youth. Twenty five percent of the youth in the program are from Brooklyn.

In San Francisco, ACTION awards in FY 85 and FY 87 has enabled Youth Advocates, Inc. to help runaway and homeless youth obtain safe housing until they can return home or be processed by the juvenile justice system.

OLDER AMERICAN VOLUNTEER PROGRAMS

ACTION's three Older American Volunteer Programs offer men and women 60 and over the opportunity to apply their knowledge, maturity and caring where they are most needed. These pograms continue to lead the way by fully using the skills and wisdom of older volunteers to help address social issues. The Foster Grandparent, Retired Senior Volunteer, and Senior Companion Programs provide unparalleled experiences in personal development and satisfaction.

FOSTER GRANDPARENT PROGRAM

The Foster Grandparent Program, since 1965, has matched low-income seniors with children who have special or exceptional needs. Volunteers are assigned to schools for the mentally retarded, disturbed and learning disabled

children, Head Start Programs, juvenile detention centers, boarding schools, foster care programs, and in some cases to a child's home. More than 7,000 Foster Grandparents assist some 26,000 children in foster care facilities; and 10,000 additional volunteers are involved in literacy programs helping about 37,000 children on any given day.

RETIRED SENIOR VOLUNTEER PROGRAM

The Retired Senior Volunteer Program, initiated in 1971, is ACTION's largest program. It currently sponsors 383,000 part-time, non-stipended volunteers who are age 60 or older. RSVP volunteers serve in nearly every area of social service, including literacy, crime prevention, in-home care, youth counseling, consumer education, and drug abuse prevention projects. Programs and services for the mentally retarded and developmentally disabled include assignments in residential and non residential settings.

SENIOR COMPANION PROGRAM

ACTION estimates that in 1988 our appropriation will fund some 5,500 Senior Companion volunteer service years through our SCP programs. These volunteers will serve more than 24,400 persons at 118 projects around the United States, including 900 volunteers who serve in 22 non-ACTION funded projects. One component of the Senior Companion Program, the Home Bound Elderly, provides thousands of older Americans an alternative to institutional living.

In conclusion, Mr. Chairman, I have travelled across America and met with thousands of volunteers as they fight the root causes of poverty. I have seen their power to overcome any obstacle. Americans volunteer spirit extends far beyond

ACTION's programs. We will tap the enormous resources our citizens offer. We will work to intensify and extend involvement with individuals, businesses, non-profit organizations and local governments to create new, lasting volunteer programs. By helping community projects become self-sufficient we are creating programs that will continue to succeed when federal funding ends. ACTION's goal is to help community projects get started and to develop the operational excellence that attracts local funding and creates new public/private sector partnerships.

Our focus is local. At ACTION, we believe that there are no greater resources for meeting the challenges of the 21st century than the independence, ingenuity and initiative of local citizens. Community volunteers have always been vital to the advancement of the United States as a free and democratic country. ACTION is committed to expanding that volunteer tradition and to ensuring that every citizen who wishes to contribute will have an opportunity to volunteer.

Mr. OWENS. Mr. Tom Nerney?

STATEMENT OF THOMAS NERNEY ON BEHALF OF THE ASSOCIATION FOR CHILDREN AND ADULTS WITH SEVERE DISABILITY

Mr. NERNEY. Thank you, Mr. Chairman.

I am here today representing TASH, The Association for Children and Adults with Severe Disabilities. TASH is an association of over 7,000 individuals in this country, Canada and abroad whose sole concern are those folks who are labeled most severely disabled by this society.

My written testimony, which I have already given in, covers some of the evidence regarding physical and sexual abuse and some of the difficulties facing families, and especially foster parents, where approximately 10 percent of all child abuse cases go either for temporary or permanent placement. My remarks today I would like to confine to two issues. I would like to discuss briefly the role of Medicaid in, first, health care, and the issue there is one of medical neglect; and, two, in terms of long-term care, and the issue there of course is physical and psychological abuse. I would like to end with a few comments on another issue, the growing use of State-sanctioned violence against children with disabilities under the rubric of aversive therapy.

Building upon the historical amendments to the Child Abuse Act 3 years ago, which provided the provision of medically indicated treatment for newborns with life threatening conditions, it is necessary I feel to ensure continued access to needed medical care for, one, abused children with disabilities and, two, children with disabilities who are at high risk for abuse. Fundamental reform is necessary to ensure adequate medical care for these two populations.

Reform of Title 19 of the Social Security Act is important, then, in conjunction with this hearing on child abuse for two fundamental reasons. First, natural, foster and adoptive parents of children with disabilities must be guaranteed equal access to health care in America, through requiring at the very least all health care providers to accept either current or enhanced payment through Medicaid reimbursement, and thereby reducing potential medical neglect of abused children with disabilities.

Second, Title 19 Medicaid must be fundamentally altered by redirecting public resources now spent to separate disabled children who are at risk for abuse from their families—that is, by paying to institutionalize disabled children. These funds redirected back to our communities provide, almost always at less public cost, services to enable a family to care for their disabled child at home and thereby greatly reduce the risk for abuse for this population.

While it is clear that this committee may not have all the jurisdiction necessary to effect these two reforms, it is possible for this committee to raise these issues in conjunction with the reauthorization of the Child Abuse Act. You have to imagine, for example, a parent turned down by a leading doctor in a community, solely because that doctor does not accept Medicaid reimbursement. Unfortunately, this is a pervasive problem facing parents with disabled children and other caretakers.

The unarticulated but very real policy of this Government unfortunately under Medicaid forces a family to surrender their child in need of services to an institution, especially if that child is developmentally disabled. The institutionalized child then is at higher risk for abuse.

The last issue that I wish to discuss has not historically been addressed under the area of child abuse. It is the growing use of aversive, often extreme aversive techniques used to modify the behavior of persons with disabilities. I would like, with your permission, to leave for the record the inquest into the death of Vincent Milletich in 1985, who was under the care of the Behavior Research Institute in Massachusetts and Rhode Island, who died while being restrained with a helmet that emitted static noise into his ears.

Mr. OWENS. You may submit it for the record.

Mr. NERNEY. Pardon me?

Mr. OWENS. You may leave it for the record.

Mr. NERNEY. Thank you.

The judge ruled in that case that it was not assault and battery because it constituted therapy and consent was obtained from the parents. Were Vincent Milletich a resident of a State prison, that would never have happened to him. Our State statutes barring this kind of abuse of animals are clear. The statutes, especially under the 8th Amendment barring cruel or unusual punishment, barring these interventions from being used with criminals, are also clear.

Given the complexity of this issue, I will ask your permission to submit one more thing for the record, and that is a monograph produced by TASH on the history and the present status of aversives in this country as they are used with severely disabled people. Although effective nonaversive procedures are available, they are not always employed or routinely administered.

From mild pain and humiliation to extreme pain and, yes, to even death, extreme aversive procedures are gradually becoming an accepted mechanism for intervening with children and adults with disabilities. The conspiracy of silence among professionals and others involved in this practice can only be broken with a thorough and competent investigation by this Congress, and hopefully this committee.

Thank you.

[The prepared statement of Thomas Nerney follows:]

THE HOUSE COMMITTEE ON SELECT EDUCATION

HEARING ON

THE REAUTHORIZATION OF THE CHILD ABUSE PREVENTION

AND TREATMENT ACT OF 1974

TESTIMONY BY

THOMAS NERNEY

ON BEHALF OF

THE ASSOCIATION FOR CHILDREN AND ADULTS

WITH SEVERE DISABILITY (TASH)

Child Abuse and Disability

Depending on the duration and severity of child abuse, often disability results, ranging from minor and temporary to major and life long. The National Center for Child Abuse and Neglect in 1986 reported 1.9 million cases of child abuse in 1985 occurring in anywhere from 10 to 20 percent of the home in the United States.

