



COMMISSION TO ELIMINATE
CHILD ABUSE AND NEGLECT FATALITIES

INTRODUCTION

Imagine a society where children do not die from abuse or neglect.

... where the safety and well-being of children are everyone's highest priority.

...where federal, state, and local agencies work collaboratively with families to keep children safe.

...where child protective services agencies no longer stand alone but share a mandate with multiple partners to keep children safe.

Imagine a society ...

...where research and data about child abuse and neglect fatalities are shared in order to identify those most at risk and make informed decisions about policies and resources.

... where state and local agencies charged with supporting families have the leaders, staff, funds, and flexibility to support families when and how it is most helpful.

Imagine a society...

...where children who grow up in foster care get the support they need to become the parents they never had.

... where all children are equally protected and their families equally supported, regardless of race, ethnicity, income, or where they live.

**IMAGINE CHILD WELFARE IN THE 21st CENTURY ...
WHERE CHILDREN ARE SAFE AND FAMILIES ARE STRONG
AND WHERE PREVENTION OF
CHILD ABUSE AND NEGLECT DEATHS IS A REALITY**

What Will It Take to Get There?

Two-year-old Ivan Merlos died at the hands of his 19-year-old mother in Los Angeles County in 2003. He was beaten in the stomach and died from massive internal bleeding. This last beating was not the first. On an earlier occasion, he was brought to the hospital with a broken leg. A nurse was suspicious of abuse and called the Department of Children and Family Services (DCFS) and the police. The broken leg was the fifth time DCFS was called to investigate the family. No services were offered to this family who clearly needed help long before Ivan died.

Ivan and his mother were well known to the Los Angeles DCFS. At least nine social workers and supervisors had been involved, but none got a full picture of Ivan's family life. They took no action because they lacked the evidence to substantiate reports of neglect and violence. And then the toddler died at the hands of his young mother.

Child protective services staff, medical personnel, and law enforcement officers all saw this child, and all failed to protect him. Imagine what Ivan's life might have been had these support systems offered services to his family or removed him to a safe placement.

If Ivan had lived, he would have been 15 years old today. He would have been a teenager in high school. Maybe he would have played soccer or basketball. Like most teens, he would have begun dreaming of his future, possibly wanting to serve his community as a law enforcement officer or even a social worker. But Ivan was failed by the systems that could have protected him. He had no future at all.

CHILD ABUSE AND NEGLECT FATALITIES AFFECT US ALL

Ivan's death, and that of every child who dies from abuse or neglect, has a profound and devastating impact. Joseluis Morales, a child protective services (CPS) supervisor in Texas, told the Commission that a fatality "is enough to just drop you to your knees. It is stuff that will stick with you your whole life." Beyond the child's immediate family and community, the ripples of each life cut short extend even further to us all. Ivan's family has an empty seat at the table. His classroom has an empty seat. His sports team is missing a player.

A 2012 study from the Centers for Disease Control and Prevention (CDC)¹ found that the total lifetime cost for just one year of confirmed cases of child maltreatment (physical abuse, sexual abuse, psychological abuse, and neglect) is approximately \$124 billion. If a child dies from abuse or neglect, the death equates to a lifetime cost of about \$1.3 million per child,² money the child would have earned over a lifetime as a productive citizen if he or she had lived. The lifetime cost of near fatalities is also extremely high, especially for children who suffer head trauma or other major injuries that require medical care and support throughout their lives.

¹ Fang, X., Brown, D. S., Florence, C. S., & Mercy, J. A. (2012). The economic burden of child maltreatment in the United States and implications for prevention. *Child Abuse & Neglect*, 36(2), 156-165. Retrieved from <http://www.sciencedirect.com/science/article/pii/S0145213411003140>. Also see the CDC website at <http://www.cdc.gov/violenceprevention/childmaltreatment/economiccost.html>.

² Ibid.

Despite these shocking figures, the monetary cost pales in comparison to the emotional cost to families, communities, and society as a whole. Every fatality and near fatality takes an irreversible toll.

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“Every child abuse and neglect fatality represents an immeasurable loss to the family and to the community, and is devastating to my workers and every health care person, every family member involved. We mourn the death of each child, but I want to learn from those deaths. I think we have an obligation to learn from those deaths.”

