MINORITY REPORT

An NCCPR Analysis of the Recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities

This report is based on the final recommendations of the Commission. It updates an earlier report based on draft documents.

NCCPR will continue to update its critique in posts to the NCCPR Child Welfare Blog, available here.

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The National Coalition for Child Protection Reform is a volunteer child advocacy organization made up of people who encountered the child welfare system in their professional capacities. Though NCCPR we work to make that system better serve America's most vulnerable children by trying to change policies concerning child abuse, foster care and family preservation. A complete list of NCCPR's Board and Staff is available on our website here.

MINORITY REPORT

An NCCPR Analysis of the Recommendations of the Commission to Eliminate Child Abuse and Neglect Fatalities

By Richard Wexler, Executive Director, National Coalition for Child Protection Reform
March 17, 2016

This analysis discusses the final report of the Commission to Eliminate Child Abuse and Neglect Fatalities. It updates a January, 2016 report that analyzed earlier Commission drafts available here and here and discussed public meetings of the Commission held via conference call.

OVERVIEW: THE SAME LOUSY SYSTEM ONLY BIGGER

It is, of course the most noble of goals: eliminating child abuse and neglect fatalities. But a commission created by a federal law and charged with recommending ways to achieve those goals has released recommendations that, if enacted, are doomed to fail. They would harm hundreds of thousands of children who were never maltreated and actually make it less likely that children in real danger will be found in time.

We estimate that just one of the recommendations from the "Commission to Eliminate Child Abuse and Neglect Fatalities" probably would add more than 700,000 new child abuse investigations every year – a 39 percent increase. Another recommendation is estimated by some members of the Commission to cost at least $1 billion. At another point in the drafting process it was suggested that the cost for all recommendations would be at least $4 billion per year – and even that may have been just the amount the Commission wanted the federal government to supply. In the end the Commission couldn't agree on what the recommendations would cost or whether to put a dollar figure on them.

But whatever the amount, these funds would have to be taken from far better approaches to reducing child abuse. And the additional 700,000 investigations would inundate the system, so overloading workers that they actually would wind up missing more children in real danger.

Another recommendation, the one on which the Commission puts the greatest emphasis, encourages or requires states (the language is unclear) to reexamine every child abuse fatality over the previous five years, looking for common "risk factors." If even one such risk factor was believed to be found, the state then would be urged – or required – to barge in on the family whenever any open child welfare case is said to have that same risk factor.

Most commissioners originally referred to this as a "surge;" others, with no sense of irony, preferred "accelerant." Eventually, they all realized that for anything so intrusive on so many innocent families they needed a euphemism, so commission staff came up with "retrospective review."

Whatever it's called it effectively targets only children left in their own homes. This appears to be based on the false assumption that at least if the child is in foster care, that child is

safe. The high rates of abuse in foster care indicate otherwise.

This recommendation gives no weight to the enormous emotional trauma of foster care, trauma so great that two huge studies found that children left in their own homes fare better even than comparably-maltreated children placed in foster care.

And once again it would divert time, energy and resources from far better options. **One state that tried this approach wound up with a huge increase in its foster care population – and an *increase* in child abuse deaths. (See p. 18).**

Indeed, if the Commission's top priority is child safety, it should be calling first and foremost for a review of every child in foster care to see if the child really needs to be there.

The members of the Commission have the best of intentions. But strip away the rhetoric and the jargon and the buzzwords about a "21st century child welfare system" and a "public health approach" and all that the Commission really is recommending is the same lousy system only bigger - a vast expansion of the current failed child protective services bureaucracy that already wreaks havoc in the lives of millions of innocent families even as it overlooks children in real danger.

A process as bad as the results

The Commission had two years, millions of dollars and plenty of staff. Yet the process of cobbling together a final report was shocking for its lack of organization. Commissioners finalized the report in marathon conference calls – four hours or more at a time. The calls were chaotic, with people joining, leaving and joining again, compounded by all the usual technical problems. In some cases Commissioners voted on recommendations they'd seen only minutes before. (For full details, see these posts to the NCCPR Child Welfare Blog.)

Apparently aware of how embarrassing the early drafts were, especially when we pointed out the failures in the first version of this report, the Commission opted not to improve, but to hide. Drafts became secret, so while the public could listen to the conference calls, they couldn't see the documents being debated.

According to one Commissioner's scathing dissent, what went on behind-the-scenes was worse.

And to top it off, there was far less reference to actual research than to the steady diet of newspaper horror stories that commissioners were fed daily by the staff.

So the Commission was chaotic, it was angry, it was dysfunctional, it was secretive and it made its decisions based on newspaper horror stories. In other words, the Commission to Eliminate Child Abuse and Neglect Fatalities didn't study the child welfare system, the Commission *re-created* the child welfare system.

The Commission added a dystopian, 21st century twist. They appear to justify the recommendations based on the notion that science has advanced to the point where the same sorts of algorithms that Netflix uses to predict which movies you want to see also can tell us where CPS workers should barge into a home and, often, take away the children.

It is much like the model depicted in the science fiction film *Minority Report*, in which people are arrested and jailed based on the predictions of three psychics in a bathtub. But instead of seeing that film as a warning, the Commission seems to view it as a blueprint.

But what the Commission does is even worse. At least the algorithms are, in theory, tailored to individual circumstances (though anyone looking at their suggestions list from Netflix may question that). The Commission is proposing wholesale changes that would apply to millions of Americans, based on wild extrapolations from studies of individual risk factors.

In other words, the Commission takes the concept of "predictive analytics," a fad that is questionable in itself, and perverts it. The result is recommendations that add up to a regime of domestic spying that would make the NSA blush.

The rationale behind these recommendations echoes the worst excesses of the so-called war on terror. Terrorists kill innocent men, women – and children. So demagogues such as Donald Trump propose that we prevent all Muslims from entering America. Most of the members of the Commission probably found Trump's proposal appalling. But it is remarkable how often otherwise sensible people resort to Trump's kind of fear-mongering and extremism when the topic is child abuse.