There is some evidence to indicate that child abuse is likely to happen in some homes of handicapped children and certain evidence that child abuse itself is at least one major cause of disability.

To the extent that data is available, understanding the under reporting in this area, children with disabilities and their families need much greater protection and resources from the present system.

Studies from as far back as 1962 by C. Henry Kempe, M.D., found that 85 of 302 abused children in 71 hospitals had suffered neurological damage and that 33 of this sample died. Janice Watson's writing in the September 1984 issue of the Exceptional Parent reported on some of the results of the Seattle Rape Relief Developmental Disabilities Project. That report estimated that as many as five hundred mentally and

physically disabled children and adults are the victims of sexual abuse each year in the Seattle area alone.

The emerging literature on disabilities and child abuse (a brief list is attached) indicate serious problems endemic to both the system set up to protect children from child abuse and those systems designed to provide services to persons with disabilities - chronicled most recently by the Senate Sub-Committee on the Handicapped Report on abuse and neglect in our public institutions for persons with disabilities.

Another serious side to this national problem lies in the lack of adequate services and monitoring for those abused children placed in foster care - a number estimated by the National Center for Child Abuse and Neglect to be approximately 10 percent of all reported cases of child abuse.

Abused children, who have been victimized and traumatized, present a totally different, and frequently exhausting, parenting challenge. Adoptive/foster parents and service providers face a myriad of unique problems and concerns when providing care, services, and/or managing these children. According to research, some young children who have experienced traumatic events (even before they possess the ability to speak) may remember these episodes accurately when they are three or four years old (Todd

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and Perlmutter, 1980). Children have the capacity to remember past incidents as well as adults (Lindberg, 1980). Abused children can and do have memories of their previous abuse, and the consequences of those "flash-backs" further compound the existing physical, behavioral, emotional, and/or educational handicaps foster/adoptive parents encounter (Purdy, 1986).

Removal from an abusive home cannot heal the child's psychological trauma. These traumas may still continue to re-surface at later times. When abuse has occurred in infancy, the "now verbal" preschool child may exhibit inscrutable behaviors of fearfulness, anger, and/or aggression. Foster/adoptive parents need to be prepared for these responses and cognizant of the probability of a link between them. Care providers also need to know the signs and symptoms of potential emotional reactions. Most of all, foster/adoptive parents of such children need to know that although these reactions may not occur, the child (even one who is very young) may "relive" or remember this abuse experience. Strategies must be provided to these parents to help previously abused children deal with their debilitating, emotional scars (Puredy, 1986).

The successful resolution or management of many of the problems of previously abused children depends upon the competence of their care and service providers. This is not an easy task when dealing with the non-abused population, but becomes even more

complex, frustrating, and difficult with previously abused children. Their families face sociological, psychological, and physiological variables when attempting to teach appropriate social skills and behaviors to these children. Families may experience conflicts associated with other family members as a result of the stress and demands imposed by providing support to the abused child.

Once children enter the legal and social service system, it is probable they will be placed in a foster placement; and perhaps, ultimately, in an adoptive placement. Service providers must not only plan for the needs of the child but be aware of the special problems confronting foster and adoptive parents. There is a general disparity in services from one area to another whether within a single state or from state to state. Often, foster parents who suspect a child has special needs do not know where to go or how to get services. They do not know how to get support for themselves in coping with these children's special needs. Service providers needs to be aware of the legal rights of foster and adoptive parents. These rights vary by county or state, and are especially critical wnen foster/adoptive parents need to access special services for these children. Getting biological parents or state permission for specialized critical medical records may be difficult as well and, in some cases, impossible (Purdy, 1986).

Foster/adoptive parents need education, information, and training. They usually do not know how to handle the emotional and behavioral sequelae associated with abuse. They need a comfortable approach to behavior management, especially as they have no way of knowing what of their own behavior may produce recall/memories from the child's past.

Given the many and necessary reforms which would be desirable, I would like to concentrate solely on the following issues today.

Building upon the historical amendments to the child Abuse Prevention and Treatment Act three years ago which required the provision of medically indicated treatment for new-borns with life-threatening conditions, it is necessary to insure continued access to needed medical care for 1) abused children with disability and 2) children with disabilities who are at high risk for abuse.

Fundamental reform is necessary to insure adequate medical care-for these two populations. Reform of Title XIX of the Social Security Act is important for two fundamental reasons:

First, natural, foster and adoptive parents of children with disabilities must be guaranteed equal access to health care in America through requiring all health care providers to accept either currnt or enhanced payment through Medicaid reimbursement

and thereby reducing protential medical neglect of the abused children with disabilities.

Second, Title XIX, Medicaid, must be fundamentally altered by re-directing public resources now spent to separate disabled children, who are at risk for abuse, from their families, (i.e., by paying to institutionalize a disabled person). These funds must be re-directed back to our communities, provide almost always at less public cost, services to enable a family to care for their disabled child at home and thereby greatly reducing the risk for abuse for this population.

While it is clear that this committee may not have all of the jurisdiction necessary to effect these two reforms it is possible for this committee to raise these issues in ways that may encourage other members of the Congress to grapple with them. Imagine the parent turned down by the leading doctor in a community solely because that doctor does not accept medicaid reimbursement. Unfortunately this is a pervasive problem facing parents with disabled children and with other caretakers. The unequal treatment of medicaid recipient children with disabilities in the provision of medical care is exacerbated by this added frustration.

The unarticulated but real public policy of this government under

Medicaid forces a family to surrender their child to an institution epecially if the child is developmentally disabled. The instititutionalized child is at higher risk for abuse.

The fundamental reform necessary in the ICF-MR program, led in the last Congress by Senator Chafee and Representative Florio would have begun to recognize families as the primary caregivers for disabled children and would have addressed two major areas where child abuse can be ameliorated. First by providing families with elementary and inexpensive services such as respite care and second, by providing incentive to bring disabled children (and adults) out of institutions where abuse and neglect are pervasive and return them with essential services to our communities.

One last issue which has not historically been addressed in the are of child abuse is the growing use of aversive often extreme aversive techniques used to modify the behavior of persons with disabilities.

On September 10, 1986 an inquest was begun in a Massachusetts court to determine the circumstances surrounding the death of a young man, severely disabled, under the care of the Behavior Research Institute. There was no debate surrounding what happened to Vincent Milletich - he was placed in restraints, both hands and feet and a helmet was placed over his head - a helmet

which emitted static through ear phones placed in it. The offense which this young man committed was to make a noise, deemed inappropriate by the staff, while he was seated. Vincent Milletich died a short time later. Although the Behavior Research Institute was cited for negligence in the design of the helmet they were exonorated of the death.

The judge ruled that what happened here was not assault and battery because it constituted therapy and consent was obtained from the parents.

I use this extreme example only to illustrate the lengths to which we have gone in authorizing the infliction of pain and punishment - pain and punishment which is already outlawed in virtually every state were it to be used on animals and is generally prohibited on criminals under the cruel and unusual punishment interpretation of the eighth amendment.

Were Vincent Melletich a resident of a state prison it is probable that this would never have happened.

Given the complexity of this issue and recognizing possible overlapping jurisdictions I would like to request that members of this committee look closely at this issue. I am providing with this testimony a monograph of the Association for Persons with Severe Handicaps entitled "Use of Aversive Procedures with

Persons who are Disabled: An Historical Review and Critical Analysis".