-- Judge John Specia, Commissioner of the Texas Department of Family and Protective Services.

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STATISTICS DON'T TELL THE WHOLE STORY

Ivan was one of many children who died at the hands of a caregiver, a crisis that continues to this day. The National Child Abuse and Neglect Data System (NCANDS), the federal system that collects data on child abuse and neglect from the states, estimates that approximately 1,500 children die from maltreatment each year.³

But experts believe that the real number may be much higher. Some suggest that a better estimate is close to 3,000 deaths a year—more than die annually from childhood cancer. This means anywhere from four to eight children die each day from abuse or neglect. Most of these children are younger than 4 years old, and the majority of those are infants.

Although the media are more likely to write headline stories about deaths like Ivan's, the causes of child maltreatment fatalities vary widely. Experts agree with NCANDS that approximately 70 percent of these fatalities result from neglect, which includes circumstances as varied as a toddler drowning in a bathtub or swimming pool or an infant suffocated while sleeping with an intoxicated adult. And one half or more of fatalities involve children and families unknown to the local CPS agency before the death occurs.

BEYOND BLAME: COMPLEX PROBLEMS REQUIRE THOUGHTFUL SOLUTIONS

In cases of high-profile fatalities, legislators, government officials, and the media react with understandable outrage. Journalists offer heartbreaking details of the tragedy and ask, How could this have happened? When the child or family was known to the CPS agency, the anger is more pointed: Why didn't CPS do anything to prevent this death? When CPS wasn't aware of the family: Why not?

³ Child Welfare Information Gateway. (2014). *Child abuse and neglect fatalities 2013: Statistics and interventions*. U.S. Department of Health and Human Services, Children's Bureau. Retrieved from <https://www.childwelfare.gov/pubPDFs/fatality.pdf>.

The commissioner of the child welfare agency and frontline workers are often targets of blame, as if their personal shortcomings had led to the child's death. Other systems and professions are rarely implicated, yet, as in Ivan's case, they are often involved with the families in some capacity. The media publish headlines. The legislature calls for hearings. The commissioner is forced to step down. A new commissioner arrives with a mandate for change. With the best of intentions, the new commissioner upends the system, calling for changes in the agency's funding, policy, and practice. Sometimes, but not always, the legislature adds a little money to hire more social workers and expand the safety net.

These agency reforms can be important steps, but they usually focus on CPS alone. And children continue to die. The cycle—high-profile child death, commissioner leaves, new one appointed—is far too likely to repeat itself. It is little wonder that the average tenure of a child welfare commissioner is 18 months.

As with most complex and persistent problems, this one cannot be isolated to a single human's error. We must look more closely at the complex causes and systems in place. Vulnerable families have numerous touch points among a network of support systems that extend beyond the child welfare system: from pediatricians and health care providers, to child care centers and educators, to law enforcement and faith-based institutions, and not least, relatives and neighbors. All have a critical role to play in interrupting the cycle of child fatalities ... and saving children's lives.

LESSONS FROM THE PAST: COORDINATED ACTION CAN REDUCE CHILD DEATHS

Reducing child mortality is not a new concern in this country. It was, in fact, one of the main goals of the U.S. Children's Bureau when it was founded in 1912 as the first federal agency in the world dedicated to the well-being of children. At the time, infant mortality rates were estimated at close to 1 in 10 live births. Like child abuse and neglect fatalities today, infant deaths then resulted from a variety of causes and risk factors. Although there was plenty of concern, solutions were not immediately evident.

The Children's Bureau led an effort to apply research, improve methods of measurement, and educate parents around child development. Working with public and private partners, they introduced a range of community-wide improvements in sanitation, living conditions, and food safety. They saw quick results: Infant mortality rates declined 24 percent from 1915 to 1921. By the 21st century, infant mortality had dropped to just 6.6 deaths per 1,000 births.

