COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

THE DISSENTING REPORT OF THE HONORABLE JUDGE PATRICIA M. MARTIN CECANF COMMISSIONER

MARCH 14, 2016

THE DISSENTING REPORT
of
The Honorable Judge Patricia M. Martin
Commissioner

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PREFACE - The Call for A Minority Report

In early 2014, The Commission to Eliminate Child Abuse and Neglect Fatalities met for the first time. We were equipped with substantial resources and a clear charge from the President and Congress. We met to begin a process that would examine the state of affairs surrounding prevention of child abuse and neglect fatalities. It was my hope that this Commission would be able to gather and to process information and to develop a plan to make a sound attempt to eliminate child abuse and neglect fatalities. Two years and $4 million later, the Commission has produced a Consenting Report that, on the whole, has failed to realize those hopes or to fulfill the Commission's charge.

$4 Million of Testimony and 30% of Child Fatalities Ignored

The Commission spent a considerable portion of its $4 million budget (money diverted from Temporary Aid to Needy Families) to hold numerous **optional** hearings around the country.[1] The purpose of these optional hearings was to hear from expert witnesses. Yet, the Consenting Report either misrepresents or ignores those same experts. For example, the Consenting Commissioners recommend immediate implementation of "predictive analytics." First, predictive analytics needs further testing and requires the building of a solid data infrastructure in order to work. Second, the expert testimony emphasized the inherent limitations of predictive analytics.

> *"So I couldn't agree more and I think that we would be mistaken to think about predictive risk modeling, or predictive analytics, as a tool we would want to employ with that end outcome specifically being a near fatality or a fatality, because I don't think, I mean this is something we can answer empirically but I don't think we will ever have the data or be able to predict with an accuracy that any of us would feel comfortable with and intervene differently on that basis."*

-CECANF Florida Transcript page 26– Emily Hornestein

"The Surge"

Another example of this practice of selective citation and arbitrary creation is demonstrated in Chapter 2 of the Consenting Report by the inclusion of Recommendation 2.1 (originally known as "The Surge" now known in the voted upon report as "Support states in improving current CPS practice and intersection with other systems through a two-year multidisciplinary action to protect and learn from children most at risk of maltreatment fatalities"). Not one witness

[1] Another major expenditure was the Commission's staff of twenty people.

recommended nor intimated such an approach to eliminate fatalities. Instead, Commission leadership unilaterally decided to include it as a "signature recommendation." More troubling is that this recommendation encourages foster care placements despite expertise and research that demonstrates that the better path for our children is providing services in home.[2]

While purporting to "save lives immediately," this signature recommendation corrupts the Consenting Report.[3] The Commission declares, "*Unless these steps are taken by the Administration and Congress, the Commission believes the same number of children will continue to die each year from child maltreatment fatalities. They are essential to reduce the number of fatalities that will otherwise occur this year and next if we fail to act.*"[4] The Consenting Report reads like a tabloid or infomercial relying on sensationalism to convince Congress and the Administration to eschew their good sense and spend an additional $1 billion annually on this recommendation.[5] This Commissioner opposed recommending new funding recognizing that such funding viability discussions are inherently a matter for Congress to address through its able skill and its use of the Congressional Budget Office (CBO). Moreover, there is no single nor one size fits all solution to CAN fatalities. Consequently, if Congress decides to increase funding, this Commissioner recommends allocating that funding across the numerous recommendations in the Consenting Report.

Reorganizing the Federal Government

The Consenting Commissioners believe, devoid of any supporting testimony or evidence of

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[2] Development and Psychopathology 18 ~2006, 57–76, http://www.kidscounsel.org/Study%20Impact%20of%20Foster%20Care%20on%20Child%20Dev.pdf. Child Protection and Child Outcomes: Measuring the Effects of Foster Care Forthcoming, American Economic Review Joseph J. Doyle, Jr.* MIT Sloan School of Management & NBER. http://www.mit.edu/~jjdoyle/doyle_fosterlt_march07_aer.pdf

[3] Transcripts of deliberations, internal communications, and the Consenting Report itself show that recommendations of this ilk and under this ambit were developed with the intent of removing children without due process.

[4] These and conforming recommendations are interspersed throughout the Consenting Report tainting it with an underlying theme of exaggeration and misrepresentation that presumes the reader's naiveté.

[5] For example, in an attempt to convince the reader of the efficacy of surge like activities in preventing CAN fatalities, the Consenting Report cites the states of Wyoming and Oklahoma as currently implementing its recommendation 6.2c (NOTE: This recommendation proposes to sequester CAPTA funds). However, taken at face value, this belies their argument inasmuch as both Wyoming and Oklahoma have increases in child maltreatment victimization. From 2010-2014, Wyoming increased 18.8% and Oklahoma increased 82.9%. Furthermore, between 2014 and 2015, CAN deaths in Oklahoma went from 34 to 60 (an increase of 57%). Child Maltreatment 2014, Tables 3-3 and 4-2. Oklahoma Child Death Review Board 2015 Recommendations, https://www.ok.gov/occy/documents/Oklahoma%20Child%20Death%20Review%20Board%202015%20Recommendations.pdf.

potential effectiveness, the answer to a failed system is to expand and/or restructure the federal government. According to Recommendation 5.1 in the Consenting Report, this would be accomplished through "Elevate[ing] the Children's Bureau to report directly to the Secretary of the U.S. Department of Health and Human Services (HHS)" and moving the Maternal and Child Health Bureau (MCHB) to the newly elevated Children's Bureau. MCHB is currently housed within the Health Resources and Services Administration (HRSA). Moving MCHB would make sense if HRSA did not exist to provide services as its name suggests. Furthermore, this new placement proposal was introduced for the first time within the last hour of the last phone deliberation - pointing to process problems. Therefore, it was never fully explored as to why this return to a 1969 (H.E.W.[6]) structure would prevent CAN fatalities today. In addition, the consenting Commissioners then wish to expand government in order to memorialize this commission by creating a "Coordinating Council" to be housed in the newly elevated Children's Bureau. Interagency coordination is a necessary step to better service provision and policy creation for preventing CAN fatalities. However, coordination should not require complete reorganization.