In this case, the Commission uses the same justification as Trump – the killing of innocent children - to justify allowing CPS workers to barge into hundreds of thousands of homes where the evidence of maltreatment is so weak that child abuse hotlines did not even accept the call for investigation. They use Trump's logic to try to justify their proposed "surge" – with Trump-style disregard for the massive collateral damage it would cause.

Still another recommendation might expand the authority of CPS workers to remove children in one of the places where such removal hurts children the most – when a parent has been a victim of domestic violence.

And like the child welfare system itself, the Commission deliberations revealed a profound bias. One draft recommendation, subsequently deleted, called for universal drug testing for pregnant mothers whose birth is paid for by Medicaid – in other words, mothers who are poor. The Commission member whose lobbying led to creation of the Commission, and who has been the strongest supporter of the most draconian recommendations, Michael Petit, once told a Congressional committee that, when it comes to preventing child abuse "the states that do the best overall are the ones that have smaller, *whiter* populations" [emphasis added]. During that same testimony, Petit perpetuated stereotypes about people of color and drug abuse.

A transcript of the December 3, 2015 Commission meeting reveals Petit still trying to minimize the role of racial bias in the disproportionate rate at which African-American and

Native American children are taken from their homes. Indeed, in a dialogue with another commissioner, Cook County Judge Patricia Martin, the presiding judge of the Court's Child Protection Division, and one of only two African-Americans on the Commission, Petit seemed to have difficulty even grasping the concept.

Later, when a subcommittee chaired by Judge Martin proposed a series of recommendations to deal with racial bias in child welfare, Petit led what sounded like a successful effort to eviscerate it. (It's impossible to know for sure. After NCCPR issued an earlier version of this report, the Commission stopped making its drafts public. So while the conference calls where final deliberations took place were public, the documents about which they the Commission deliberated were secret.) Judge Martin was one of two Commissioners to vote against the final report. She wrote a scathing dissent, blasting both the Commission process and the results.

Even if one thinks it's worth this massive undermining of civil liberties in order to reduce child abuse fatalities, there is another problem with this approach: It will backfire. In fact, it already has. All over the country, high-profile child abuse deaths have led to demands to investigate more cases and take away more children. That's led to foster-care panics – sharp sudden spikes in removals of children from their homes. Over and over, in those jurisdictions large enough to detect a pattern, these panics have been followed by increases in child abuse deaths.

The recommendations are a formula for a nationwide foster-care panic, on a massive scale.

The Commission recommendations involve a huge increase in the number of people to be investigated and spied upon by child protective services agencies. We know that state and local governments aren't going to raise taxes to pay the more than $1 billion per year or $4 billion per year or maybe much more that this will require. Rather, they will turn to one of two alternatives: They will cut back on other human services programs – programs that are far more likely to curb child abuse – or they will simply increase the workload of existing staff.

Indeed, at a time when Congress finally is giving serious consideration to allowing funds now reserved for foster care to be used for safe, proven prevention and family preservation programs as well, the Commission proposes diverting some of this funding into training "mandated reporters" – professionals required by law to call child protective services to report any suspicion they may have that someone they've come in contact with may be a victim of abuse or neglect.

At least two other recommendations appear aimed at coercing medical professionals, in particular, to turn in even more families to child protective services.

If you cut effective child abuse prevention programs the result is obvious: more child abuse. If you overload staff they have less time to investigate any case properly, so they make more snap judgments in all directions. So even as more children are taken needlessly from their homes, more children *also* are left in danger.

"But you don't understand, we just want to help families"

We can hear some of the Commissioners now, insisting that we've misunderstood. They'll claim this vast expansion of government surveillance and intrusion into families is just a way to find families in trouble and offer them help. Indeed, the report is slathered in language talking about "prevention" and "services." And we're sure some of the Commissioners sincerely believe it. (Some, but not all, would make this claim. As is discussed below, discussion of prevention and helping families almost always met fierce resistance from Michael Petit.)

But the rhetoric is at odds with the recommendations, which put a heavy emphasis on intrusion, coercion and surveillance.

If providing help really were the goal, then none of the harmful recommendations in the final report would be necessary – because none of them is needed in order to offer help to a family. Vastly increasing the number of cases investigated by people empowered to take away children, and using the law to twist the arms of doctors into reporting against their professional judgment are things you need only if you want to increase the *coercive* power of the state to investigate families and take away their children.

Judge Martin, for one, was not fooled.

Yes, it DOES hurt to look

Most of the awful recommendations in the Commission report revolve around when a report alleging child abuse can be investigated. So what could be the harm in just looking in on a family?

The harm can be enormous.

A child abuse investigation is not a benign act. It can cause serious emotional harm, in and of itself.

Here's how three of the leading scholars of child welfare in the 20th Century, Anna Freud, Joseph Goldstein and Albert J. Solnit put it, in arguing for a high threshold before the state investigates a family:

"Children react even to temporary infringement of parental autonomy with anxiety, diminishing trust, loosening of emotional ties, or an increasing tendency to be out of control. The younger the child, and the greater his own helplessness and dependence, the stronger is his need to experience his parents as his lawgivers, safe, reliable, all-powerful, and independent ..."[i]

It is striking how often parents who had never read experts like Goldstein, Freud and Solnit say the same thing in their own words.

There was the parent who was being harassed by a neighbor. Their young child repeatedly was

pulled out of class for questioning by CPS workers who came to his school. Each time the case would be labeled "unfounded." The worker even knew the neighbor and agreed it was harassment; but, he said, there was nothing he could do. If the hotline didn't screen out the call, he or his colleagues had to put the child through the trauma over and over and over again. (One of the main Commission recommendations, discussed below, would eliminate screening for hundreds of thousands of cases. Another would require an investigation in any case where there had been a previous call to the hotline about the family.)