It is my contention that horrible abuse and demeaning interventions - interventions which meet the definition of child abuse, are more and more routinely sanctioned by professionals in every part of this country. Although effective non-aversive procedures are available they are not always employed or routinely administered. From mild pain and humiliation to extreme pain and yes, even death, extreme aversive procedures are gradually becoming an accepted mechanism for intervening with children and adults with disabilities. The conspiracy of silence among the professionals and others involved in this practice can only be broken with a thorough and competent investigation by this Congress and hopefully this committee.

SELECTED REFERENCES
ABUSE OF HANDICAPPED CHILDREN

Beckman, P. Influence of selected child characteristics on stress in families of handicapped infants. Am. J. of Mental Deficiency, 1983, 88, 150-156.

Behring-Tarver, Shari; Barkley, Russell A.; & Karlsson, Jennifer. The mother-child interactions of hyperactive boys and their normal siblings. Amer. J. Orthopsychiat., 55, 2, 1985, 202-209.

Bell, R.Q. & Harper, L.V. Child Effects on Adults. Lincoln, NE: University of Nebraska Press, 1977.

Benedict, Mary I. & White, Roger B. Selected perinatal factors and child abuse. Amer. J. of Public Health, 75, 7, 1985, 780-781.

Blacher, J. A dynamic perspective on the impact of a severely handicapped child on the family. In J. Blacher (Ed.) Severely Handicapped Young Children and Their Families, New York: Academic Press, 1984.

Briggs, R. (Ed.) Child Abuse and Developmental Disabilities: Essays. Washington, D.C.: U.S. Department of Health, Education, and Welfare, DHEW Publication No. (OHDS) 79-30226.

Brookhouser, P.E., Sullivan, P., Scanlan, J.M. & Garbarino, J. Identification of the sexually abused deaf child: The otolaryngologist's role. Laryngoscope, February, 1986, 96, 2, 152-158.

Camblin, L.D. A survey of state efforts in gathering information on child abuse and neglect in handicapped populations. Child Abuse and Neglect, 1982, 6, 465-472.

Caputo, D. & Mandell, W. Consequences of low birthweight. Develop. Psycho., 1970, 3, 363-383.

Council for Exceptional Children. We Can Help: Specialized Curriculum for Educators on the Prevention and Treatment of Child Abuse and Neglect, 1979, Reston, Virginia.

Egeland, B., & Brunnquell, D. An at-risk approach to the study of child abuse. Journal of American Academy of Child Psychiatry, 1979, 18, 219-236.

Elmer, E. & Gregg, G.S. Developmental characteristics of abused children. Pediatrics, 1967, 40, 596-602.

Embry, Lynne H. Family support for handicapped preschool children at risk for abuse. New Directions for Exceptional Children, 1980, 4, 29-57.

Friedrich, W.N., & Boriskin, J.A. Primary prevention of child abuse: Focus on the Special Child. Hospital and Community Psychiatry, 29, 4, 1978, 248-251.

Friedrich, W.N., & Boriskin, J.A. The role of the child in abuse: A review of the literature. American Journal of Orthopsychiatry, 1976, 46, 580-590.

Frodi, A.M. Contribution of infant characteristics to child abuse. American Journal of Mental Deficiency, 1981, 85, 341-349.

Green, A. Self-destruction in physically abused schizophrenic children: Report of cases. Archives of General Psychiatry, 1968, 19, 171-197.

Hanson, R. Institutional Abuse of Children and Youth. New York: Haworth Press, 1982.

Harrell, S.A. & Orem, R.C. Preventing Child Abuse and Neglect: A Guide for Staff in Residential Institutions. Washington, D.C.: U.S. Department of Health and Human Services, DHHS Publication (OHDS) 80-30255.

Holroyd, J. & McArthur, D. Mental retardation and stress on the parents: A contrast between Down's syndrome and childhood autism. Am. Journ. of Mental Deficiency, 1976, 80, 431-436.

Horner, T.W.; Theut, S.; Murdoch, W.G. Discharge planning for the high-risk neonate: A consultation liaison role for the infant mental health specialist. Am. J. Orthopsychiat., 1984, 54 (4), 637-647.

Jaudes, Paula Kienberger; Diamond, Linda, J. The handicapped child and child abuse. Child Abuse and Neglect, 1985, 9, 341-347.

Kline, Donald F. The Disabled Child and Child Abuse. Chicago: National Committee for the Prevention of Child Abuse (pamphlet), 1982.

Klopping, H. The deaf adolescent: Abuse and abusers. In G.B. Anderson, & D. Watson (Eds.), Proceedings of the National Conference on the Habilitation and Rehabilitation of Deaf Adolescents. Washington, D.C.: National Academy of Gallaudet College, 1985, 187-196.

Leventhal, John M.; Egerter, Susan A.; Murphy, Janet M. Reassessment of the relationship of perinatal risk factors and child abuse. AJDC, 138, 1984, 1034-1039.

Lynch, M.A. Ill-health and child abuse. Lancet, 1975, 2, 317-319.

Nesbit, W.C., & Karagianis, L.D. Child abuse: Exceptionality as a risk factor. Alberta Journal of Educational Research, 1982, 28, 69-76.

O'Day, B. Preventing Sexual Abuse of Persons With Disabilities. St. Paul, Minnesota: Minnesota Program for Victims of Sexual Abuse, 1983.

Reinear, Eileen E. Sexual assault and the handicapped victim. In Anne Wolbert Burgess, Ed., Rape and Sexual Assault: A Research Handbook. Garland Pub. Co.: New York, 1985.

Sandgrund, A., Gaines, R., & Green, A.H. Child abuse and mental retardation: A problem of cause and effect. American Journal of Mental Deficiency, 1974, 79, 327-330.

Soeffing, M. Abused children are exceptional children. Exceptional Children, 1975, 42, 3, 126-133.

Solomons, G. Child abuse and developmental disabilities. Develop. Medicine & Child Neurology, 1979, 21, 101-106.

Souther, M.D. Developmentally disabled, abused, and neglected children. In Perspectives on Child Maltreatment in the Mid-'80's. Washington, D.C.: U.S. Department of Health and Human Services, DHHS Publication No. (OHDS) 84-30338.

Starr, R.H., Dietrich, K., Fischhoff, J., Ceresnie, S., & Zweiger, D. The contribution of handicapping conditions to child abuse. Topics in Early Childhood Special Education, 4, 1, 55-69.

Watson, Janice Daar. Talking about the best kept secret--sexual abuse and children with disabilities. The Exceptional Parent, 1985, 14, 6, 13-22.

Webster-Stratton, Carolyn. Comparison of abusive and nonabusive families with conduct-disordered children. Amer. J. Orthopsychiat., 1985, 55, 1, 59-69.

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10-86

Mr. OWENS. I want to thank you all for testifying and for waiting. It has been a long morning but we are under extreme time constraint with respect to completing the reauthorization process for this bill. Therefore, it was necessary to have this as a concluding hearing and we wanted to hear from as many people as possible.

I would like to open the questions with a basic question. Ms. Joyce Thomas will be sitting in to replace Mr. Roberts and deal with any questions related to that area.

Protective services are funded extensively by the Government, already. To what degree can our problems be solved by calling for a revamping of protective services, the way they are handled, or the inclusion of more preventive services under the protective services programs? Is that a reasonable approach? What has your experience been which would lead you to believe otherwise, or any comments you would like to make on that?