If the aforementioned were not enough, the consenting Commissioners suggest in Recommendation 5.1c that the Domestic Policy Council be expanded to include a duplicative position to handle child welfare and family matters across the administration.

Children 5-18

Tragically, the consenting Commissioners were content to ignore preventing fatalities for 30% of the population it was statutorily charged to study – children 5-18. In fact, the only mention of this population occurred when the Consenting Commissioners allowed for a special examination of Native American children; however, the Consenting Commissioners deleted the relevant narrative leaving the recommendation pertaining to this age group without context in the Consenting Report.

The transcripts and Consenting Report reflect that the Consenting Commissioners refused to regard the testimony of experts on Native American children and minority disproportionality of the same importance as those testifying regarding non-minority issues. This perhaps explains why the Consenting Commissioners relegated over half of the recommendations on these children to inappropriate chapters or to the obscurity of Appendix G. In short, for the most part, and especially when dealing with matters of disproportionately affected segments of children, i.e., poor whites, Native Americans, and African Americans, the consenting Commissioners

[6] HEW was the acronym for the Health Education and Welfare Department which preceded the creation of HHS.

balked at the tough questions necessary to eliminate child abuse and neglect fatalities.

A Flawed Process

The Consenting Report reflects that the Commission had no effective process for deliberations. The questionable practice of endorsing organizations rather than methodologies throughout the Consenting Report diminishes the seriousness of any recommendations associated with such promotions. Consequently, the Consenting Report reads both as a failure to fulfill the charge articulated in the governing legislation (The Protect Our Kids Act), and as an inappropriate advertisement of programs. Any disclaimers in the footnotes of the Consenting Report related to endorsements are more of an admission of the existence of rather than an attempt to remove the appearance of impropriety.

The unorthodox process for editing the Consenting Report raises serious concerns. Commissioners have been allowed to submit changes and additional materials after the final vote. Those changes were incorporated into the Consenting Report without being seen, deliberated, or voted upon by the entire Commission. Moreover, the final report incorporating those changes was not released to this Commissioner prior to submission for printing. A simple comparison of the voted upon draft and the final report reflects substantive changes. Thus, the full Commission was deprived of information to perform its duties and/or select commissioners were granted favor to privately shape the report devoid of deliberation. For example, Recommendation 6.2a of the Consenting Report could be viewed with suspicion because the entire corresponding discussion regarding military children and El Paso County CPS was never presented in the voting draft copy of the report. The value of the military paradigm for determining child abuse and neglect is self-evident, but its after-the-vote inclusion elucidates the flawed process. This practice was repeated in association with Recommendations 5.3. Therefore, it is this Commissioner's position that the validity of the Consenting Report must be viewed with trepidation.

Finally, the independent submission of this Dissenting Report is yet another reflection of the flawed process. As the reader may be aware, there were two dissenting commissioners. The process was structured such that the opinions of individual commissioners were limited to two page letters to be printed with the Consenting Report. No commitment was made for dissenting opinions. Instead, the Chairman of the Commission stated that he would review dissents and then decide unilaterally whether to exclude the dissent, to edit the dissent, or to include the dissent without alteration in the Commission's official submission to the President and Congress. As a result, this Commissioner chose to submit the two page letter and to absorb personally the costs of printing and distributing this official document.

THE DISSENTING REPORT

Introduction

In light of the previously raised concerns, this Dissenting Report has been constructed to give the President and Congress a valid perspective of the Commission's work. The following recommendations seek to give the reader a more robust view of the expert testimony and recommendations received, as well as any logical conclusions arrived at from those expert testimonies and recommendations.

Through a systematic evaluation of individual professional observations, research reports, as well as the expert and practical testimony heard throughout 11 separate hearings in different parts of the country, certain conclusions can be reached as to what are the next steps in eliminating child abuse and neglect fatalities. This report captures those conclusions and proffers 19 applicable recommendations to create a clear national strategy for combating CAN fatalities. The National Strategy discussed herein offers The Administration and Congress an alternative to the draconian "Surge" based national strategy and conforming recommendations made in the Consenting report.

Creating An Effective National Strategy

The methodology employed in creating a national strategy should be based in a philosophy of simplicity and common sense. Not to diminish any of the expertise that is relied upon to develop the recommendations in this report, but child welfare and child protection must first be implemented within the context of human behavior. Community elements such as culture and demographics are the foundation for how human behavior is exhibited throughout the world. Research is then applied to those elements which influence human behavior to develop methodologies to further refine human behavior.

As elementary as it may seem, to create a national strategy, it should not be dismissed that:

- In order to prevent child abuse and neglect fatalities, preventing child abuse and neglect is essential.
- Measuring what has happened is necessary to analyze and improve the situation. Thus, child abuse and child neglect must be universally defined and applied in order to accurately

measure progress in the prevention of child abuse and neglect fatalities.