"I trusted my parents explicitly," this child's mother said. "I knew they loved me. They had control over things. When they took my son into the principal's office, I had no control over whether they could do that or not. Mother's a fixer in these kids' eyes. Mother couldn't fix it this time. Mother had no power."[ii]

The trauma is compounded if the worker, almost certainly in a hurry, decides the fastest way to find out if the child might have been physically abused (whether or not that was the original allegation) is not to talk to a whole lot of people who know the child or contact the child's pediatrician but simply to stripsearch the child – or take the child to some doctor he doesn't know and have the stripsearch done there.

Call it whatever you like (one state prefers "forensic medical examination" another likes "visual inspection") but it's a stripsearch. If anyone else did it, it would be sexual abuse. Indeed, all over the United States, child protection agencies send workers into schools to teach children, correctly, that "your body is your own." But if you're the subject of a Child Protective Services investigation, it's not.

All of that harm occurs before even reaching the damage done if the child is needlessly removed from the home.

Although the report is larded with horror stories, most parents who lose children to foster care are neither brutally abusive nor hopelessly addicted. Far more common are cases in which family poverty has been confused with "neglect." Other cases fall between the extremes, the parents neither all victim nor all villain. What happens to these children when they're taken away?

- When a child is needlessly thrown into foster care, he loses not only mom and dad but often brothers, sisters, aunts, uncles, grandparents, teachers, friends and classmates. He is cut loose from everyone loving and familiar. For a young enough child it's an experience akin to a kidnapping. Other children feel they must have done something terribly wrong and now they are being punished. The emotional trauma can last a lifetime.

So it's no wonder that two massive studies involving more than 15,000 typical cases – not the horror stories – found that children left in their own homes typically fared better even than comparably-maltreated children placed in foster care.

- That harm occurs even when the foster home is a good one. The majority are. But the rate of abuse in foster care is far higher than generally realized and far higher than in the general population. Multiple studies have found abuse in one-quarter to one-third of foster homes. The

record of group homes and institutions is worse.

• And, of course, the more that workers are overwhelmed with false allegations, trivial cases and children who don't need to be in foster care, the less time they have to find children in real danger. So they make even more mistakes in both directions.

None of this means no child ever should be taken from her or his parents. But foster care is an extremely toxic intervention that should be used sparingly and in small doses. For decades America has prescribed mega-doses of foster care. The Commission recommendations, if they were to become law and policy, would have the effect of further upping the dose.

The flawed assumption at the heart of the Commission's work

One recommendation after another is based on the notion that if we can just widen the net of coercive intervention far enough, we can predict who is going to kill their children and "intervene" – a euphemism for "take away the children" – before it happens.

Indeed, in a statement remarkable for its hubris, Michael Petit insisted during a January 16 Commission conference call that the proposed "surge" will allow caseworkers to go into homes to determine "who among these children *is going to be killed*" [emphasis added].

The report is filled with claims that when one or another "risk factor" is present, a parent is X times more likely to kill her or his child. So, for example, the report states that

Children with a prior CPS report had almost a six times (5.8) greater risk of death from intentional injuries.

There are two problems with this:

First, we don't really know if it's true – at least not if we can believe another claim from the Commission. The Commission, and many others, often claim that there are more child abuse deaths than we know about. And, in fact, given the enormous variations in how child deaths are investigated, this may well be true. If so, odds are most of those undiscovered deaths involve children who were never "known to the system" at all.

If those fatalities were included in statistics, the proportion of deaths in which there had been previous reports would decline. This almost certainly applies to many other "risk factors" as well, since the characteristics of the population under study – perpetrators of known child abuse fatalities – may be different from the characteristics of perpetrators of fatalities we don't know about.

But let's assume that the claim is accurate. Let's assume that "Children with a prior CPS report had almost a six times (5.8) greater risk of death from intentional injuries." That still tells us almost nothing. And the reason for that is one for which we all should be grateful: In 2014, there were 1,580 known child abuse fatalities. That same year there were 75,020,077 Americans under age 18 – in other words, potentially under the jurisdiction of child protective services.

Now, just for the sake of argument, let's assume the real number of child abuse deaths is double the official figure. Even then, that means that 99.9958 percent of American children were not killed by a parent or other caretaker in 2014. In other words, the chances of a parent killing her or his child in any given year are far lower than the chances of finding an impurity in a bar of Ivory Soap.

Child abuse deaths are among the worst tragedies imaginable. The only acceptable goal for such deaths is zero. But the odds of any parent, or other caretaker, killing a child are infinitesimal. If the data concerning prior reports and fatalities are correct, it means only that the odds of a parent who has had a previous CPS report killing a child are very slightly less infinitesimal. The same applies to all those other "risk factors."[1]

In other words, for every murderous parent whose case has one or more of the "risk factors" there are thousands upon thousands of homes where the same risk factor is present and the parent does not kill the child – or, for that matter, harm the child in any way.

So it is grossly misleading and irresponsible for the report to claim that "a report to CPS is strongly associated with later injury or death."

Another way to understand this is to consider a hypothetical: In State X, 10,000 children are the subjects of reports to the state child abuse hotline. One of those children dies. Another child, who was never the subject of a report, also dies.

One then can say that in this state, fully 50 percent of the children who died had been the subject of a child abuse report before their deaths! But it's also true that 99.99 percent of the children subject to such reports did not die.

So it's no wonder that a group that specializes in analyzing data about children, ChildTrends, put the whole notion that we can use "risk factors" to predict who will abuse a child in the number one position on its list of Top Five Myths About Child Maltreatment. They write:

Myth: We can predict which children will be maltreated based on risk factors [emphasis in original].

ChildTrends continues:

Risk factors associated with child maltreatment include extreme poverty, family unemployment, caregiver substance abuse, lack of understanding of child development, and

[1]The attempt to use these sorts of "risk factors" reaches its most ludicrous extreme when people say: If Mom has a boyfriend in the home, there is a greater chance the child will be killed because the boyfriend has no blood tie to the child, so we'd better place the child in foster care – where no one has a blood tie to the child.

neighborhood violence. However, each of these only weakly predicts the likelihood of maltreatment. For example, although maltreatment is more common among families living in poverty than among other families, the majority of parents with low incomes do not maltreat their children.