Other more recent examples also show that coordinated, directive action can reduce child deaths. The incidence of sudden infant death syndrome (SIDS) was vastly reduced by a range of activities, legislation, and policy change. The SIDS Act of 1974 recognized it as a major public health issue. Research found a link between SIDS deaths and babies who slept on their stomachs. A national campaign to promote babies sleeping on their backs was launched by the American Academy of Pediatrics and other organizations. The Surgeon General issued a policy statement, and the executive branch of government added its voice to the effort. Since the campaign's inception, the SIDS rate has dropped more than 60 percent.

There was no magic bullet for either of the above campaigns, just as there is no magic bullet to prevent child fatalities from abuse and neglect. But these campaigns and others—successful reduction of automobile deaths from using seat belts, reducing cancer deaths

through cigarette warnings—show that public will, policy change, and coordinated leadership can make a difference.

IT'S TIME FOR A NATIONAL STRATEGY

CECANF Commissioners heard from a few communities that have come together in ways that appear to be reducing deaths from child abuse and neglect. Some of those stories are reproduced here, through the course of this report.

These approaches are promising, but the Commission found no state or local response that included all elements we believe are necessary to achieve widespread, lasting results. Also lacking is a coordinated national response to this issue—one that brings all of our collective knowledge about the problem to bear in creating solutions that can be implemented locally to meet the needs of children, families, and communities everywhere.

To succeed, we need a national strategy in which leaders at all levels work together across agencies, collecting better data to make sound decisions about policy and practice. We need to reach beyond the CPS agency alone for solutions, effectively marshaling the knowledge, skills, and resources of all government and community agencies that come into contact with families who have young children. Finally, we need public will and state and federal legislative support to bring such a national strategy to life.

In short, we have reached a tipping point where it is necessary to move away from old patterns and adopt a new course of action to prevent child maltreatment deaths. A new national strategy will be built on safety and on answering the question: If we all had the tools and resources we needed to solve this problem, what would it look like?

- What would it look like if the issue of child abuse and neglect fatalities was elevated and coordinated at a federal level?
- What would it look like if CPS, law enforcement, public health agencies, and other partners were enabled and empowered to share resources and data on behalf of children, thus enhancing communication and collaboration so that fewer children fall through the cracks?
- What would it look like if we had standardized data on children and families at risk of fatalities, data that allow child protection agencies and their partners to allocate resources to those most vulnerable?

As we will show throughout this report and in our recommendations, a coordinated national strategy will create an environment in which promising practices and policies can be brought to scale. It will test new theories and policies for safety and sustainability. It will address the limitations of many CPS agencies across the country. It will prioritize critical services for troubled parents of infants, including home visiting and treatment for substance abuse, mental illness, and domestic violence. It will include updated technology and data analytics to serve those most at risk. It will encompass parental education and support before problems lead to crisis. Finally, it will build political will to create lasting change.

As a Commission, we are convinced that together, we *can* save lives. It's time to stop imagining change and make it a reality.

END OF INTRODUCTION

CHAPTER 1: CPS AGENCIES IN CRISIS

In 2014, a young mother from Lehighton, PA, fell asleep in bed with her 6-week-old son. The baby, named Brayden, died from asphyxia. The mother, Tory Lyn Schlier, had been prescribed methadone, as had Brayden, who had drugs in his system when he was born. Blood samples from Schlier on the day of Brayden's death revealed that she was also taking amphetamine, methamphetamine, and alprazolam, an anti-anxiety drug.

Schlier pled guilty to involuntary manslaughter and is serving time in prison. The CPS agency labeled the death "serious physical neglect." The coroner called it a homicide. Whatever it is called, this rollover death was a tragedy long in the making.

As a teenager, Schlier was the subject of a CPS referral due to her "incurable behavior" and drug use. She was expelled from school. Her father had a history of drug abuse, and her stepmother gave her Vicodin. Throughout her teens, despite involvement in CPS and the criminal justice system, Schlier received little in the way of services or support and remained at home.

In 2013, Schlier was sentenced to probation for possession of a controlled substance and required to participate in a drug or alcohol treatment program. Her probation was revoked in 2014. When Brayden was born, health care officials made no referral to CPS for drugs in his system because methadone is a legal drug.