- Child abuse and neglect fatalities involve child maltreatment; thus, one could conclude that efforts which reduce child maltreatment probably will have some effectiveness in reducing child abuse and neglect fatalities.
- Near fatalities due to child abuse and neglect are probably reliable predictors of impending child abuse and neglect fatalities. The difference between a near fatality and an actual fatality quite often can be reduced to medical intervention. Thus, to develop the most effective child abuse and neglect fatalities prevention model, it is essential to examine the mitigating and underlying circumstances of near fatalities due to child abuse and neglect.
- Being able to conclusively predict human behavior with 100% accuracy is impossible; yet, recurring circumstances resulting in the same outcomes establish a pattern not to be ignored.
- Where research, strengthened by empirical data, meets common sense approaches, may be the starting point for efforts aimed at innovation in human behavior modification and eliminating child abuse and neglect fatalities.
- The fact that we don't have enough data is critical. We need to build an infrastructure for using predictive analytics appropriately. Experts agree that currently, predictive analytics is not a viable tool for child protection. Nonetheless, a true 21st century approach is one that fills the data gaps, promotes data sharing, and builds a proactive system from that data exchange.

Statistics show, in 29 reporting states, that only 12.2 % of the CAN fatalities were known to CPS in the prior 5 years immediately preceding the deaths. Extrapolated, that would suggest that 88.8% of those CAN deaths were of children never reported to CPS[7]. This fact points out the greatest deficiency with ensuring our kids' safety through our current child welfare approach – no effective monitoring of our children's well-being before abuse and neglect occurs. The system must be reformed with Primary Prevention Strategies.

Enhance Protective Factors Before Abuse Occurs – Primary Prevention Strategies

The current Child Welfare System is not designed to prevent child abuse and neglect fatalities. Instead, a closer look would suggest that at best, it is designed, through Child Protective Services, to react to abuse and neglect that too often results in a child fatality. The current system ostensibly seeks reunification as the ultimate goal of any removal, though, ironically, it seldom focuses on enhancing protective factors. Hence, the Child Welfare System in our

[7] Child Maltreatment Report 2014 at page 56

country is reactive and somewhat ineffective in the prevention of child abuse and neglect fatalities.

Policy changes to attempt improvement upon the system may occur when a CAN death receives high publicity. However, in its current state, child protection efforts generally do not occur until after abuse or neglect is suspected and, in many cases, has already occurred. Depending on the severity of the abuse or neglect, child protection is a moot issue because of a fatality. In short, the current Child Welfare System has no primary prevention function; it is designed to reactively manage family crises.

Yet, it is impractical and socially dangerous to dismantle the current CPS structure. However, the Commission heard key testimony that suggested elements which could give the system a preventive light and reform the Child Welfare System to include a primary prevention approach to child abuse and neglect. Those elements include reducing poverty, home visiting, addressing disparities, implementing coordinated multi-disciplinary efforts, data sharing, and continued effective data collection on CAN fatalities and near fatalities. Therefore, if the current approach is modified by including these preventive strategies, a deliberate reduction of child abuse and neglect fatalities becomes attainable.

Definitions

In order to create a national strategy to eliminate CAN fatalities, all stakeholders must be speaking the same language. Varying definitions of what is and what is not child abuse or neglect may be one of the greatest hindrances to effectively combating abuse and neglect. Without universal definitions that apply across the board, measurements and data collection will continue to suffer thereby negatively impacting secondary prevention efforts and innovations.

At the Federal level, the Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as:

> *"Any recent act or failure to act on the part of a parent or caretaker, which results in death, serious physical or emotional harm, sexual abuse, or exploitation, or an act or failure to act which presents an imminent risk of serious harm"*

States and their agencies have developed definitions of their own to conform to this definition. However, given the serious nature of CAN fatalities, more uniformity is needed. Therefore the following recommendations are proffered:

RECOMMENDATION 1.1: Congress, in partnership with the Administration and State Child Welfare Directors, should develop a more thorough and universally agreed upon definition(s) of child abuse and child neglect to be included in the next CAPTA reauthorization.

Data Collection

Current data on CAN deaths is inaccurate. This inaccuracy occurs, if for no other reason, states are not required to report them to the National Child Abuse and Neglect Data System (NCANDS). Reporting is voluntary although through CAPTA, funding is directly tied to submission of data to NCANDS. The Protect our Kids Act anticipated that the Commission would develop a recommendation to address the lack of available data to make an accurate count of CAN fatalities. In 2014, only 29 states reported CAN fatality data through NCANDS.[8]

Too often, interagency sharing of CAN within states is difficult because of confidentiality concerns. The problem is further complicated when that same information needs be shared across state lines.

As well, some states have "birth match" programs. These programs make it mandatory for hospitals to report births of children born to parents who have a previous termination of parental rights (TPO). The result is that services for these families begin immediately. This is a good example of a coordinated multi-disciplinary response where no abuse has occurred; however, the prevention begins immediately.

Because we know that a prior report to CPS, regardless of its disposition, is the single strongest predictor of a child's potential risk for injury death (intentional or unintentional) before age 5[9], we can ill afford not to embrace birth matching. This practice can be further developed to screen not only for risk factors but to confirm protective factors thereby ensuring a comprehensive safety assessment on behalf of children and families.