When risk factors are present, protective factors can mitigate the likelihood of maltreatment. Such protective factors include parental social connections, knowledge of parenting and child development, concrete support in times of need, and children's social-emotional competence. Because maltreatment is so difficult to predict, prevention approaches that strengthen protective factors among at-risk families broadly—even if the risk is low—are likely to be most effective in reducing maltreatment.

The Center for Public Policy Priorities, a liberal think tank in Texas that at one time crusaded for taking away more children in that state, has been less prone to do so ever since they did a study which came to similar conclusions. They found:

- Screening in more calls to child protective hotlines did not curb child abuse deaths.
- Investigating more cases did not curb child abuse deaths.
- Substantiating more cases did not curb child abuse deaths.
- Taking away more children did not curb child abuse deaths.

Instead they came to the same conclusion as ChildTrends – broad-scale approaches to strengthen families and reduce poverty are among the key approaches to preventing child abuse deaths.

But the Commission appears so enamored by the "psychics in a bathtub" approach, that its recommendations ignore what really works in favor of a vast increase in coercive intervention into families.

What really happened in Tampa

The case for "predictive analytics" appears to be based almost entirely on only one real-world application in the child welfare field, in Hillsborough County (metropolitan Tampa), Florida. But there is no real evidence that the improvements there had anything to do with predictive analytics.

In the Florida system, almost all child welfare services are privatized. Regional "lead agencies" oversee both foster care and in-home supervision.

Between 2009 and 2012 there was what newspapers love to call a "spate" of child abuse deaths in the county – nine in all. The state terminated the contract of the "lead agency" and replaced it with one that had a particularly good reputation. That agency adopted a predictive analytics tool called "Rapid Safety Feedback." Since then, it has been repeatedly claimed, there have been no child abuse deaths. (This is not quite accurate, but to find that out it's necessary to look at endnote 32 in the Commission report.)

But whatever the exact figure, if there's a reduction RSF must have caused it and everyone should rush to embrace it, right? That's what the Commission seems to think.

But correlation is not causation.

For starters, we have yet to see an account of the supposed miracle in Tampa that tells us how many child abuse deaths there were in Hillsborough County in the years before the "spate." Presumably, since the 2009 to 2012 events raised such an alarm, there must have been few or none in the preceding four years.

In addition, determining whether a death is due to child maltreatment is not as easy as it may seem. As the Commission report itself explains well on page 77, it's actually as subjective as almost everything else in child welfare.

For example, suppose early one Sunday morning, while Mom and Dad are asleep, a small child manages to let himself out of the house, wanders to some nearby water and drowns. Was that an accident or neglect? Given the biases that permeate child welfare, odds are if it was a backyard pool in a McMansion it's going to be labeled an accident; if it was a pond near a trailer park, it probably will be labeled neglect.

The picture is further muddied by the peculiar politics of Florida. In that state policy and guidance concerning what kinds of deaths to label as maltreatment have changed several times in recent years, making it even harder to make a true comparison.

And there was another change in Tampa: A lot of additional caseworkers were hired. But unlike in so many other cases where this happens in the wake of high-profile tragedies, the new lead agency and the state Department of Children and Families worked hard to ensure there was no foster-care panic – no sudden surge in child removals in that region. So the new workers actually had time to do their jobs, instead of drowning in new cases. (Sadly this did not last. Driven largely by grossly inaccurate news coverage, a statewide foster-care panic has sharply increased entries into care. So the record concerning deaths may not last either. Indeed, statewide, deaths of children "known to the system" have increased.)

The Commission held an entire hearing in Tampa – but chose to ignore a crucial warning from a key witness, Prof. Emily Putnam-Hornstein of the University of Southern California School of Social Work, who said:

"[W]e 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 [preventing] a near fatality or a fatality, because … 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."

Of course you won't find this in the Commission report – only in Judge Martin's dissent.

Finally, there is one other possible reason for what happened in Florida: Dumb luck. Even a story in the *Chronicle of Social Change*, an online publication that has been cheerleader-in-chief for predictive analytics, had to acknowledge that "given the rarity of

these events, a lapse in child deaths could be as much anomaly as anything else."

Indeed, the director of quality assurance for the new lead agency told the *Chronicle*: "I never try to claim causality."

The Commission shouldn't either.

SPECIFIC RECOMMENDATIONS – AND WHY THEY ARE SO HARMFUL TO CHILDREN

Of all the recommendations in the Commission's report these stand out for the extent of the harm they would do to children:

The report appears to propose that CPS agencies investigate all hotline calls for children under age 3

One difference between the final report and earlier drafts is a penchant for vagueness. There's no way to know if the ambiguity is deliberate obfuscation or just sloppy writing as the Commission stumbled and bumbled its way to a conclusion (if that sounds harsh, check out the commission's "deliberative" process in these NCCPR blog posts.)

But as a result, it's not clear if the Commission still wants to require child protective services hotlines to screen in every call about a child under age 3 and every call involving a repeat report, or just strongly encourages it. Here is the Commission recommendation:

If states find, during [a process called for in another recommendation] that investigation policy is insufficient in protecting children, their fatality prevention plans should ensure that the most vulnerable children are seen and supported. States should review current screening policies to ensure that all referrals of children under age 3 and repeat referrals receive responses.

So, is the second sentence contingent on the first, or does it stand alone? We don't know.

But here's what we do know:

● The commission has lowered the maximum age for this recommendation from age 5 in earlier drafts to age 3.

● The commission now claims that the "response" doesn't have to be an investigation – but efforts to do anything else are being undermined all over the country.

The commission wants to, at a minimum, strongly encourage and possibly require a gigantic increase in coercive intervention into families.

This recommendation is rooted in the statistic noted above – that if there is a prior report

alleging maltreatment, even if that report was screened out, the odds of that parent killing a child are ever-so-slightly less infinitesimal than if there is not.

Based solely on that, the Commission proposes to inflict traumatic child abuse investigations on a staggering number of additional families, and create a staggering increase in the workload of child protective services workers.