Ms. COHN. The data that we have gathered to date on preventive services suggests that home health visitors, various kinds of parenting education and parent support programs, other programs that emanate out of hospitals or community centers, are those that appear to be the most effective. It would be my belief that those are probably best offered by hospitals, community agencies, and the like, public health nurses, if you will, rather than by protective services.

So I think that if we are thinking in terms of primary preventive services, we probably need to look to some other agencies within State government to take at least a significant portion of the responsibility. On the other hand, if you were to look at the——

Mr. OWENS. What of the funding, the funds that are provided via protective services?

Ms. COHN. Well, we would have to figure out some ways to involve the right kinds of people.

Mr. OWENS. What if these other agencies were made eligible to receive those funds?

Ms. COHN. It would be important to seek the right kind of people to deliver those services, I think. These are not services that are necessarily best offered by a social worker, which is the typical kind of——

Mr. OWENS. That is not what I had in mind. The great problem is that we need funding. If some of these activities related to prevention and adoption and justice, et cetera, were eligible for funding under the child protective services——

Ms. COHN. Where I think the value would be, would be with the vast number of cases that are reported to protective services, families that are labeled as at high risk, many of which are opened up for treatment. What they need are some preventive or early intervention services, and there I think protective services could play a very substantial role.

Mr. OWENS. Any other comments?

Ms. THOMAS. Yes. I would like to add to the issue, again pointing to the high volumes of minority children who are in the system and the whole question of using funds and utilizing funds for training of increased sensitivity on how to handle these families, how to work with these families, and also the criteria for decisionmaking.

You alluded earlier to the issue of high numbers of unsubstantiated cases. There really still is an issue in terms of how decisions are being made, what kinds of tools are used by individual workers, and all of these aspects now, taking some of factors we know about child abuse and neglect and refining and sophisticating our approach, particularly for the high volumes of vulnerable children and the very complex cases that we are faced with.

Mr. OWENS. You say minority children are in the same category as handicapped children? Color becomes a handicapping condition?

Ms. THOMAS. Well, it is really hard to pit one child issue against another in that respect. I think there are many handicapped children who are minorities, and vice versa. I think the question of need, particularly when you look at what is being counted, certainly keeping in mind those things that are not well counted, which is the volume of handicapped children in the system, really points to we need to do something about the problems that we do see.

We know that there is an overabundance of cases of minorities in the system, and we know the training and the materials and sensitivity for workers has not been at the level to address these families. We see this in the burn-out. We see this in lack of leadership in the area, and the problem does continue. We need to get on both ends of the continuum, in the acute area as well as in the preventive area.

Mr. OWENS. Any other comments on the basic question about protective services? You have firsthand knowledge of——

Ms. YOUNG. I would like to speak to the issue of prevention programs through protective services. I think we need more prevention programs in the various disciplines. Protective services is in a good position to administer or apply or put together prevention programs, but we are so overwhelmed with the work that we are doing at the present time, that we have not been able to address this area as fully as we might if we had funding to do more in the way of prevention programs.

Mr. OWENS. Any other comments?

[No response.]

A lot of frustrations are expressed here. We feel them on our side, too, and I wonder what could a more effective NCCAN advisory board do in terms of helping to resolve some of these problems and make better use of the limited funds? We agree you all have limited funds and need more funding, but are we using what we have as effectively as we can, and could the NCCAN advisory board play a major role in seeing to it that we use what we have more effectively? Dr. Chadwick, you expressed a great deal of commitment and frustration, I think, in your——

Dr. CHADWICK. Well, I am not so sure if it belongs in the advisory board, where it is probably already there, but I think that within the NCCAN itself and close to the top—first of all, the whole organization needs to be moved up a notch or two closer to the Secretary in order to be able to do something useful, but that has been said a bunch of times before, and then there needs to be a greater health presence there. There needs to be a doctor in NCCAN.

Mr. OWENS. Any other recommendations for the NCCAN advisory board?

Dr. CHADWICK. Or a nurse.

Mr. OWENS. No one has any recommendations for the NCCAN advisory board?

Dr. CHADWICK. Or a public health person.

Ms. COHN. I think that every day there are decisions that are probably made at NCCAN or above NCCAN that directly influence the kind of programs that they fund and, in the longer term, how they will use the results that they get back from those programs and that research. It seems to me that with a staff of 8 or 10 or 15 or 20, people who in essence are somewhat isolated from what is going on in the field, one can't always make rational or useful decisions. I think the advisory board is a beginning. There are about 15 public members on that, as well as representatives from across the——

Mr. OWENS. Well, does your organization have any input in recommending people for NCCAN, or any of your organizations have input?

Ms. COHN. No, no.

Mr. OWENS. You are not consulted on any of those recommendations?

Ms. COHN. It is not my belief that that is how people are selected, and that would certainly be a useful thing to do, to ask the field, "What kinds of people do you think should serve on this advisory board?" but then once you have an advisory board, to ask for their advice. You know, if you are thinking about dramatically changing how the Federal Government funds a study that gathers the only national data base that we have, the national data base that the American Humane Association has now been gathering for 13 years, and there is a thought about changing that in a dramatic way, it would make sense, at least to me, to get some advice from people in the field.

If you have an advisory board, that is the place to begin. Now they may not all be the experts on this, but they may be able to recommend other people who can. That is the kind of decision that is being made this week or this month, that I think desperately needs input from the field. I would recommend that the advisory board be used extensively for that.

Ms. THOMAS. I would like to add to that point. There is an advisory board and it is made public in the Federal Register, which again means that when these meetings are held which are open to the public, a large percentage of people who do not have access to the Federal Register may not even be aware of the presence of this advisory board, which only meets twice a year.

To add to that, the field is more sophisticated. I think we can look at history from the time that Dr. Kempe first talked about the battered child syndrome and go back 25 years. We have learned a lot but it is more sophisticated. We have more complicated kinds of topics that require forums for discussion from members of the field, that lends itself to enhancing and understanding of the people inside of the National Center. I think that those kinds of forums, in addition to the advisory committee, should be established.

We have talked about situations where custody is an issue and there is an allegation of abuse. We have talked about issues of handicapped children, issues of minorities, and numerous complex topics. In order to grapple with these, there need to be some semi-

nars and forums, not in a conference mechanism which is designed primarily as educational, but for think-tank approaches to clarify a central kind of thought as to how the priorities should be set.

Some of these things simply are not occurring. It is a frustration for those in the field who look to the National Center for leadership and advice and clarity as they are trying to prepare programs of innovation in the community. It is very difficult to find those kinds of resources, and that adds to the problems of implementation of this legislation.

Mr. OWENS. Would it be useful to have the legislation encourage, I won't say mandate but encourage the establishment of coordinating committees of some kind at the local level, coordinating committees which would involve people in the area of serving the handicapped, the child abuse prevention group, the family violence prevention group, et cetera, and maybe even mandate that one-third of the people serving must be former victims? Would that be useful or would it just create a lot of turmoil unnecessarily? They would have a function in terms of coordinating and recommending who gets what funds, for example, in the local area and for preventive programs.

Ms. THOMAS. I would probably suggest a task force to make a firmer recommendation on that question would perhaps be best, rather than to respond immediately. The issue——

Mr. OWENS. I want your gut reaction.

Ms. THOMAS. Well, the coordination is certainly significant and should be formalized. I would say yes, it would be important to have that kind of information available. We all know coordination, again, is people issues, and sometimes that becomes more complicated. I think because the field is so broad, that it would really be helpful to really question the whole utilization.

I even suggested, in the development of some of these materials, that we look at the staffing and get a better understanding of what the problem really is. Is it the same, the turnover, the rapid loss of specialists in given areas, is it the same issues within the center as affecting professionals in the field? That is a question I don't think too many of us know and understand. We know what is in the field. We know what burn-out is. We know why people become overwhelmed. It may be similar within the institution.