Six weeks later, admittedly high on illegal substances, Schlier rolled over onto her baby in bed and killed him. For years, Schlier had attention from numerous child welfare, criminal justice, education, and medical professionals, all of whom missed opportunities to help steer her life in another direction. In the meantime, Brayden's short life was over.

When tragedies like Brayden's death occur, we naturally look to the county- or state-run child protective services (CPS) agency for answers. CPS is the government body responsible for protecting children from abuse and neglect by caregivers. Child safety is its mantra and its primary charge. But as was evident in the cases of both Ivan and Brayden, the CPS agency does not always succeed.

In general, this is not because child welfare leaders and social workers fail to take their responsibilities seriously. In fact, most are dedicated public servants who have the best interests of children at heart. They ensure the safety of the vast majority of the more than 6 million children who come to their attention each year. In most cases, these children remain safely at home, sometimes with services provided to support their families. When removal from the home is necessary, CPS strives to place children in safe kinship or foster homes. Many are able to return to their birth parents once safety threats are resolved. Others are placed in new permanent families.

Yet child maltreatment fatalities persist, leading many to wonder: Why does CPS still fail all too often to identify and address the small subset of families who pose the most serious risk to their children? Why do children, approximately 80 percent of them babies and toddlers,⁴ continue to die at the hands of their parents or caregivers?

The Commission believes that deaths like Brayden’s can be prevented, but we must look beyond the CPS agency for broader solutions. This chapter will show that CPS agencies, in their current configuration, are burdened by a host of systemic and policy limitations that inhibit their efforts to keep children safe and prevent fatalities from abuse or neglect. At the end of this chapter, we provide an overview of the Commission’s proposed National Strategy to address these problems.

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Child Safety: An Accident of Geography?

We can all agree that every child is entitled to be safe from harm, regardless of where he or she lives. In reality, however, the state or local jurisdiction in which children live can have a tremendous impact on the degree to which they are protected.

- **Case screening**—Hotline calls are screened at the state or local level to determine whether there is enough information to pursue an investigation or assessment and whether the alleged incident meets the state’s definition of child abuse or neglect. Although the Child Abuse Prevention and Treatment Act (CAPTA) specifies minimum standards, each state establishes its own definitions of maltreatment. Some allegations are screened out before they are even investigated because they do not fit the definitions in that state, even though they might be screened in elsewhere.
- **Triage**—For cases screened in, the agency assesses the urgency of the response required based on the level of danger present. Again, these criteria are defined by state or county agency policy. As these policies vary, so does the amount of time that is considered acceptable for a child to wait before an investigator is dispatched to assess the child’s safety (these can vary from immediately to 5 days or more).
- **Substantiation**—Investigators determine whether a case should be substantiated as abuse or not, with the accompanying monitoring and protection that such a determination entails, according to the outcome of safety and risk assessments and standards of evidence that vary by state.
- **Removal and services**—There is no standard safety assessment tool to determine whether children are in sufficient danger to be removed from the home. Services offered to families—including mental health, domestic violence, substance abuse treatment, and more—are often based on availability and waiting lists, as much as by families’ needs.

These differences may play a role in the vastly different rates of child maltreatment fatalities reported from state to state—ranging from 0.00 to 4.54 per 100,000 children in the population, according to NCANDS—which means child safety is, at least in part, an accident of geography. Some states lack the resources to do better. Others don’t have the will.

⁴ Child Welfare Information Gateway. (2014). *Child abuse and neglect fatalities 2013: Statistics and interventions*. U.S. Department of Health and Human Services, Children’s Bureau. Retrieved from <https://www.childwelfare.gov/pubPDFs/fatality.pdf>.

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THE CURRENT CPS SYSTEM: OVERBURDENED AND UNDER-RESOURCED

Put simply, the present-day child protection system is not always able to serve the very children and families who need help the most. High caseloads, stressed workers, and limited services affect social workers' ability to do their job. State and federal budgets do not keep up with the needs of children or the CPS agencies that are charged with protecting them.

Predicting which families have problems that will lead to fatalities is an exceedingly complex challenge. Risks associated with fatalities are multifaceted, including child factors (such as low birthweight, disability, and persistent crying), familial factors (including parental drug abuse, domestic violence, mental illness, stress, and limited caregiving knowledge), and ecological factors (such as poverty, social isolation, and community violence). As these factors interact, a child's risk for fatal maltreatment is exacerbated. However, families in which children die often look like many other families with similar risk factors...until they don't.