How staggering? Well, actually, we're not sure. And neither is the Commission. That's because there are no precise, public national data tracking the ages of the children in cases that are screened out. (Indeed, it is likely that in some such cases the ages of the children are unknown.)

But here's what we do know: According to the federal government's latest "Child Maltreatment" report, among those children alleged by CPS workers to be victims of child abuse or neglect 48.3 percent are under the age of 3. Assuming that the same proportion of screened out cases involve that age group, **the Commission proposal would add nearly 700,000 additional cases to the workload of CPS investigators every year.**

And even that 700,000 figure may be an underestimate. The Commission also wants to encourage or require agencies to screen in any case in which the case had been called in to the hotline at any time previously. In other words, if the same crank caller calls twice, the call must be accepted. If a neighbor wants to harass a neighbor or divorcing spouses want to harass each other, just call twice and the harassment is guaranteed.

The recommendation specifies no time limit. Under this recommendation, if the second call comes five years after the first, it doesn't matter – it still should be investigated no matter what. Add in all the people who call twice and are well-meaning but simply wrong and there is potential to add another huge number of cases to the burden carried by already-overloaded workers.

As noted above, at one point the Commission itself was circulating an estimate that this could cost more than $1 billion per year. Later that $1 billion figure was transferred to the "surge" recommendation. State and local governments aren't going to raise taxes to pay for this. Rather, they will turn to one of two alternatives: They will cut back on other human services programs – programs that are far more likely to curb child abuse – or they will simply increase the workload of existing staff. And 700,000 more cases would increase the workload of existing investigators by an average of about 39 percent.

Either way, as noted above, it backfires. If you cut effective child abuse prevention programs the result is obvious: more child abuse. If you overload staff they have less time to investigate any case properly, so they make more snap judgments in all directions. So even as more children are taken needlessly from their homes, more children *also* are left in danger.

How the screening process works.

The proposal is even more absurd when one understands the screening process – because

the cases now screened out are, by far, those least likely to involve actual child maltreatment.

Child abuse hotlines vary in their power to screen in or screen out calls. In some states, virtually every call, no matter how absurd, already must be screened in. In many other states, any call in which the alleged acts or omissions meet the state's definition of child abuse or neglect must be accepted. And those definitions are themselves breathtakingly broad. Typical state statutes define lack of adequate food, clothing, shelter or supervision as "neglect." By that definition, almost every impoverished child in America could, at some point, be labeled "neglected."

There is no attempt to assess the credibility of the caller – and callers can remain anonymous. So if a call can't meet such a low bar, the odds are excellent that there is no child abuse in that home.

To get a further sense of how unlikely it is that there is abuse in a case that was screened out; consider what happens with the cases that are screened *in*. Only 18 percent are "substantiated." People who support the current system often claim that's only because abuse couldn't be "proven." But no proof is required. The determination that a case is "substantiated" is made by a caseworker on her or his own authority. And in most states "substantiated" means only that the caseworker believes, in her or his own mind, that it is slightly more likely than not that there is abuse or neglect.

We are aware of only one study that attempts to "second guess" substantiation decisions. That study found that caseworkers were two to six times more likely to wrongly substantiate a case than to wrongly label it unfounded.[iii]

So 18 percent almost certainly overstates the proportion of cases in which there is actually child abuse.

Now the Commission proposes to add an estimated 700,000 additional cases, and probably more, in which the chances of finding actual maltreatment are even less likely.

Yes, we keep saying unlikely or rarely – we don't say never. No one can. But in response to the mountain of facts showing that accepting 700,000 reports will traumatize families and result in more real abuse being missed because workers are overloaded, the Commission has no facts of its own. It offers only that one statement about risk factors – and horror stories about children who died when their cases were screened out.

There will be many more such horrors if workers are forced to spend even more time spinning their wheels investigating even more false reports.

In fact, by the report's logic, there's no reason to wait for anyone to call the hotline. Why not just send Child Protective Services workers into every home in America to snoop around and see if maybe, just maybe, there's a child abuser under the bed?

If anything, the evidence is overwhelming that screening at child protective hotlines

should be tightened – beginning with banning anonymous reports.

Of all the sources of child abuse reports, anonymous reports consistently are the least reliable. They're almost always wrong. A study of every anonymous report received in the Bronx, New York, over a two-year period found that only 12.4 percent met the incredibly low criteria for "substantiating" reports – and not one of those cases involved death or serious injury.

The researchers found that "one case was indicated for 'diaper rash' one case for welfare fraud, and two cases because the apartment was 'dirty.'"

Anonymous reporting should be replaced by confidential reporting. If someone who may have a grudge or someone who simply may be clueless wants to claim that, say, a neighbor is abusing a child, that person should be required to give the hotline operator his or her name and phone number. That information still should be kept secret from the accused in almost all cases, but the hotline needs to know. That will immediately discourage false and trivial reports.

There always will be screening in child welfare. The choice is not between screening and no screening. The choice is between rational screening and irrational screening. The more cases that cascade down upon investigators the less time they get for each one. So some get short shrift. It is far safer for children if cases are screened rationally by doing things like eliminating anonymous reports, rather than irrationally based on which file floats to the top of the pile on a caseworker's desk. In contrast, the Commission's recommendation calls for a vast increase in irrational screening.

As the authors of the Bronx study put it, in recommending that anonymous reports be rejected:

The resources of child protective agencies are not limitless. The time and energy spent investigating false reports could better be given to more serious cases, and children may suffer less as a result.

The recommendation formerly known as the "surge"

Another recommendation, the brainchild of Michael Petit, and the one that gets the most emphasis in the report, is the one that used to be called a "surge." Now, it's called a "retrospective review."

This recommendation also suffers from wording that's either meant to be ambiguous or is just sloppy. By using the words "will" and "should" interchangeably, the Commission leaves unclear if it wants to force states to follow the recommendation, or just wants to push them hard in that direction.

But it appears that the Commission wants the federal government to require states to review every child abuse fatality during the past five years. Then if they find even one common "risk factor" the states would be encouraged or required to re-investigate every open case that

has that one risk factor.