Mr. OWENS. I am concerned about, do social workers in the protective agencies talk to people in the preventive programs, and do they all talk to district attorney representatives, police department representatives, and what kind of structuring from the Federal level might encourage that they do more of that?

Ms. YOUNG. Because I am on the local level and I don't have the familiarity with all the national issues that many of my colleagues have, I can only speak to my experience in my community. We do attempt to get together to talk about a coordinated program, and we do include citizens' action groups. We have the benefit——

Mr. OWENS. So you have met with representatives of the district attorney in the last year or so?

Ms. YOUNG. That is correct. We do get together. In fact, our county is trying to put together a child center which would bring together services to abused and neglected children, a prevention program, sexually assaulted children, all under one roof, so we are

fortunate because we are a relatively affluent county, and this is not——

Mr. OWENS. This is all done informally?

Ms. YOUNG [continuing]. This is not something that can be done——

Mr. OWENS. Is this done informally, or is there some county mandate or State mandate that they get together?

Ms. YOUNG. The county has mandated that we bring together these services, but we have all been trying to do that for some time. I think what Joyce Thomas has said is true, that we need to look at ways of communicating with one another.

We need to look at ways of making that happen, and I don't think that we have had enough experience in looking at the various ways that we can communicate to say, "Well, this is the way" or "That's the way," but we need an opportunity to start to study the best ways to put together programs that won't get bogged down in special interest groups polarizing and just blocking the process of delivering these services to children, but will actually facilitate communication and cooperation and will make it happen.

Mr. OWENS. Yes, Ms. Cohn?

Ms. COHN. Actually, if you look across the country it is sort of an interesting picture. The 41 States that now have Children's Trust Funds at the State level have some kind of an advisory body made up of public members who represent the variety of interests within the field of child abuse, as well as people perhaps from corporations or other kinds of private concerns, so that is one way in which at the State level you get some kind of coordination going on, at least with respect to funding.

I can't give you the exact number, but it may be somewhere between 18 and 20 States in addition to that which have Governor's Advisory Committees on Child Abuse that look both at the way in which the Protective Service System is working and also at what other kinds of things need to be happening in the State, and those most often are composed of people from the variety of different kinds of State agencies who are concerned with the problem, as well as concerned citizens.

We also, the National Committee for Prevention of Child Abuse, have chapters in all 50 States, and most of them will bring together people who represent the variety of interests in one way or another. That is typically at the State level.

Then when you go to the local community, in most States, in most counties or at least in some jurisdiction you will find some form of a child abuse coordinating council. Some of them today are probably more skeletal than actually vibrant organizations, just because of all the work that people who normally serve on those councils have to do within their own agencies. They don't have the time to go and coordinate because they are so overburdened with the cases they have, but you will find in many, many communities either they have been there, are there now, or maybe in some cases in fact are pretty vital organizations.

It seems to me that a wonderful role for the Federal Government to play would be to look at ways to provide incentives to communities, as well as States that maybe don't have Governors' Advisory Committees, but specifically to look at incentives for communities

to develop or at least refurbish those kinds of councils where they have existed, so they can play the kind of role that needs to be played, which is that kind of coordination and communication.

Mr. OWENS. Dr. Chadwick?

Dr. CHADWICK. Well, Mr. Owens, you have a very radical notion. We have been calling this thing with which we deal with child abuse a system for years, and of course there has never been one, and what you are talking about is, maybe it could become one. I absolutely endorse what Ann Cohn is saying about providing Federal incentives to move in that direction.

We have, California has, a Children's Trust Fund. We have 50-odd counties. Each one of them has a Child Abuse Coordinating Council. We have one. We get together. We are vibrant. We are educational. We do a lot of stuff, but we do not behalf like a system. We process. As soon as a child abuse report is made, we process children. We process families. We spit something out the other end. God knows what we are doing.

The one thing that needs to be looked for is some way of computing accountability, responsibility, and some way of tracking what is happening by tracking children and families through this system to know how well we are doing. The person who starts it has no idea how it ends, the way things work now. Although we get together and talk, we do not have a systematic approach to the process that we are attempting to control, and in fact we do not control it. We do not manage it.

Mr. OWENS. Mr. Nerney?

Mr. NERNEY. Clearly one of the relationships that ought to be forged at the State level is between the State childprotective agency and the State protective and advocacy agency funded under the Developmental Disabilities Act. Where you have some expertise in disability under the P and A system which is often missing from the child protective agency, I think that would go a long way toward helping in the investigation of incidents of abuse that affect people with disabilities. Clearly that is a resource that is in place right now. That kind of relationship between those two agencies I think would go a long way towards beginning to deal with the problem, certainly, of children who are abused and who are also disabled.

Mr. OWENS. Thank you. Thank you all again. We will take into consideration your written comments as well as the comments you have made today. We do appreciate your patient waiting today. Thank you again.

The hearing of the subcommittee is now adjourned.

[Whereupon, at 1:39 p.m., the subcommittee adjourned, to reconvene subject to the call of the Chair.]

[Additional material submitted for the record follows.]

WRITTEN TESTIMONY SUBMITTED TO

THE SPECIAL EDUCATION SUBCOMMITTEE
OF THE
COMMITTEE ON EDUCATION AND LABOR
UNITED STATES HOUSE OF REPRESENTATIVES

ON THE REAUTHORIZATION OF THE
CHILD ABUSE PREVENTION AND TREATMENT ACT

BY
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MAY 4, 1987

Chairman Owens and members of the Special Education Subcommittee:

I am Marlene Young, Executive Director of the National Organization for Victim Assistance. Founded in 1975, NOVA is the umbrella organization for this country's victims' movement, representing a membership of some 5,000 agencies and individuals and the millions of us who are victimized every year.

Your subcommittee is considering reauthorization of the Child Abuse Prevention and Treatment Act, the pioneer in Congressional support of improved treatment of crime victims. Though NOVA is warmly supportive of that entire program, my comments will be confined to an addition to the program, the Children's Justice and Assistance Act (CJAA), passed last year largely at the urging of this subcommittee.

The special merits of CJAA in improving the Federal program of dealing with child abuse can be summarized as follows:

- o It puts a special focus on child sexual abuse -- a horrific, large portion of the overall abuse problem, and one that has been insufficiently addressed up to now;

- o It recognizes the critical roles of law enforcement and prosecution in responding to these cases;

- o And most important, CJAA puts special emphasis on interdisciplinary approaches in reforming laws, policies, and practices to handle these cases and aid its victims.

Our problems with CJAA are not over these substantive features but over its funding mechanism. Initially proposed to have a $12 million authorization and appropriation, it was ultimately funded with a 4.5 percent share of the "Crime Victims Fund", a dedicated trust fund created by the Victims of Crime Act, or VOCA. The 4.5 percent share translated into about $3 million this year.

The pragmatic reasons for tapping into the VOCA fund were these:

- o The nominal "loser" in the transaction was a 5 percent share going to aid victims of Federal crime, (reduced to 1 percent under the CJAA anendment). The Department of Justice had never implemented that program, and indeed, at the time that CJAA was being considered, the Department was deferring spending its first-year allocation of the "Federal 5 percent".

- o There being no current beneficiaries of the "Federal 5 percent", it seemed fair to the CJAA proponents to steer those VOCA dollars to where they were both needed and wanted -- and a "real" $3 million for the Children's Justice program was preferable to an "empty" authorization of $12 million.