RECOMMENDATION 2.1: Congress should require that all states report CAN deaths to NCANDS.

RECOMMENDATION 3.1: Congress, in consultation with the Administration and State Child Welfare Directors should develop a universally agreed upon data sharing plan that would allow real time risk and protective factor assessment of children beginning at birth to be included in the next CAPTA reauthorization.

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[8] Maltreatment Report 2014, page 56
[9] See Testimony of Emily Putnam-Hornestein, CECANF Tampa Hearing

Multidisciplinary Coordination

The current child welfare system has many components. The world of CPS is just one part of that system. While CPS is the reactive part of child welfare, it should be looked to as the secondary prevention layer. The primary layer of prevention must occur before abuse or neglect occurs.

Other players in the child welfare system include law enforcement, clergy, courts and the medical profession. However, the current paradigm lacks consistent coordination between these entities. Still, in order for the primary prevention of child abuse and neglect to occur, coordination is critical.

As with birth matching the medical profession is coordinating with CPS through data sharing, so much more can be accomplished on both the primary prevention and secondary prevention levels if more child welfare partners simply share the relevant data.

Home Visiting

Over the past 25 years, several reports have been published around CAN deaths and child welfare in general with the hopes of preventing child abuse and neglect. Governmental and non-governmental organizations independently study the subject matters and made recommendations. The Commission was provided a compendium of the recommendations from 25 reports since 1990, highlighting the 5 foremost of those reports, and citing the top 25 child welfare recommendations.

It was determined that the recommendation most elucidated of the foremost reports was that home visiting be made available for all families[10]. Unfortunately, home visiting for all families is not available. However, where home visiting is available, there seems to be evidence that it is an effective preventive child abuse and neglect strategy[11]. Testimony from the Commission hearings echoed these facts.

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[10] Moving the Marker Forward 2015, Table 2 at page 7.
[11] Avellar, S., Paulsell, D., Sama-Miller, E., Del Grosso, P., Akers, L., & Kleinman, R. (2015). Home visiting evidence of effectiveness review: Executive summary. Office of Planning, Research and Evaluation, Administration for Children and Families, U.S. Department of Health and Human Services. Washington, DC. Retrieved from http://homvee.acf.hhs.gov/HomVEE_Executive_Summary_2015.pdf

ONE SIZE DOES NOT FIT ALL

"Many researchers believe that discussions of race obscure the true contributing factor poverty, which affects roughly one in two American Indians and one in three African American and Hispanic families, but only one in nine white or Asian families (American Almanac Statistical Abstract of the United States, 1994)…Others have suggested to this Board that the problem is not poverty, but psychological stress caused by dealing with limited opportunities and the effects of racism. These important questions remain unanswered."

A Nation's Shame 1995

American Indian/Alaska Native Children

The Commission formed the American Indian/Alaska Native (AI/AN) subcommittee to examine child fatalities in Indian Country. Although it is widely known that data from the tribes is not always widely available, according to 2011-2013 NCANDs data, the rate of AI/AN child abuse and neglect fatality victims was nearly two times the rate of white children and, per 2014 NCANDS data, AI/AN children represented child abuse and neglect or maltreatment victims at a rate of one-and-a-half times that of white children.

The overarching theme from the testimony across the multiple Commission meetings was that child abuse and neglect fatalities of AI/AN children can be properly addressed only when tribal nations take responsibility and are allowed to take responsibility for their children. This can be achieved only as the U.S. federal system acknowledges and participates with Indian Country under a paradigm that views each individual tribe as a sovereign nation.

Specifically, the federal response to the question of child fatalities in Indian Country must accept the U.S. government's own description of Native American tribal nations as "domestic dependent [sovereign] nations within our borders." Therefore, the U.S. government is bound to operate with the tribes under the principle of a trust relationship. In addition, the federal government has a "duty to protect" the tribes, implying the necessary legislative and executive authorities to effect that protection. Further implied is the federal government's debt of care to these sovereign nations based on history and treaty.

Special attention must be paid to child fatalities due to abuse and neglect in Indian Country because of a particular and unique paradigm. In Indian Country, child abuse and neglect fatalities are not relegated to an examination of one age group of children, but considers all of the age groups. Thus, when speaking of child abuse and neglect fatalities in Indian Country, equal urgency is made regarding infants dying and teen suicides resulting from abuse and neglect.

Therefore, the recommendations to prevent child abuse and neglect fatalities must encompass strategies to address children from 0-18 years of age.

Throughout testimony during CECANF meetings in Burlington, VT, and Denver, CO, as well as a meeting dedicated to discussing tribal considerations in Scottsdale, AZ, the Commission heard from a wide range of speakers about the specific challenges in preventing child abuse and neglect fatalities including:

- Data Deficiency - the lack of data and data systems within many tribes to track key data around child abuse and neglect and child abuse and neglect fatalities.
- Jurisdictional Navigation - the multiple jurisdictional challenges when a child abuse and neglect fatality of an AI/AN child occurs on tribal lands and on nontribal lands.
- Inadequate Accessibility and/or Availability to Funding and Services - the numerous challenges that continue to persist around tribes being able to remain sovereign and at the same time access funding, training and technical assistance, and developmental opportunities that will promote parity between tribal child protection/child welfare agencies and state child protection/child welfare agencies.
- Impact of Historical Trauma and Poverty – Historically, AI/AN children have been exposed to the negative impact of colonization. Erosion of culture and a continued misrepresentation of tribal communities have traumatized generations of AI/AN children resulting in a cycle of hopelessness, thereby fostering generational exposure of children to violence (including exploitation and trafficking) and elevated substance abuse challenges in Indian Country. With few exceptions, AI/AN children experience poverty at an alarming rate. This poverty is one of the factors contributing to an environment wherein crises associated with child abuse and neglect fatalities are catalyzed.