Though the Commission backed off from earlier drafts which specify this review would be limited to cases in which children were allowed to remain in their own homes, known as "in-home supervision" cases, the laws of mathematics ensure the same limitation.[2]

How many "in-home supervision cases" are there? Trying to figure that out leads into a definitional quagmire, but our rough estimate: At least 635,000 cases nationwide, and probably more.[3]

Presumably, with the "surge" limited to cases with specific risk factors that would lower the number. On the other hand, the 635,000 figure is a single-year estimate, and many cases are open for more than one year – so that could bring the number back up again.

So once again, a Commission recommendation calls for an enormous drain on resources that could better be applied to better approaches to keeping children safe.

But even more disturbing is the mindset behind this recommendation. Even though study after study shows alarmingly high rates of abuse in foster care, there is no call for a review of those cases – apparently in the belief that no child has ever died, or even been harmed there. Or rather, as Michael Petit indicated on a January 14 conference call, discussed in more detail below, not *enough* children died there.

The recommendation, and Petit's rationale, reveal the deep-seated bias in favor of child removal and against families that permeates much of the report.

Several times, when Judge Martin raised concerns about the surge, or suggested that it be broadened to include children in foster care, Petit dismissed those concerns.

"But we're talking about taking kids away from parents so they won't be killed. You have to talk about how to train parents to be better parents," Judge Martin said during a January 14 conference call. Petit replied: "But there is an irreducible population of kids who will never

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[2] Here's why. The Commission wants the states to review only fatality cases. As noted throughout this report there are very, very few such cases even among the general child population of more than 75 million. So while the proportion of fatalities in foster care may well be the same, since the total number of children in foster care on any given day is about 415,000, the raw number of such fatalities will be too low to determine a pattern - so even though there is far more abuse in general in foster care than in the general population, this particular methodology won't turn up a pattern that will lead to an examination of foster care.

[3] The federal government estimated that 1.2 million children received "postresponse services" in 2013. More than two-thirds of them received only services in their own home, the rest either were placed in foster care or received both in-home services and foster care. But here's where it gets complicated: Many of those who received these services are described as "nonvictims" which may, or may not, mean they were siblings of child maltreatment victims. So it's not clear how many of the 1.2 million children would be included in the cases that this recommendation demands be reopened. But assuming all of these cases would have to get a second look, that would be roughly 635,000 cases (the number of children would be higher, but once again this estimate assumes 1.3 children per case.)

The surge that backfired

We are aware of only one instance in which a state actually engaged in a "surge" like the one the Commission recommendeds. It backfired.

It happened in Connecticut in 1995 after the death of Emily Hernandez and two other tragedies.

Governor John Rowland ordered a review of thousands of cases in which the Connecticut Department of Children and Families investigated a family but did not remove the children, to see if they should be taken away – the same sort of approach recommended by the Commission.[iv]

What was the result?

The president of the Connecticut Association of Foster and Adoptive parents warned that children were being needlessly removed for lack of concrete help, citing children placed with her when their mother was homeless and didn't know how to budget her money.[v] A juvenile court judge declared that in a single week, he returned seven children home after finding that DCF never should have taken them away in the first place. That's twice as many as he'd returned that way in the previous two years.

The results were aptly summed up by the *Hartford Courant* eight years later: "…child protection workers began removing children in record numbers, only to leave many languishing in foster care for months and sometimes years, while waiting for permanent homes."

But it least it stopped the deaths, right?

Wrong.

Child abuse fatalities increased in the years following the review and the spike in removals. Though it is impossible to truly know in a state as small as Connecticut if the review and subsequent panic caused it to happen, we do know that there is no evidence that this approach made children safer.[4]

be safe in their own homes."

When Judge Martin asked about also looking at children in foster care Petit dismissed the notion by saying "The foster care system already provides for reviews on an ongoing basis." There also are reviews of in-home cases, but somehow, for Petit, those reviews are not enough.

Petit also dismisses the notion of looking at foster care cases because "The last [federal] report showed that *only* five kids in foster care were killed" [emphasis added]. The hypocrisy in

[4] Things didn't go well for the governor either, by the way. Rowland went to jail as a result of a scandal involving construction of a hideous juvenile jail.

this argument is almost mind-boggling:

● Michael Petit would be the first to blast anyone who attached the word "only" to the number of child abuse deaths in any other context. If, in fact, even one child abuse death is one too many, that should apply even if the death happens to be in foster care.

● The Commission itself warns that you can't rely on official figures for fatalities.

● Even if you could rely on official figures, the database Petit refers to is voluntary, and as the Commission report itself explains, state reporting of official figures can be unreliable or, in some cases, nonexistent.

● Official figures concerning any form of maltreatment in foster care are particularly suspect – just look at the difference between what states report as their official rates of maltreatment in foster care and what all those studies show.

● And if you were to go back for, say, five years, and compare the *proportion* of deaths in foster care and the foster-care population to the *proportion* of deaths among children in their own homes to the general population, the rate of danger probably would be similar.

Part of the reason for using the term "retrospective review" is to cast the surge as a learning experience, almost an academic exercise to help determine what causes child abuse fatalities. Indeed, supposedly it will allow them to predict, again in Petit's words "who among these children *is going to be killed*" [emphasis added].

For all the reasons noted above concerning risk factors, this logic is faulty. But there are at least two other problems.

First, the lesson is distorted. As Judge Martin points out in her formal letter to the Commission (included with the Commission report) as well as in her longer dissent, this methodology provides no way to learn about the hundreds of thousands of other families who may have the same "risk factors" but where the children are not harmed. Systems gain no insights into family strengths and "protective factors" which could help them provide the services necessary to keep more children safely in their own homes.

That's one more indication that the real goal behind Michael Petit's pet project is simply to take away more children.

There's also another "problem" – though in the larger sense it's good news: In smaller states, even over five years there may well be too few such deaths to find anything in common that has enough statistical significance to allow anyone to draw any conclusions.