There were, then as now, some difficulties with that reasoning:

- o Most obviously, there are indeed victims of Federal crime

who have no services available to them -- even though it is the fines of Federal offenders -- their offenders -- which fund VOCA. Thus, CJAA made Federal victims suffer for the Justice Department's misuse of the "Federal 5 percent" program.

o Ironically, even while it reduced the Federal victims' share to one percent, CJAA also reformed the Federal victims' program to protect it from future neglect or mismanagement by the Justice Department. Thus, that program is now a far tighter, mandatory service to such victims -- but it has next to no resources to carry out its mission.

o Substantively, the Children's Justice program is an anomalous add-on to VOCA (although a welcome improvement to the child abuse program). Unlike the other VOCA components, CJAA does not pay just for direct services. Also, VOCA had already made programs aiding child abuse victims one of three priorities to receive VOCA victim assistance subgrants. Generically, child abuse got a second bite on the apple.

o And most basically, Congress was legislating further aid to the victims of state crime -- and inducing states to reform their criminal laws and procedures -- while reducing aid to the victims of crimes that are exclusively under the dominion of Congressional legislative authority.

NOVA made these and other arguments to Congress in urging that some other mechanism be found to fund CJAA. Though unavailing at the time, we have since learned more about the needs -- the unmet needs -- of Federal victims since the CJAA/VOCA marriage was arranged.

The following examples suggest the desirability of Congressional re-examination of the wisdom of substituting a new child abuse program for the sole program for Federal victims:

o The families of hostages held in Beirut -- as well as repatriated hostage families -- are all victims of a uniquely Federal crime. Both expert counsel and the wishes of the families themselves agree that the powers of mutual support -- among the far-flung loved ones of a given hostage, and across the affected family groups -- are the most effective tools of coping with the extreme stresses of hostage-taking. In fact, the families were once able to get together periodically, and to have their long-distance phone bills subsidized, until their private and donated resources ran out. Now, they carry on in painful isolation.

o Last summer, 14 U.S. postal employees were murdered and several others were wounded by one of their co-workers in the Edmond, Oklahoma, post office. No Federal "crisis response team" existed to help orchestrate services to this close-knit family of grieving Federal employees, much less to the emergency workers or members of the larger community who were stunned by this massacre. Instead, a volunteer team of NOVA

staff and consultants filled in, as we have since done after other disasters, including a second one with a special tie to the national government, namely, the Conrail-Amtrak train crash near Baltimore last winter.

o A problem affecting a larger number of Federal victims is the near-void of services to the victims of felonious violence found on many American Indian reservations. In a recent speech at a NOVA training conference, Iva Trottier, working for the Indian Health Service on the Ft. Peck Reservation, described the overwhelming numbers of child sexual abuse cases she is faced with -- and she has no counterpart victim counselors on most reservations. And the Justice Department recently spent much of its Federal victim assistance funds this year to aid the many victims of just one child molester who had been a BIA teacher on the Hopi reservation in Arizona.

I should underscore that our own education in the need for a Federal victim assistance program on Indian reservations has focused on the near-epidemic of child sexual abuse on some reservations. While that situation should be of special concern to this subcommittee, I should also stress that there are thousands of other cases of traumatic crime committed on these reservations -- and in other places where Federal criminal justice authorities have exclusive jurisdiction -- and these victims also deserve responsiveness from Congress.

So how might we begin to respond more compassionately to these Federal victims of child abuse and other forms of cruelty?

Perhaps the most obvious -- and surely the most pragmatic -- answer would be to simply repeal the Children's Justice and Assistance Act. After all, as I understand it, not one cent of its VOCA allocation has yet been spent. Like the "Federal 5 percent" program last year, CJAA has no "current beneficiaries".

That is a pseudo-solution that NOVA resists very strongly.

When CJAA was hastily put forward with its new funding scheme, NOVA opposed it on two grounds of principle:

o Victims who have been promised government aid should not be treated as non-beneficiaries merely because the bureaucrats have not yet made good on that statutory commitment;

o And policy-makers should not seek to aid one group of deserving victims by taking resources away from another group of deserving victims.

We hold to these principles today. Victims of Federal crime should not see their hopes of compassionate services realized at the cost of abolishing a highly promising Federal initiative to aid the victims of child sexual abuse.

A more reasoned and principled solution would be to sustain the

$3 million Federal subsidy of that reform effort, but to do so in the same manner that the rest of the Child Abuse Prevention and Treatment Act activities are funded -- through the regular authorization and appropriation process.

Having conferred with a number of victim advocacy organizations, I feel confident in saying that NOVA and others -- including child abuse-oriented groups -- would actively support such a plan.

Speaking personally, I would go further: should Congress sadly fail to act on this proposal this year -- when the Child Abuse Prevention and Treatment Act is up for reauthorization -- I would oppose a "counter-attack" on CJAA next year -- when it is VOCA's turn to be reauthorized.

Indeed, I would even be reluctant to abandon VOCA's funding of CJAA next year unless CJAA already had in hand both an authorization and a fair appropriation. Thus, I would hope that both will be enacted this year.

In expressing these views, I am plainly going beyond the policy guidance given to me by my board, and I am certainly unable to speak for our colleague organizations in the field of victim rights and services. But I should stress that my comments fairly reflect the spirit in which many of us are seeking to restore a program of helping Federal victims even as we seek to retain a new program to aid victims of child sexual abuse.

We are, in short, approaching this difficult problem in good faith. Though this subcommittee has little jurisdiction and perhaps less constituent interest in the plight of Federal victims, we trust that it too will act in good faith in resolving the problem that I have presented here -- a trust which we hope will be neither misunderstood nor misplaced.

In behalf of all those who share the painful, common bond of criminal victimization -- children and adults, men and women, and "state" and "Federal" victims alike -- I express my appreciation for this opportunity to urge the subcommittee to take the first step in correcting an unintended wrong by making a $3 million authorization for Children's Justice and Assistance Act activities in the Child Abuse Prevention and Treatment Act.

TESTIMONY OF THE NATIONAL COMMITTEE FOR ADOPTION BEFORE THE HOUSE SUBCOMMITTEE ON SELECT EDUCATION REGARDING THE 1987 REAUTHORIZATION OF THE ADOPTION OPPORTUNITIES ACT

On behalf of the entire membership and the Board of Directors of the National Committee For Adoption, we would like to thank Chairman Owens and the entire Subcommittee for this opportunity to provide written testimony on this very important program.

The National Committee For Adoption (NCFA) is the headquarters of a non-profit, voluntary movement to strengthen adoption and related services. NCFA was formed in 1980. Today we have over 130 voluntary sector adoption or maternity services agencies in membership; thus NCFA has more private, non-profit adoption agencies in membership than any other national, non-sectarian organization. These agencies work with all types of adoptions: infant, special needs, international. NCFA is also a national sponsor of the Council on Accreditation of Services for Families and Children, the major accrediting body for child welfare services, including adoption.

Title II of the Child Abuse Prevention and Treatment Act, the Adoption Opportunities Act, forms, along with Public Law 96-272, the linchpin of our federal policy towards children in out-of-home care and in need of adoption services. While we are hampered by a lack of complete data regarding these children, this linchpin appears to have been rather

successful. A 1977 national survey, for example, estimated that there were over 500,000 children in foster care in this country. By 1984, the Federal government estimated that this number was 270,000. Problems exist with this linchpin, as we shall discuss, but there is no question that Congress' commitment to these two programs has done much to protect American children.