If we are to prevent fatalities, we cannot wait for a serious incident to take place and bring the family into the child welfare system. In hearings across the country and in written testimony, Commissioners learned about a host of fundamental, complex reasons that CPS agencies, acting alone, cannot successfully prevent fatalities.

Many Children Who Die Are Not Known to CPS Agencies Before Their Death

Perhaps most significantly, the Commissioners heard repeatedly that as many as half of the child abuse and neglect fatalities each year affect children who were *not known* to their local CPS agency before they died. A key reason for this is that infants and the youngest children (under age 4) are at greatest risk of a fatality. These children have not yet reached school age, when they are more likely to draw the attention of mandated reporters. In the most extreme cases, few beyond the immediate family even know of their existence.

Pediatricians, nurses, family physicians, hospital personnel, and child care providers are perhaps the most likely to see very young infants at risk, but they do not always have the right training to recognize abuse or neglect or act on their suspicions. This is made even more difficult when no abuse or neglect has yet occurred. In these cases, professionals must be able to recognize dangerous caregivers, not just the physical signs of abuse or neglect of a child. This issue reaches back to pregnancy as well, when OB-GYN physicians see pregnant women such as Tory Lyn Schlier taking drugs and fail to raise an alarm. As a result, even in families previously investigated by the CPS agency for a serious injury, if the case is closed, a new baby may pass under the radar screen undetected until it is too late.

CPS Agencies Primarily Respond to Incidents After They Happen, Not to Risk of an Incident

To prevent the potential for overstepping by government, in most jurisdictions CPS is empowered to intervene with families only after a child has been harmed or experienced a direct threat of harm. For these children, an accurate assessment of their safety and the likelihood of future serious harm or death is critical to preventing fatalities. However, rarely are CPS agencies alerted to families with similar risk factors who have not yet endangered

their children—even if those risk factors might lead to severe harm or fatalities in the future. In fact, when families at risk are the subject of a hotline call, they may be screened out if the caller fails to describe an actionable incident of abuse or neglect.

CPS Agencies Are Held Solely Accountable for Addressing Child Abuse

CPS, by statute in most states, carries the sole responsibility for safety. However, CPS leaders know well that they cannot solve the problem of child fatalities alone. They recognize that, as with Ivan and Brayden, a host of other professionals and systems have contact with vulnerable families. Child welfare leaders know it is important to collaborate with law enforcement, health care, education, and treatment programs for substance abuse, mental illness and domestic violence.

Still, effective collaboration varies from state to state and jurisdiction to jurisdiction; rarely is it systemic, sustained, or adequately funded. CAPTA, the Child Abuse Prevention and Treatment Act, requires CPS agencies to collaborate with other child- and family-focused partners, but making it happen is up to CPS, and there is no mechanism to hold agencies accountable for doing so. Although professionals in other fields want to help, they are not always enabled or supported by their own agencies' policies or funding streams. Sometimes they are hampered by privacy policies that have the unintended consequence of interfering with their ability to take action that would best protect children. Families themselves may be reluctant to ask for help from CPS, since wisdom on the street is that CPS removes children.

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Could Phoebe Jonchuck Have Been Saved?

Early on the morning of January 8, 2015, 5-year-old Phoebe Jonchuck was dropped by her father, John Nicholas Jonchuck, Jr., over the edge of the Sunshine Skyway Bridge in Tampa, FL. She fell approximately 60 feet and drowned in the water below. In the days preceding Phoebe's death, there were two hotline calls raising concerns about Jonchuck. The first was on December 29, 2014, when concerns were raised about past physical violence. The second call was received less than 12 hours before Phoebe's death; the caller raised concerns about Jonchuck's behavior earlier that day.