The positive side of those challenges highlighted by speakers is the resiliency of the clan and family structures within tribes to maintain their sovereign tribal communities. Of great importance is the notion that the tribe is one family and that well-being of all the children is the responsibility of the family – the tribe. It is with that lens that several examples of work within specific tribes were highlighted through testimony. The following example stood out as sustainable and potentially effective in mainstream systems:

> **Eastern Band of Cherokee Indians' Multisystem Collaboration Example:** The Eastern Band of Cherokee Indians has developed a multi-jurisdictional, multi-agency,

and multidisciplinary approach to child protection built on common goals and a common language across all systems and jurisdictions involved. This multisystem collaboration has focused on services and accountability, using a results-based accountability framework to measure and monitor progress and areas for continued development.

The Eastern Band also has developed an integrated child welfare team that has child protection, foster care, case managers, and behavioral health staff all working in one central place to promote teaming in working with families. To enhance that work, the Eastern Band is also leveraging Medicaid dollars to free up other resources to provide more in-home supports to families.

The Commission has set out to develop a set of recommendations around the needs of AI/AN children that (1) aligns with the CECANF National Strategy, (2) promotes an actionable and focused approach to address clearly identified challenges, and (3) develops an improved set of conditions in how tribes, states, and the federal government work together around the investigation, reduction, and prevention of child abuse and neglect fatalities.

Data Deficiency

Effective leadership and accountability in this area can be demonstrated when tribes, states, and the federal government recognize the sovereignty of tribes and the shared interests among tribes, states, and the federal government to protect all children both on tribal and nontribal lands and to ensure that families have the supports they need. Tribes, states, and the federal government should have a common goal for sharing data across tribal and state child protection/child welfare systems that would be supported by the provision of resources and support for a data infrastructure to help tribes collect and provide needed data.

Fatality data collected in tribal lands is woefully inadequate. Accordingly, a common refrain from those tasked with assessing deaths among Native American children is that "we don't know what we don't know because we don't have the data". Too often, critical yet generally easy to ascertain information related to child deaths simply is not recorded. For example, while the Bureau of Indian Affairs records deaths in Indian Country, there reporting instruments have no delineation of whether a death is a child or an adult. This data deficiency can be relieved by adopting the following steps:

RECOMMENDATION 4.1: Congress and the Administration should mandate that the Bureau

of Indian Affairs (BIA), at a minimum, immediately implement the practice of distinguishing child and adult homicide victims when reporting fatalities in Indian Country.

RECOMMENDATION 5.1: Congress and the Executive Branch should require the FBI to identify key data that tribes could track and that the BIA could collect. At a minimum, the FBI should ask BIA to use the National Incident-Based Reporting System (NIBRS) or request that BIA provide more detailed child-specific information. BIA and FBI data collection about AI/AN children and child fatalities should be coordinated to be complementary and comprehensive.

Jurisdictional Navigation

The notion that there must be a collective responsibility for safety in order to curtail the death of children in Indian Country is critical. No one side of the sovereign nations involved in this undertaking, be it the federal government, states, or a tribe, is able to adequately overcome the jurisdictional hurdles that continue to bar proper prevention and intervention strategies.

In most tribal lands and states, jurisdiction in child welfare and fatalities becomes a conundrum. Often, discrepancy arises as to which agencies and courts should intervene and adjudicate cases involving children without regard to tribal standing. As well, cases against perpetrators are often mishandled under the color of jurisdictional uncertainty, especially if they are non-Indian. However, this Commission received testimony from Indian Country where deliberate cooperation between tribes, states, and the federal government has been effectuated. The Eastern Band of Cherokees has been able to hammer out working relationships across jurisdictional lines in a multi-disciplinary paradigm which appears to be effective in combating child abuse and neglect fatalities. Therefore, we believe that further success can occur for all tribes by taking the following steps.

RECOMMENDATION 6.1: Increase reporting upfront to the Bureau of Indian Affairs (BIA) on tribal and state child welfare cases involving AI/AN children.

RECOMMENDATION 7.1: Congress should mandate the provision of training and technical assistance for tribes around collecting data and building data systems.

RECOMMENDATION 8.1: Federal policy should provide incentives for states and tribes to increase participation and deputation agreements and other recognition agreements between state and federal law enforcement agencies.

RECOMMENDATION 9.1: Coordination between and among jurisdictions should be mandated, facilitated, and incentivized.

RECOMMENDATION 10.1: The federal government should mandate the recognition of

tribal criminal jurisdiction in Indian Country in cases of child abuse and neglect, regardless of the perpetrator's race and/or ethnicity.

Impact of Historical Trauma and Poverty

Throughout the Commission's work, it has been well established that the historical trauma associated with the displacement of American Indians and Alaska Natives has resulted in high incidence of teen suicide, depression, disproportionate substance abuse, human trafficking and domestic violence on tribal lands. As well, this cadre of social epidemics has ravaged the fiber and stability of Indian youth. Efforts must be made to restore a positive self-awareness in Indian Country, especially among American Indian and Native Alaskan youth, in order to curtail the incidence of child abuse and neglect fatalities, including suicide.