There is now a need for even greater commitment. Among state social service administrators, representatives of private service providers, child advocates, researchers, etc., there is a general consensus that once again the number of children in foster care is rising. We have all heard the tragic tales of the "Boarder Babies", often healthy babies living in cribs with cages on the top in New York City hospitals because not enough foster and adoptive homes are available. The crisis in New York City though, must be seen as a symptom of a national problem. As the foster care population swells, agencies, both public and private, are struggling in an often overtaxed system to find permanent homes for these children. More and more children are coming into the system. It is expected that more and more children will be, or are already becoming, free for adoption and in need of adoptive families. Agencies and professionals working to provide homes for these children are facing tremendous barriers, not the least of which are inadequate funding of services. Given this current situation, we believe that it is time to authorize the Adoption Opportunities Act at a higher level than its current $5 million authorization. This program has been authorized at $5 million since its passage in 1978.

The Adoption Opportunities Act has often been described as the "glue" used to fix specific fractures in the Federal policy toward foster care and adoption services. The Adoption Opportunities Act is currently not being applied to at least two major fractures adequately: minority adoption and the provision of Post Legal Adoption Services.

In 1978, when this Act was passed, finding adoptive homes for waiting minority children was a major challenge facing the child welfare system. Today, it is still a major problem. The federal government estimates that there are 36,000 children legally free and waiting to be adopted in this country; other estimates go as high as 50,000 to 100,000. These children are disproportionately minority. The federal government estimates that 52% of these children are White, that 39% of these children are Black, that 4% are Hispanic, and that 5% are classified as "other".

Not only are minority children more likely to be in foster care waiting to be adopted, they are less likely to be moved into permanent adoptive homes. Federally funded research has found that the one characteristic most likely to result in a child continuing to wait to be adopted is minority status. Federally funded research that examined minority adoption in 1986, found that waiting minority children were less likely to have a disabling condition and were more likely to have fewer placements while in foster care. Yet, minority children were still found to wait twice as long on the average to be adopted when compared to nonminority children: two years as compared to one year. Furthermore, each year we seem to only be successful in finding

adoptive homes for approximately 40% of the waiting minority children. A national survey in 1977 estimated that homes were found for 37% of the waiting Black children. This survey estimated that homes were found for 54% of the waiting White children that year. In 1983, the Voluntary Cooperative Information System (operated by the American Public Welfare System) estimated that homes were again found for only 37% of the waiting Black children and only 42% of the waiting White children. A 1986 study conducted by WESTAT of eight representative sites around the country found that, in those sites, 47% of the waiting minority children were placed and 87% of the waiting nonminority children were placed in adoptive homes. Clearly the problem of finding homes for waiting minority children has remained a major concern for the 10 years since the enactment of the Adoption Opportunties Act.

We urge the Subcommittee to tackle this problem head on by authorizing sufficient funds earmarked to minority family recruitment and placement. Currently, most agencies, both public and private, are trying to address this problem with severely constrained resources. Federal funds are yet to be specifically targeted at this problem in a systematic way. The Discretionary Grants Program under the HHS Office of Human Development Services has funded some demonstration programs in this area. However, those demonstration programs specifically addressing minority adoption have not reached a sufficiently large segment of the affected population. We believe it is time for the Federal government to take an even greater lead in addressing this problem. We appreciate the fact that throwing money at a problem is often not the solution. However, in this situation, service providers,

lacking adequate funds, are unable to provide the intensive services necessary, in a great enough quantity. Private, non-profit adoption agencies, for example, often lose thousands of dollars when they do a special needs adoption placement because the purchase of service rate from the State does not accurately represent the actual costs of delivering services. Minority children, because they are disproportionately represented among waiting children, are disproportionately affected when a lack of funding resources prevents an agency from bringing all of the necessary resources to bear. Some agencies, for example, feel unable to serve as many waiting children as they believe they should because of this.

We also urge the Subcommittee to include a strong evalution component in this new section providing funds for minority recruitment and placement. As we've mentioned, there is a great lack of data regarding adoption in this country. We really do not know who these children are nor who adopts them. We do not know what types of programs work most effectively and efficiently to find homes for these children. The demonstration programs funded under the Discretionary Grants Program of OHDS do not have strong evaluation components. Without this kind of evaluation data, it is not possible for us to construct a system that is both effective and tax dollar efficient.

Attached to this testimony is an excerpt from a recent copy of National Adoption Reports, our bi-monthly newsletter. This is an article entitled "Despite Advances, Minority Children Lack Permanence." We ask that this be entered into the record along with this testimony.

The second service need we urge the Subcommittee to address regards Post Legal Adoption Services. Post Legal Adoption Services refers to those collection of services specifically tailored to families created by adoption. The field of adoption has progressed to the point where we recognize that, while adoption is simply another way to create a family and adoptive families and children are as "normal" as other families and children, there do exist issues unique to adoption. For some families, these issues may require professional services to allow resolution; or other issues that also require professional service may coalesce around those issues unique to adoption. Too often though, adoptive families find themselves with no services available or find themselves in a mental health system that lacks any understanding for adoption.

Federal policy towards children and adoption has always seen the goal as the maintenance of the family. The Adoption Opportunities Act has as its goal the provision of permanence for children; the natural outgrowth of this goal is the maintenance of families created by adoption. We see the goal of Post Legal Adoption Services as maintaining adoptive families. Good Post Legal Adoption Services are designed to make supports available for families so that they may maintain a positive family relationship. This applies to the situation where a family has adopted a child with special needs and is in need of ongoing services to help them c[illegible] with the child's acting out behaviors; this applies to the family who adopted a three-year-old, who as a toddler was involuntarily removed from an abusive home situation,

and is now, at age 17, dealing with issues revolving around separation; and this also applies to the family who adopted a child as an infant and now, 15 years later, is having difficulty dealing with very natural questions regarding the child's birthparents. We urge the Subcommittee to bring the Adoption Opportunities Act to the same state of evolution as the field of adoption by creating a new section funding demonstration programs for Post Legal Adoption Services. The goal of these programs should be maintaining families of adopted children aged up to 18 years. These demonstration programs would go a long way towards filling gaps in needed services.

We shall not discuss in too much depth the need for Post Legal Adoption Services, especially in the area of special needs adoptions. We know others providing testimony, both written and oral, will be providing the Subcommittee with this information. We would like to simply emphasize two points regarding this need. Post Legal Adoption Services must be seen as encompassing all forms of adoption -- healthy infant as well as special needs. This, we believe, is consistent with the purpose of the Adoption Opportunities Act, if the purpose is seen as providing positive adoption opportunities to all children. Secondly, it must be recognized that Post Legal Adoption Services that view adoption as simply another way of creating a family are the best services. Services that view adoption as pathological or inherently creating dysfunction are the worst services.

We do wish to discuss the need for Federal funding of these services. Lacking funds to help defray the costs of these services, many adoption

agencies are unable to provide these services. The result is that families may not be served by those that understand adoption the best -- adoption professionals. Instead, these families find themselves navigating a mental health system that does not understand the dynamics of adoption or, worse, views adoption as pathological in itself. We have heard tales of adoptive families who, lacking appropriate services, have sought help from community mental health service providers who were ill prepared to meet their unique needs. As a result some of these families have found themselves literally $30,000 to $40,000 in debt. And as a result, an issue that may have started out as relatively simple, has mushroomed into severe distress. Providing federal funds in the area of Post Legal Adoption Services will allow adoption agencies, both public and private, to develop responsible community services in this area of specialization. Unfortunately, other funding is simply not available -- not from State coffers and not from most health insurance.

The National Committee For Adoption looks forward to working with members of the Subcommittee on the reauthorization of the Adoption Opportunities Act. And we commend Congressman Owens and the other members of the Subcommittee for holding hearings on this very important program.