Though the family had an extensive CPS history and Jonchuck had an extensive criminal history, including domestic violence, both CPS and law enforcement concluded they did not have grounds for intervention. To law enforcement, Jonchuck did not meet the criteria for an involuntary mental health evaluation under Florida law. His behavior was erratic, but law enforcement officials believed he was not currently threatening harm to himself or others. The CPS intake worker concluded that the agency, too, did not have an applicable allegation upon which to initiate an investigation. At the time of the call on the day of Phoebe's death, Jonchuck was not currently supervising Phoebe, so she was not perceived to be in present danger from his bizarre behavior.

This case did not meet Florida guidelines for action and led to tragedy for Phoebe. Her story might have been different if law enforcement and CPS had

communicated, sharing the information they had about the family. Had they done so, the danger to Phoebe from her father might have become more apparent, and they might have taken action based on the clear threat of future harm. But it was too late for Phoebe.

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CPS Agency Staff Are Burdened With High Caseloads and High Turnover Among Colleagues

Those who testified in the Commission’s public hearings stated repeatedly that social workers are overwhelmed with the level of decisions they are tasked with making, especially when high caseloads limit the amount of time and the quality of support they can give to families in the system. Frontline workers are often young and inexperienced. It is an entry-level job in most jurisdictions. Social workers’ training by itself does not prepare them for the life-and-death decisions that often require specialized knowledge about the medical, domestic violence, substance use, and mental health needs of the families they serve. Workers burn out and turnover is high, which means more workers have to be trained and come into the job without experience.

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From a Worker’s Point of View

Emily Douglas, Associate Professor of Social Work at Bridgewater State University, testified before the Commission in Vermont. She read the following statement from a child welfare worker:

“The blame for a child death usually lands on the frontline worker. We cannot live with the families we work with. While a good service worker can prevent some maltreatment, it is impossible to prevent all maltreatment. In some situations, workers do not have the evidence needed to legally mandate a family into services, which might prevent the maltreatment. As a worker, I am extremely stressed by my caseload and frequently worry that a child will die. I work weekends and sometimes until 8:00 or 9:00 p.m. to keep up with the work, but if one child dies, I will never feel that I did enough. Most child welfare workers truly care about the families on their caseloads. But... we are fighting a losing battle. My entire academic experience as a professional social worker has prepared me for this job, and I am still overwhelmed by the massive responsibility.”

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A High Proportion of CPS Agency Resources Support Children at Low Risk of Harm

The door to child protective services is a wide one, and many children and families enter when the children are at low risk of harm. Too many children stay in care longer than 15 months, the federal requirement for permanency. Youth in particular are likely to have long-term stays in residential facilities, the most costly placements of all. This means a disproportionate percentage of title IV-E dollars are focused on families at low risk of fatalities, and on services that don’t fit their needs.

Evidence-Based Practices to Prevent Fatalities Are Lacking

CPS investigators are charged with making some of the most important decisions one person can make about another, including when it is necessary to remove children from their parents and when families can be safely reunited. Yet the Commission learned that evidence-based tools to accurately predict the likelihood of future harm do not exist. The current safety assessment protocols used across the country largely lack scientific evidence of validity, and there is little information about the fidelity with which these tools are used from state to state and worker to worker.

There is evidence that some practices, including adult and child mental health treatments, substance abuse treatment programs, and domestic violence services, can prevent abuse. But we currently lack research to show that these programs are effective in preventing fatalities or data to help CPS agencies identify which families should be prioritized to receive services.

Many CPS Agencies Lack Access to the Services Families Need

Total child welfare expenditures from all sources in fiscal year (FY) 2012 reached approximately \$28 billion, with the overwhelming percentage of these funds going to out-of-home placement.⁵ Foster care services are often necessary to keep children safe, as are services to intervene with struggling families who might be helped to get off a track that leads to future harm to their children.

Availability and accessibility of services beyond foster care—those that could help keep a struggling family safely intact—vary widely across the country. The Commission repeatedly heard testimony about long waiting lists and limited access to services, especially in rural areas. The problem is extreme in Indian Country. On one reservation, just one social worker was responsible for an area spanning 2 million acres.

In addition, CPS agencies almost always rely on services implemented by community partners, which means these services are not dedicated to CPS clients. Families in the child welfare system must compete for access with other populations, sometimes resulting in long waits for families and children who can least afford them. Better-funded jurisdictions have been able to address this problem by directly purchasing such services for their families, but this is not true across the country.