The impact of historical trauma and poverty cannot be overstated. Yet, amongst Alaska Natives and in the Navajo nation, when cultural approaches have been utilized, and children have been reintroduced to their native culture, reductions in suicide and violence in general has been noticed.

Cultural considerations are very critical in Tribal lands. Traditional ceremonies, multi-shift employment and upward mobility efforts are too often overlooked when examining funding and service provision for tribal lands. Many times, service provision does not correspond with tribal members' ability to access the services because of cultural constraints. It is critical that the paradigm elevate these considerations to ensure the best possible approach to child welfare is provided in preventing child abuse and neglect fatalities.

Simply stated, the services must fit within a framework that is culturally appropriate for tribes. Assistance given to the tribes is unlike assistance given to states or to other countries. Assistance given to tribes are based on a duty of care and already existing treaties yet to be fully honored in spirit or letter. There is a federal duty to intervene on behalf of tribes with respect to child welfare and safety. One of the foremost demonstrations that the federal government can display is to commit to the revitalization of Native American culture to preserve the lives of children in Indian Country. To do so:

RECOMMENDATION 11.1: Congress and the Administration should address the ability within tribes to support child/family/tribal access to needed services, supports, early literacy services, home visiting, and education by, at a minimum, promoting access to services, supports and education outside of the standard 9 a.m. to 5 p.m. service hours.

RECOMMENDATION 12.1: Congress and the Administration should explore the

development and implementation of educational curricula connecting youth to their cultural traditions, particularly around native language renewal and positively presented Native American history, to be used at all levels of pre-collegiate education.

RECOMMENDATION 13.1: Congress and the Administration should mandate the implementation of service approaches that prioritize keeping children within their tribes as a primary alternative to out-of-home placement.

RECOMMENDATION 14.1: Conduct longitudinal research about the leading factors related to child abuse and neglect fatalities of AI/AN children, 18 and under. It may be possible to integrate a longitudinal research component in the Tiwahe Initiative (a partnership between HHS, DOJ, and DOI) currently being piloted in four tribes.

RECOMMENDATION 15.1: The federal government should promote and facilitate peer-to-peer connections around examples of well-formed efforts focused on AI/AN children and families.

> *"One mystifying issue is the large overrepresentation of African American families in known child abuse and neglect fatalities, which is twice or three times the rate seen in other racial groups. The data show a dramatic overrepresentation of African Americans in fatal abuse and neglect deaths, but there has been almost no study to understand this issue. Yet the numbers should deeply concern policymakers and the public: one study showed the homicide rate of African American infants studied over a 10-year period to be 25 per 100,000. This approaches the rate of violent death for African Americans (39 per 100,000), which, in contrast, is a widely discussed area of concern (Levine et al, 1994; Levine et a), 1995)."*

A Nation's Shame 1995

Disproportionality

Child abuse and neglect fatality data available through NCANDS tell us that while African American children are approximately 15 percent of the child population nationally, they are 33 percent of the child abuse and neglect fatalities, which is approximately three times greater than white children (NCANDS 2014).

Over twenty years ago, the federal government commissioned the U. S. Advisory Board on Child Abuse and Neglect to produce a report about the state of child welfare in our country. The board found then that there was a glaring overrepresentation of African Americans in fatal abuse and neglect deaths with almost no study to understand the issue. That glaring overrepresentation still

remains. While research in this area has not flourished, we are now better able to understand some of the nuances that perpetuate disproportionality. As well, we are able to observe practices that may combat disparities.

> *"I think we need to look at abusive head trauma and why it is according to much of the research that abusive head trauma cases are misdiagnosed for white kids. I think that suggests that we really need to go back in and look at that data and it is possible that implicit bias could be contributing to that misdiagnosis of abusive head trauma with regard to white kids and that might give us information that will allow us to move forward."*
>
> Dr. Rita Cameron Wedding
> CECANF Testimony – New York

It could be that disproportionality is a double edged sword that directly disparately treats African Americans while inadvertently depriving Whites of proper assessments and diagnoses. Accordingly, the subcommittee studied disproportionality with this in mind and formed its recommendations with the intent that its recommendations would aid in the prevention of fatalities for children of every ethnicity and race in the United States.

The effect of disproportionality and disparities in the child abuse and neglect fatalities cannot be understated with regards to the impact on the affected communities. It is conceivable that such loss in the minority community may contribute to a cycle that ravages families, decimates neighborhoods, increases poverty, and produces an overall environment of hopelessness due to an overload of negative and/or unfair interaction with the child welfare system. As a result, mistrust of the system becomes established in the community disposition. Child abuse and neglect increases or goes unattended. Children in minority communities die at a disproportionate rate.

Attention must be given to the root causes of what can appear to be a systemic problem stemming from historically disparate treatment of minorities. It is undeniable that equality in other civil areas including education and criminal justice for minorities lags in progress. It is likely that such a systemic tragedy further spurs predisposition in the attitudes of players in the child protection systems. Law enforcement, courts, social workers and medical professionals alike often times demonstrate what can be characterized as bias when interacting with the minority community.