For example, in the five most recent years for which data are available, Montana reports seven child abuse fatalities, North Dakota six and Wyoming reports five – and those are all fatalities not just deaths "known to the system."

The problem is likely to be even worse in those states where individual counties run the systems since, for the "surge" to teach any lessons, it would have to take place in each county.

A better alternative

Child welfare systems err in all directions. The only way to know how a system typically fails is to look at typical cases – in other words, a random sample.

Any multi-disciplinary team should be tasked with taking an in-depth look at a random sample of cases. There already is a process for doing this every few years. It's called a Child and Family Services Review (CFSRs). But the sample size for CFSRs is so small that the results are meaningless.

What is needed is a sample large enough to be statistically significant. It would be similar to the "case readings" done by groups that sue child welfare agencies.

The random sample should include both cases where the children were left at home and cases where the children were placed in foster care. The case reading would look at everything that went wrong, and right, in each case. It would examine whether children at home need to be placed in foster care – and whether children in foster care could be returned home (and whether they needed to be placed at all). It would look at whether the families under supervision need more supervision, less supervision – or no supervision.

It's also important that any multi-disciplinary team include a variety of perspectives. That means it should include representatives of community-based organizations in impoverished neighborhoods and institutional providers of defense counsel for families, instead of just being a round-up of the usual suspects.

Some on the Commission might argue that this doesn't target fatalities. But it does. The best way to reduce fatalities is to have workers who have the time and training to do a smart, careful investigation of every case. The best way to learn how to succeed in general is to learn where the failures are in general.

A better word than "surge"

Though "surge" was the most common term suggested for this particular intervention (and that's now been changed to "retrospective review"), during a January 16 conference call, some Commissioners said they preferred to call it an "accelerant."

The most common definition of "accelerant" is a substance used to spread a fire; often in cases of arson.

That seems like the more appropriate term here.

Domestic violence

It would seem to be only common sense: If a woman is beaten by a husband or a boyfriend, don't punish her again by taking away her children. And don't punish her children by tearing them from the arms of a loving mother and throwing them into foster care.

But in a classic example of the same sort of flawed logic that permeates the Commission report, when studies purported to show that "witnessing domestic violence" harmed children, states and localities rushed to remove not the abuser, but the children. In a system prone to jumping on the latest fad - i.e. predictive analytics – the fad for taking away children of domestic violence victims was among the most harmful.

It took a class-action lawsuit to put an end to the practice in New York City.

The judge found that the city child protective services agency "routinely" took children from mothers just because those mothers had been beaten, and he ordered the practice stopped.

Yes, "witnessing domestic violence" can be harmful to some children. But the judge found the consensus of expert opinion is clear: Taking children from battered mothers is much, much more harmful. One expert testified that, for the child, a removal under such circumstances "is tantamount to pouring salt on an open wound."

The section of the Commission report speaking to the matter sounds frighteningly like the equivalent of "please pass the salt."

The report states:

Research shows that perpetrators of domestic violence present a risk not only to their spouses or partners, but also to any children in the home. All who answer or investigate domestic violence calls need to make sure they look out for the safety of the children as much as for the adult victims. In testimony, the Commission heard that law enforcement, domestic violence, and child welfare agencies have critical insights to share with one another in the interest of protecting children in potentially lethal situations.

Maryland and Utah have programs in which professionals use a special lethality assessment protocol at the scene of a domestic violence call. This helps to better flag children in families at risk.

While it is encouraging that this language does not explicitly engage in victim-blaming, there is not one word in a report, purportedly about protecting children, concerning strengthening protections against having them torn from their mothers just because the mothers have been beaten.

And anything suggesting that we follow the lead of Utah in this context should raise a red flag. That state has been among the most fanatical when it comes to launching child abuse investigations because a child saw his or her mother being beaten. Although the Commission

was told of times when the protocol was used to protect mothers and children from abusers, often that's not Utah's approach. In fact, as of 2009, the single largest category of substantiated maltreatment in Utah was children "witnessing domestic violence."

While it is possible that Utah has learned in the intervening years, that should be examined closely before Utah ideas in this area are taken nationwide.

Recommendations concerning drugs

The problem of drug abuse, like the problem of child abuse, is serious and real. But both are easily susceptible to hype and hysteria – and when the two combine, the results are enormously harmful to children.

Every few years we are told about a new "drug plague" – always "even worse" than the previous drug plague - in which the behavior of pregnant mothers who use a given drug supposedly dooms their children – unless, of course, we take the children away. The media said it about crack, and they were wrong. They said it about meth and they were wrong. Now there's a new epidemic of hype about pregnant women who use drugs, both legal and illegal. Those claims are wrong, too.

There are times when a parent's drug addiction is so severe that the child must, indeed, be taken away. But far more often, when there is a real problem, drug treatment almost always is a better option than foster care. (That $1 billion, or maybe it's $4 billion, or maybe more, that the Commission seems prepared to see spent all those new child abuse investigations would by a lot of drug treatment.) That's a lesson we should have learned from one of those earlier drug "plagues."

A landmark study compared two groups of children born with cocaine in their systems – one group left with their mothers, the other placed in foster care. At six months of age the children were compared using the normal measures of infant development, sitting up, reaching out, rolling over. Consistently the children left with their birth mothers did better. For the foster children, the separation from the mothers was more toxic than the cocaine.

And both current law and the Commission recommendations widen the net to include a vast number of cases where there is no need for intervention.

The report calls for strengthening a requirement in the federal Child Abuse Prevention and Treatment Act (CAPTA) that already has done considerable harm. That provision requires every hospital to have a so-called "plan of safe care" often including a requirement that that the mother be reported to child protective services if the mother is suspected of using illegal drugs – whether the infant has been exposed or not – or if the infant is showing symptoms of "withdrawal" – something that can happen even when a parent is using a legally-prescribed painkiller or sometimes even over-the-counter medication.

The stereotypes about "drug abusing" mothers notwithstanding, this definition can

include a mother who smokes a marijuana cigarette – or drinks marijuana tea – to ease the pain of labor. There have been several cases in which children have been taken from their parents under such circumstances.

