



**Testimony to Special House Committee on Child Abuse and Neglect  
February 28, 2007**

Good Afternoon Madame Chair and Members of the Committee. I am Mary Anne Badaracco, MD, Immediate Past President of the Massachusetts Psychiatric Society, (MPS) representing over 1700 physicians from across the state. I am a Child and Adult Psychiatrist and the Chief of Psychiatry at the Beth Israel Deaconess Medical Center, and served as a member of the March 2006 Governor's Special Panel for the Review of the Haleigh Poutre Case. Much of my testimony today is very similar to the Conclusions and Recommendations of that Panel.

We are once again faced with the tragic outcome of a child treated by mental health professionals and monitored by a state agency who nevertheless died as a result of abuse and neglect. We are horribly saddened by this, determined to understand what happened, and focused on designing and implementing changes to assure a robust child welfare system that will reliably protect children in our care. Sadly, we cannot guarantee that no child in our care will ever again be beaten into a coma or die from abuse and neglect. We can certainly implement changes that will lessen the likelihood of that occurring. Were these changes in place, it is quite likely that neither Haleigh Poutre nor Rebecca Riley would have suffered as horribly or died.

Today I will focus on five specific recommendations to strengthen our child welfare system. None of these are new. We have had many panels and commissions with remarkably similar conclusions. It is now surely time to implement them.

A robust child welfare system must:

1. Ensure a clear focus on the **child** in the system.
2. Value the safety of the child above all other considerations.
3. Develop an actuarial-based risk assessment tool as an enhancement, not a substitute for, the clinical judgment of social workers and other professionals in the child welfare system.
4. Have timely access to expert child abuse teams, preferably based in pediatric hospitals, in all parts of the state.
5. Have timely access to psychiatric and other medical experts for individual, independent case review. Liability protection, fair compensation, and consistent funding must be assured. This is so critically important that MPS will focus on it in our FY '08 budget request and will make it a legislative priority for the coming year.

I will briefly comment on the first four recommendations as they are detailed in the report from the Governor's Special Panel. The final recommendation for access to psychiatric expertise is the most crucial and the most do-able. It requires immediate implementation.

**First**, a clear focus must be maintained on the **child** referred to the child welfare system. The file of every child in any child welfare system is full of countless abuse/neglect reports, medical records, family evaluations, educational assessments, and many recommendations. There is often minimal communication among those seeing the child. The child is lost in all these details. The multiple reports, records, and assessments must be pulled together to create a **unique** picture of **each** child at risk, outlining the child's specific strengths, weaknesses, and needs. This is a daunting task, but is absolutely essential if we are to maintain a clear focus on the **child** in the system.

**Second**, the safety of the child must be a priority. Working collaboratively with the family is obviously preferable to adversarial approaches, but it sometimes does not work. Decisions cannot be based exclusively on an a priori assumption that an intact family is better for every child in every family. The state's Division of Social Services (DSS) is aware of this, and is committed to balancing family approaches with a focus on child safety. MPS applauds this commitment and is aware that its implementation is extremely difficult and requires great skill and sensitivity.

**Third**, an actuarial-based risk assessment tool must be developed. The airline industry, hospitals and other high risk safety focused industries and professions have developed cutting edge innovations to identify high risk situations and minimize the errors in decision making and implementation. These systems use measurable indicators to determine situations in which particularly bad outcomes are likely to occur. DSS needs a risk assessment tool, a reliable way to determine whether a child is at low or high risk of serious harm. This tool would use medical knowledge of abuse and neglect to create categories of low, medium, and high risk. For example, certain types and patterns of injuries and fractures such as a spiral fracture of the arm, are associated with a high likelihood of abuse. Actuarial tools prompt the collection of specific data and its interpretation. They enhance rather than conflict with clinical judgment. They encourage, rather than diminish critical thinking. In fact, a clinician's "bad feeling" about a case is often one of the most powerful indicators of an eventual bad outcome. Expertise about these risk assessment tools exists and should be made available to DSS.

**Fourth**, DSS needs timely access to expert child abuse teams, preferably based in pediatric hospitals across the state. Much is known about child abuse and neglect, its patterns, its assessment, and its treatment. Unfortunately, this expertise is not readily available to assist DSS in its assessment of children at risk. DSS workers need access to child abuse and neglect teams on an immediate basis. Workers need to be able to pick up the phone, speak with a known colleague at a local hospital or other health care facility and ask how a particular behavior, injury, or reaction should be handled. We should ensure that all DSS workers across the state have access to this type of expertise, especially in areas outside Boston and Worcester.

**Fifth**, DSS must have timely often urgent access to psychiatric and other medical experts for independent case review. DSS has dedicated social work and other staff who are devoted to the care of children and families. They are trained in social work, but are not trained as nurses or physicians, and so cannot make medical diagnoses, assess medication, or recommend medical treatments. Currently, DSS workers are limited to accepting the reports of the treating physicians and other clinicians. When they question medical treatment and judgment, they cannot escalate their concern to independent medical experts. Massachusetts has some of the best hospitals and best psychiatric and other medical training programs in the world. There is no excuse for us to deprive our children from this medical and psychiatric expertise. When a DSS worker questions a child's assessment, diagnosis and treatment plan, including medications, that worker should be able to escalate the case to an independent expert physician review including an interview of the child if necessary. We can do this. We need to assure adequate and fair compensation for the consulting physician's time, along with liability protection. Whatever funding mechanism is designed must be consistent. It cannot be buffeted by the vagaries of changing administrations and politics. Independent expert psychiatric and medical consultation must be made available and must be made available **now** before another child suffers irreparable harm or death because we did not have the courage and will to implement this.

Massachusetts trains psychiatrists and other physicians whose experience and expertise alleviates suffering around the globe. We can certainly figure out a way to alleviate suffering in our own back yard.