As the Commissioners heard testimony, discussions focused on some of the challenges to

combating the disproportionate number of child abuse and neglect fatalities in minority communities:

- Data Sharing and Assessing Risk – Disproportionality typically reaches the African-American community in more than one social context, although much information is available that can be utilized to produce the best health outcomes in the community. However, how risk is assessed in minority communities does not mirror non-minority risk assessments. This is largely due to implicit bias and a lack of cultural competence. Too often data from law enforcement, health, education, and other social services organizations and/or programs are unfairly presented and produce a climate that reduces the allocation of resources and services to disadvantaged communities and produces community distrust of the child protective system resulting in a concerted effort to avoid usage of the social services system by the community.
- The Impact of Racism – The impact of racism cannot be underestimated. Although racism remains a difficult subject to discuss, it is critical to understand that it is the basis for implicit bias. Implicit bias can impact decision-making related to minority children being overrepresented and possibly other children being underrepresented in the child welfare system. For example, it has been established that when an African American child is seen for a head injury in the emergency room, a CT scan is the protocol at a much higher rate than for a Caucasian child presenting the same symptomology. Thus, corresponding data would suggest a need to overcompensate intervention and prevention efforts when observing African American children and undercompensate when observing Caucasian children.
- Poverty – Minorities experience poverty at an elevated rate. Elevated poverty is one of the factors contributing to an environment wherein crises associated with child abuse and neglect fatalities are catalyzed. The formula for continued disparity in minority communities is a platform that consists of a lack of quality services, and a social services workforce that is often hamstrung with implicit bias, cultural incompetency, and improper data interpretation being imposed upon an economically disadvantaged community. Moreover, in concert with such an untenable platform available in impoverished communities, an escalation of trauma due to avoidance of the system perceived to be inadequate and unfair becomes the culture of that community, thereby disproportionately raising the documented incidents of child abuse and neglect fatalities.

Fortunately, the Commission had the opportunity to hear about two examples that illustrate focused work to address disproportionality related to child abuse and neglect fatalities:

Michigan's effort built an accountability and business case for addressing disproportionality and

promoting equity as a social justice issue. Bringing a broad group of stakeholders together, demonstration projects were implemented to address disproportionality, with an emphasis on training the workforce, partners, and mandated reporters, and formulating policy and programs that promote prevention and access to interventions that build strength and resiliency in individuals and families.

Sacramento County, CA's focused work on addressing child fatalities of African American children is an example of a community working to identify why the problem of disproportionality for child fatalities of African American children persisted for some 21 years without being addressed. This is also an example of mobilizing a broad range of stakeholders to address the issue. The entire community including faith based organizations, courts, educational professionals, hospitals, child care providers and law enforcement were enlisted to combat the travesty of child disproportionate fatalities.

> *"We have oftentimes identical risk factors for black families and white families but when the risk factors are identical, white families are more likely to get family and home support and black families are more likely to have their children removed. And families know that. So they're not going to stick around. They're not going to tell us things. They're not going to give us information, critical information that we need to have in order to save their children, to help them save their children."*
>
> Dr. Rita Cameron Wedding
> CECANF Testimony – New York

A climate of distrust of the very system that should be a tool to assist families in unification, health, and wholeness has been developed due in large part to the way information is processed and shared. Thus, African American families, particularly in emergent healthcare situations, avoid utilizing the social support system for fear of the professionals' bias. It is necessary to rebuild the trust in these communities. Disproportionately affected communities must be able to trust the system designed to protect its children. By taking measures to reduce bias and to improve screening methodology with the goal of child safety in the context of family unity and wholeness, trust will rebuild. Demonstrated systemic fairness must be presented to these communities in order to prevent further child abuse and neglect fatalities.

Continuing to address child welfare with a one size fits all mentality that ignores the necessity for diversity is simply untenable. The system will never be able to stop the preventable deaths of children due to child abuse and neglect if a serious and concerted effort is not made to remake it

both in policy and practice. Policies that ignore the multicultural nature of our society must be redressed. As well, professionals charged with effectuating child welfare and well-being must be re-oriented to understand that proper and effective implementation efforts to prevent child maltreatment, abuse, neglect, and fatalities must be conducted with a multicultural mindset.

"[S]ee poverty as a condition and not as a character flaw"

Dr. Renee Canady – CECANF Testimony, New York

Poverty – A Lack of Community Resources

The inadequate community platform perpetuated by poverty in minority communities is accentuated by the clear lack of quality services starting at the intake process, proceeding through the judicial adjudication, and finally ending in placements that ignore the possibility of reunification with family of any sort. Quality services (effective, culturally appropriate, and targeted) are needed to support children and their families disproportionately represented in child welfare and other child-serving systems. Efforts at the federal, state, and local levels need to address quality with the same emphasis as availability and accessibility.

When poverty is seen as a condition rather than an individual or group character flaw, true efforts can be made to eradicate this underlying hindrance to family preservation efforts. Because poverty is a condition of neighborhoods, quality of services provided, accessibility to services, quality of infrastructure, health equity, educational equity, and equal opportunity to earn livable income, it is essential that these issues be examined. Poverty first happens to a community and is then manifested in an individual. Poverty therefore is a lack of resources translated into a lack of quality social services, products, and opportunities.

Throughout the life of the Commission, emphasis has been made on having as many eyes on the children as possible. This train of thought is vital in communities already receiving disparate treatment and/or are demographically disadvantaged. Where we have seen potential improvement in outcomes related to disproportionately represented populations, there has been a direct correlation between an all hands on deck community response of mandatory reporters from various sectors including clergy, care providers, law enforcement, educators, and doctors.