Funding for Preventive Services Is Limited

Because of the emphasis on responding to past incidents of maltreatment, most child welfare agencies across the country struggle with a lack of resources to prevent harm to children before it occurs. Prevention of harm is very much on the mind of child welfare leaders and practitioners, but few jurisdictions have the resources, support, or infrastructure to make preventive services part of standard operating procedure. Child death reviews sometimes conclude, in hindsight, that many fatalities could have been prevented with the right intervention at the right time.

⁵ DeVooght, K., Fletcher, M., & Cooper, H. (2014). *Federal, state, and local spending to address child abuse and neglect in SFY 2012*. Retrieved from <http://www.childtrends.org/wp-content/uploads/2014/09/2014-47ChildWelfareSpending2012.pdf>

CPS gets most of its federal funding from title IV-E, an entitlement program that contributes matching funds to states. But IV-E mainly covers support for out-of-home placement, and there are few funding streams for programs to support families *before* a crisis leads to severe harm or fatalities. The federal agencies that do offer funds for preventive or aftercare services have much smaller budgets to be distributed across 50 states. This means limited opportunity to build and evaluate new services and programs and limited impact.

CPS Investigators Do Not See the Family’s Entire Circumstances

Few investigators have the time for a comprehensive look at a family’s past history and living experiences (unless the family has previously been in the system). They may also lack access to information in other systems that could contribute to a more complete picture of the whole family. Poverty, lack of adequate housing, unemployment, and crime-ridden communities all contribute to stress that, in vulnerable families, can reach a tipping point. There is no evidence that these factors lead to fatalities, but families that deal with such difficult environmental conditions are often under extreme stress.

A STRATEGY FOR THE 21st CENTURY

The Commission’s strategy, outlined in this report, proposes a child welfare system for the 21st century. It responds to the struggles and shortcomings we heard described by many experts—both within and beyond CPS agencies—in public hearings across the country, as well as in written testimony and extensive meetings with stakeholders. With the input of all of these contributors, we are proposing fundamental changes in how child protection is understood and operated today. These changes will require policy changes, planning, and a shift in how resources are used. **It does not add to our government infrastructure but, rather, establishes partnerships with existing government and community agencies.**

When implemented, this National Strategy will establish a comprehensive, multifaceted system that reaches far beyond CPS. It is a strategy that both seeks to strengthen CPS and calls on federal and state governments and many other partners to close policy and communication gaps that currently leave children and families vulnerable. Only with such an extensive strategy will we reach families at risk of seriously harming their children and solve the complex problems that have led to our current crisis.

The Commission’s strategy builds on three interrelated, core components that the Commission believes have the greatest potential to impact the prevention of child abuse and neglect fatalities. *Section One* of this report discusses these components in detail:

- 1. Collective Responsibility for Safety**—A proactive, multisector response to preventing child maltreatment fatalities
- 2. Leadership and Accountability**—Aligned leadership to drive change, define measures of success, marshal the necessary human capacity and resources to achieve results, and regularly assess progress
- 3. Decisions Grounded in Stronger Data**—Data that are more complete, standardized, valid, and reliable



Caption: A National Strategy Based on Three Core Components

Section Two of the report shows what can happen when these components come together. It articulates specific ways that a new, more broadly configured child protection system, supported by strong leadership and better quality data, can be empowered to apply what is known about child abuse and neglect fatalities right now to more effectively keep children safe in strong families. It also explores how, moving into the future, we can continually expand the cutting edge of our capacity to build safety cultures, analyze data, and employ resources based on the findings to protect vulnerable children.

Section Three discusses specific considerations for applying the Commission's recommendations with American Indian/Alaska Native communities and military families, and for addressing the disproportionate impact of child fatalities on minority communities.

With this new strategy, the Commission believes communities will be better positioned to apply what is known and evaluate programs and services designed to support those families at risk of seriously harming or even causing the death of their children.

We believe implementing this strategy is both feasible and necessary to create an effective and all-encompassing child welfare system in the 21st century. To paraphrase Maya Angelou, now that we know better, we must do better. Our children's lives are at stake.

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