Yet the Commission demands that enforcement of this requirement be strengthened.

But when medical professionals don't automatically report every case they see, it's probably because they understand these realities and used their professional judgment. That judgment is likely to be superior to that of an often-overloaded CPS worker, who, in some states, can be on the job with no more than a bachelor's degree in almost anything and minimal training.

But the best indication of how misguided the Commission is when it comes to its approach to pregnant women who use drugs can be seen by looking at the state the Commission probably would view as a model. West Virginia has a national reputation for being particularly strict about demanding that medical professionals turn in any mother who uses illegal drugs or has an infant "exposed" to drugs whether legal or illegal.

The Commission wants us to believe "plans of safe care" are just ways to get help to families. But that's not how it worked out in West Virginia.

West Virginia tears apart families at a rate higher than all but two others, even when rates of child poverty are factored in. The rate of removal in West Virginia is more than two-and-a-half times the national average. Nationwide, in 2014, children were taken from their parents 264,000 times. But if every state were like West Virginia, the foster care system would be flooded with 680,000 entries into foster care – year after year after year.

We should beware of any Commission proposal that risks taking the West Virginia model nationwide.

And we should have learned by now: Whenever we take a swing at so-called bad mothers, the blow lands on the children.

The "plan of safe care" recommendation isn't the only place where the Commission appears to want to strongarm doctors. Elsewhere the report says that "Medicaid should create greater accountability for health-care providers to screen families at elevated risk for maltreatment." Neither screening nor accountability is defined.

For a Commission that says over and over and over and over that it wants a "public health approach" to child welfare, it sure doesn't seem to trust doctors very much.

Racial and class bias

It could have been even worse.

Earlier drafts included a proposal – not included in the final report - that gave away the

fact that the profound biases of race and class that permeate the child protective services process were present at the Commission as well. The draft states:

CMS [the federal Centers for Medicare and Medicaid Services] could require universal drug testing for all newborns where Medicaid is the source of payment for delivery services.

The idea that, in a free society, a Commission would even consider a call for mandatory universal drug testing of *any* group is appalling. Police can't search someone's home without "probable cause" – at least in theory - yet this even more invasive form of search is something the Commission considered trying to make routine -- but only if you're so poor that your maternity care is covered by Medicaid.

All evidence shows that middle-class and wealthy Americans are just as prone to use drugs as poor people. And as the Annie E. Casey Foundation notes in this report, "Black and Hispanic Americans use drugs at levels comparable to, and in some instances, lower than white Americans." Yet the recommendation targets poor, pregnant women, who also, of course are more likely than wealthier Americans to be people of color.

Of course the Commission might say they wrote the recommendation that way because CMS only has jurisdiction where Medicaid is the method of payment. But there are all sorts of other federal programs that affect hospitals and could be used to strongarm them into doing what the government wants. But the Commission focused only on the agency that deals with poor people.

And the bias was clear during commission deliberations.

It was only at the very end of a two-year process, during chaotic, marathon conference calls that the Commission got around to debating draft chapters on Native American child welfare and racial bias in child welfare. If those chapters in the final report seem rather thin, there's a reason.

Judge Martin led the effort to get the Commission to address these issues. But she didn't seem to get very far.

One recommendation after another was voted down. This does not mean all the recommendations were good – it's hard to know without actually seeing them, but we probably would have disagreed with at least one of them – but it sounded as though the chapters were pretty well eviscerated.

Worse was the way it was done. Judge Martin was in transit during much of the time the conference call discussing the racial bias recommendations took place. She would call in from an airport, then have to get off the call, then call in again from a taxi. She did everything she could to be a part of the process.

But the Commission did nothing to accommodate her. On the contrary, several times Commissioners asked if Judge Martin was on the phone so she could answer a question. When

she wasn't there, they proceeded to vote the recommendations down anyway; one after another after another.

The Commission Chair, David Sanders, might argue that there was no choice; they were on a tight deadline. But that's only because of the chaos that characterized the Commission's work as they raced to get the final report to the printer.

And then, according to Judge Martin, Sanders threatened to edit or censor entirely any dissenting report he didn't like. So Judge Martin decided to publish her dissent separately.

CONCLUSION

We spend much time in this report discussing a flawed assumption at the heart of the commission's work – the one about applying a "three psychics in a bathtub" approach to child welfare.

But there's another flawed assumption, the one on which the very existence of the Commission depends: That is the assumption that the best way to reduce child abuse deaths is to isolate that issue from every other issue in child welfare.

But that simply can't be done – for that reason for which we all should be so grateful: Child abuse deaths represent a very small number of needles in a very large haystack. You won't find the needles by trying to vacuum up the haystack.

Or, as Judge Martin wrote in her dissent:

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.

In fact, it appears that the focus on fatalities was a tactic to squelch any solutions that do not call for investigating more families and taking away more children. Over and over recommendations geared to helping families would be dismissed, particularly by Michael Petit, as having nothing to do with reducing fatalities.

But, for the reason Judge Martin suggests, those recommendations have everything to do with reducing child abuse fatalities.

The more sensible approach is the one suggested by Judge Martin and by ChildTrends and by the Center for Public Policy Priorities: Target a reduction in the conditions that lead to child abuse in general. That will reduce child abuse deaths, and ease the misery of many more children and families.

ENDNOTES:

[i] .Joseph Goldstein, Anna Freud, and Albert J. Solnit, *Before The Best Interests of the Child* (New York: Free Press, 1979) pp.9, 25.
[ii] Personal communication.
[iii] Study Findings: Study of National Incidence and Prevalence of Child Abuse and Neglect: 1988 (Washington: U.S. Dept. of Health and Human Services, National Center on Child Abuse and Neglect, 1988), Chapter 6, Page 5.
[iv] Jon Lender, "Children Moved to Foster Care," *Hartford Courant*, April 14, 1995.
[v] Susan Pearsall, "Foster Parenting's Love and Structure," *The New York Times* Connecticut Weekly April 9, 1995.