In the African American community, historically, faith-based organizations have been an integral part of the social structure. This dynamic has not changed. Thus, when abuse and neglect happen in the African American community, it is probable that someone in a faith-based

organization had eyes on the victim. Yet knowing how to report, willingness to report and requirements to report have remained unclear.

Only now, social justice and consciousness demands have moved the faith-based community into partnerships requiring regulatory sophistication and government oversight. This is a positive development. However, while care providers, law enforcement, educators, and doctors have benefited from education and training in mandatory reporting, by in large, clergy have not – partly due to a lack of professional status. While 27 states require clergy to report child abuse and neglect, only 11 states require that clergy be registered with the state.

There is an opportunity to radically expand the mandatory reporting pool in the African American community. Just counting churches alone, there are approximately 69,738 faith-based organizations in the African American community. Statistics show that 53% of African Americans engage a faith-based organization on a weekly basis at a minimum. These numbers suggest the potential to gain thousands more eyes on kids.

RECOMMENDATION 16.1: Congress should mandate that all organizations receiving federal funding or benefits for the purpose of serving children have at least one responsible party who is registered in a federal registry, and that said party be trained in the nuances of mandatory reporting of child abuse and neglect. In the case of faith-based organizations, clergy should have the ability to report under the shield of anonymity.

RECOMMENDATION 17.1: Congress and the Administration should promote the standard that all CPS cases consider the total well-being (physical, mental, and emotional) of (1) the child, and (2) the nuclear family and shall proceed with the presumption of preserving the holistic health of the family in anticipation of reunification and/or kinship care where practicable.

RECOMMENDATION 18.1: Congress should encourage increased emphasis on teen pregnancy prevention, especially for young men and women in high poverty areas and those in foster care. There needs to be more attention given to young men in the development of effective teen pregnancy programs.

RECOMMENDATION 19.1: The Administration should bolster efforts to involve probation officers and parole officers in the multi-disciplinary outreach to monitor the safety of children where parolees and those on probation reside.

Combating Poverty-Strengthening Families

While the current system ostensibly seeks reunification as the ultimate goal of any removal, it seldom focuses efforts on refining the pathway to preserving the family structure. Specifically,

the clutter of poverty and poverty related perspectives manifested through a system wide attitude leaning towards removal of children is regularly the outcome for minority families encountering CPS.

Once a child is born and leaves the hospital with their family, the chance for primary protective services diminishes. Protective factors in the home are then the most important shield to abuse and neglect. This is particularly critical for children of underserved communities. In the unfortunate case that CPS becomes involved in the life of a family and child(ren), the Court becomes the champion for ensuring the safety of our children. Thus, serving as the fulcrum of the current system is the court.

Courts are the final authority on whether a family will be reconfigured, dismantled, or preserved. However, a general philosophy of how best to address child abuse and neglect fatalities has yet to be established in the field of jurisprudence. While the general default position with respect to family issues is "children first", the obvious starting point of any child protective services situation is a family and must focus on protective factors present in the home – especially in underserved communities.

Hence, and in light of the ostensible goal of reunification, it should logically follow that family interventions would be the first line of defense in protecting children and adjudicating child protection cases. Therefore, the courts must find their platform built on a philosophy of preserving families, thereby preserving communities. The court will then play an active role in weakening the influence of the poverty that contributes to the proliferation of systemic disparate treatment of minorities and poor whites alike. The courts have the positioning to provide some relief to families coming from communities dominated by poverty. To do so:

RECOMMENDATION 20.1: Congress should incentivize the establishment of Family Preservation Court or Intact Family Court[12] demonstration projects that feature a multi-

[12] **Intact Family Court – Through public/private partnerships develop place-based pilots focused on communities with disproportionate child abuse and neglect fatalities to address the needs of young children (5 years old and under) where there is a substantial risk of abuse or neglect. Elements of the Intact Family Court would include:**

- **Referrals from medical workers, law enforcement, clergy, or social workers**
- **Voluntary process for family to engage in**
- **Initial intake would include a physical for every child**
- **Guardian ad litem needed, instead of a lawyer for the child**
- **No lawyers engaged**
- **Assessment to provide focused coaching and supportive services to family**
- **Confidential process**

disciplinary team approach in order to promote the survival of healthy families and communities otherwise decimated by disproportionate incidence of child abuse and neglect and child abuse and neglect fatalities. This approach should not be limited to federal funds, but could be implemented through public/private partnerships.[13]

CONCLUSION

Humbly, this Commissioner has submitted this Dissenting Minority Report with the hope that The President and the Congress will look upon the Commission as a success. Often time, dissenting opinions are the key to discovering the balance between parties. Consenting, too often can mean business as usual and/or complete surrender. Dissent, more often than not, reveals the strength of points of agreement between parties.

In my humble opinion, I believe the reader of this report will find that where there is intersection between the Dissenting and Consenting reports, the strongest and most actionable recommendations that the Commission can sincerely make are presented in an effort to provide a National Strategy for Eliminating CAN fatalities.

Respectfully Submitted.

- **Social worker drives the Intact Family Court process and can still pursue more formal dependency process if necessary**
- **Court's role is expanded to be a resource both in the Intact Family Court, as well as in their current role in more formal dependency proceedings**

[13] The Intact Family Court will evaluate protective factors and provide pre-emptive supports to prevent child abuse and neglect fatalities. The process could have similarities among the pilots, but not be too prescriptive to address the unique needs in a specific community and provide targeted supports to families.

Summary of Recommendations