Despite Advances, Minority Children Lack Permanence

At a time when some want to legalize a new industry to create babies for would-be parents (see cover story), the field of adoption is facing a crisis in finding homes for the thousands of American children waiting to be adopted. The federal government puts this number at 36,000 children; other estimates range from 50,000 to 100,000. All agree these children are disproportionately Black children; the federal government believes that approximately 40% are Black, yet the entire U.S. population is only about 12% Black.

This current situation makes the federally funded research entitled *Adoption Services For Waiting Minority and Nonminority Children* (WESTAT, 1986) all the more timely. The research was limited by two factors: the survey covered eight representative sites rather than the entire country and some conclusions were made without adequate supportive data. Nonetheless, the study provides some very useful insights into the challenges posed in finding homes for minority youngsters at a time when most in the child welfare field admit to being largely unsuccessful.

Race A Major Factor

WESTAT found that minority children were less likely to be in adoptive placement than nonminority children. While two-thirds of the nonminority children had been placed (67%), only 47% of the minority children were in placement. Minority children were also found to wait longer for an adoptive placement. While 45% of the nonminority children waited less than 6 months, only 27% of the minority children did so. The average waiting time for nonminority children was one year while the average waiting time for minority children was found to be two years.

Perhaps the most disturbing finding of the study was that minority children waiting for adoption wait longer than nonminority children solely because of their minority status. WESTAT compared the waiting minority children and the waiting nonminority children in the sample on several characteristics. Minority and nonminority children did *not* differ in their age distribution, reason for entering foster care in the first place, or on whether the agency had made specific recruitment efforts on their behalf.

Differences were, however, found on three characteristics. Minority children were *less* likely to have a diagnosed disabling condition. Forty-one percent of the minority children had no disabling condition whereas 29% of the nonminority children had no disabling condition. Minority children tended to have *fewer* previous placements in foster care. And minority children were less likely to have an identified foster family as an adoption resource.

Characteristics that would be expected to result in the minority children being more likely candidates for adoption—fewer disabilities and fewer previous placements—did not have that effect. Rather, conclude the researchers, "the findings . . . indicate that minority status was a more powerful determinant of adoptive placement rates than any of the other child characteristics we examined" and that "[b]ecause they are relatively healthier as a group than nonminority children, the minority children should have some advantages in adoptive placement. The fact that they are less likely to be in placement despite this advantage makes their relatively low adoptive placement rate even more remarkable."

Suggested Solutions No Answer

WESTAT next examined efforts on the part of agencies to find minority families for minority children. Most efforts were not found to directly improve the adoptive status of waiting minority children specifically. Rather, some efforts were found to be indicative of a commitment on the part of the agency to place all children, minority and nonminority alike. For example, while the development of a family recruitment program was not found to improve the placement rate of minority children in relation to the placement rate of nonminority children, it was found to improve the placement rates of all children. Thus, it was shown that the problem of finding homes for the disproportionate amount of waiting minority children did not go away despite these specific agency efforts. It was shown though, that the fate of all children could be improved by virtue of an agency wide commitment.

First, WESTAT found the adoption rate for minority children was not affected by the size of the minority population in the agency's community. For example, of the seven sites studied on this variable, the agency with the least amount of potential minority parents per waiting minority child had a better minority adoption rate than the agency with the third highest amount—a 47% compared to a 41% minority adoption rate.

It has long been contended that the hiring of minority staff will significantly improve minority adoption rates. However, when WESTAT examined this variable, no relationship was found. For example, one agency's staff, with 11 percent minorities, had a 59% placement rate for both minority and nonminority children. A second agency's staff, with 60% minority workers, only had a 41% placement rate for minority children and a 67% placement rate for nonminority children. "We

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discovered that the percentage of minority staff did not have a consistent impact on the difference in adoptive placement rates between minority and nonminority children for individual agencies," the researchers wrote.

Critics of adoption agency practice have also maintained that agencies do not actively recruit minority families. This is not supported by the WESTAT research. In all eight sites there was a well developed recruitment program; some though, were found to have been in existence longer than others. The researchers looked at the effect of recruitment on reducing the differences between minority placement rates and nonminority placement rates. They concluded that recruitment was an effective tool: in agencies that had an established recruitment program, 58% of waiting children were in adoptive placements while in agencies that did not have an established program 47% were in adoptive placements. (While the researchers noted that all agencies had recruitment programs, they did not define how they determined which agencies had an "established" program and which did not.) The researchers did not, however, find that recruitment resulted in minority children being adopted as readily as nonminority children. "[W]hen looking at the effects of such agency practices as active recruitment programs," the researchers wrote, "... we found that these practices were related to an increased adoptive placement rate for all children, but did not in themselves help to overcome the disadvantage experienced by minority children."

Foster Parents Found To Be The Key

WESTAT did find what may be the key to placing minority children, or at least they found a variable necessary for further study and development. The availability of a foster parent resource was the factor that had the greatest effect upon a minority child's likelihood of being adopted. A foster family resource was defined as a foster family who is willing to adopt a child placed in their home.

When an agency had an active recruitment program *and* there was a foster family resource available for the child, the differences between minority and nonminority placement rates disappeared. In cases where both of these factors were in place 75% of nonminority children were in adoptive placement and 79% of minority children were in adoptive placement. While these specific findings are based on a total of only 30 children, they point to the need to further develop foster parents as adoptive resources. Of course, the optimism that this finding generates is somewhat tempered by the fact that WESTAT found minority children to be significantly less likely to have a foster care resource than nonminority children.

Agencies have also been criticized for supposedly screening out potential minority adoptive families by using so-called "middle-class" selection criteria. This criticism is not supported by this research. In fact, the study shows that agencies have been aggressively working to expand the pool of potential minority families.

For example, while only 14% of the nonminority adoptive families had family incomes below $20,000 per year, fully 50% of minority adoptive families had incomes less than $20,000. And 20% of the minority families had incomes below $10,000 per year. For comparison, the preliminary poverty level for 1986 for a family of four was an annual income of $11,200.

Forty-five percent of the fathers in the minority families were age 45 or over, with 14% age 61 or over. Only 19% of the nonminority adoptive fathers were age 45 or over and only 2% were age 61 or over.

Eighteen percent of all adoptive parents were single females or males. While WESTAT did not examine marital status by minority status, given that the data show that minority adoptive applicants are held to different criteria than nonminority applicants, it is likely that a greater percentage of minority adoptions were with single parents than is true for nonminority adoptions. Clearly, these data do not support the charge of biased, "middle-class" criteria being applied to minority applicants.

The Placement Gap

The concluding paragraph of the study shows that a gap of nearly 20% exists between minority and nonminority placement rates. The researchers write that the study "appears to have reemphasized earlier study findings that minority children wait longer to be placed in adoptive homes and are less likely to be in placement than nonminority children. In 1977, 37 percent of the minority children as compared to 54 percent of nonminority children free for adoption were in adoptive placements (Shyne and Schroeder, 1978). Both figures decreased in 1982 with 26 percent of the minority children and 39 percent of the nonminority free for adoption placed in adoptive homes (Maximus, 1983). This percentage did not include children placed with foster parents planning to adopt. In WESTAT's study of eight sites, 47 percent of the minority children as compared to 67 percent of the nonminority children free for adoption were in adoptive placements." WESTAT notes that its study was not based on a national sample, but the continuing and ominous disparity in placement rates, given the numbers of children currently in care and those expected to enter the system, should spur everyone to work even harder to remedy the situation.

—Jeffrey Rosenberg, MSW

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