



NICWA
National Indian Child Welfare Association
Protecting our children • Preserving our culture

An Overview of Child Maltreatment in American Indian/Alaska Native Communities

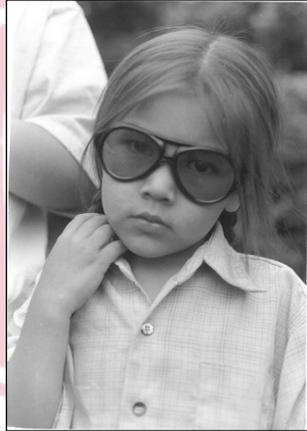
Terry L. Cross, MSW, National Indian Child Welfare Association

Historic Context and Lived Experience

- Diversity of tribes
- Historical context (cultural practices, colonization, and research trends)
- Inadequate resources



Data Issues for AI/AN Communities



- AI/AN specific data on risk factors is lacking
- Exclusion of AI/AN from data sets/analysis (NIS-4)
- Often confusion about who reports and to where.
- Little engagement/sharing of data by federal and state agencies that collect and report AI/AN data.

Parental Risk Factors

- 34 % of AI/AN children live in households with incomes below the poverty line as compared to 20.7 percent of children nationwide. (Maternal and Child Health Bureau, 2012)
- 18% of AI/AN adults needed treatment for an alcohol or illicit drug use problem in the past year compared to the national average of 9.6%. (SAHMSA, 2010)

Parental Risk Factors

- AI/AN parents are more likely to struggle with mental health issues, and distress related to unresolved trauma.
- AI/AN adults had the highest rate of a serious psychological distress (25.9%), and the highest rates of a major depressive episode (12.1%) (UIHB, 2012).

Child Risk Factors

- AI/AN are more likely to have special needs and be served by the Individuals with Disabilities Education Act (IDEA) at a higher percentage than any other group of children.
- 14% of AI/AN children received services under IDEA, compared to 9% of the general student population. (DeVoe & Darling-Churchill, 2008).

Family Risk Factors

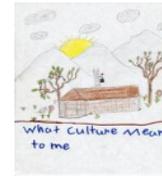
- Major barrier to health services for AI/AN individuals is social isolation, including cultural barriers, geographic isolation, and low income. These are all risk factors and common in reservation communities. (Office of Minority Health, 2012)
- 39% of AI/AN women report having experienced interpersonal violence (IPV) at some point in their lives (CDC, 2008)

Community Risk Factors

- 24% of AI/AN children live in areas of high concentrated poverty compared to the national average of 11%. (Kids Count, 2012)
- AI/AN individuals are more likely to live in communities with high rates of criminal victimization and under-policing of the community. (Wells and Falcone, 2008; US Department of Justice, Office of Tribal Justice, 2001)

Definition of Child Maltreatment

- Inconsistent across states
- States definitions do not match tribal definitions
- Definitions used by many states contain bias
- Vague state definitions have historically been employed broadly when states work with AI/AN families



Prevalence Data in AI/AN Child Maltreatment

- Federal data system is NCANDS
- NCANDS reports only state data
- State data includes only 61% AI/AN children in the child welfare system (Earle, 2001)
- State data reflects state CPS worker's bias



Prevalence Data in AI/AN Child Maltreatment

- Reports of AI/AN child maltreatment are proportionate to their population.
- Studies show AI/AN children in a state system are:
 - 2x more likely to be investigated,
 - 2x more likely to be substantiated, and
 - 2x more likely to be placed out of home (Hill, 2007)
-

Prevalence Data in AI/AN Child Maltreatment

- AI/AN children experienced a rate of child abuse and neglect of 11.4 per 1,000 AI/AN children compared to the national rates of victimization of 9.1 per 1,000 (Children's Bureau, 2012).
- Of all child victims, AI/AN children are more likely to be confirmed as victims of neglect (89.3 %) and less likely to be confirmed as victims of physical abuse (15.6%) and sexual abuse (5.6%) (NCANDS, 2012).

Prevalence Data in AI/AN Child Maltreatment

- 2.2 AI/AN children out of 100,000 were reported as fatalities due to child maltreatment, compared to 2.2 of 100,000 children nationwide (NCANDS, 2012).
- Approximately 85% of all AI/AN child maltreatment cases are related to substance abuse. (NICWA, 2005).

Legal and Services Framework

- Myriad of laws and entities with authority/responsibility to report, investigate, treat, and adjudicate AI/AN child maltreatment.
- Complexity and lack of clear understanding of roles and authority contribute to gaps in system.
- Tribes and states have developed measures to address gaps and promote more effective responses.



Legal and Services Framework

- No formal legal or established framework for addressing child maltreatment fatalities on tribal lands.
- Could be any number of public or private entities involved in the investigation and determination of cause of death.
- Unclear as to how child fatalities are being classified in Indian Country (tragic accident or death as a result of child maltreatment).
- Criminal prosecution can also be complex and contain serious challenges.

Legal and Service Framework (Civil)

System Element	Possible Provider	Variables
Reporting child abuse or neglect	Mandatory reports under state, federal, or tribal law; on or off reservation; or concerned individuals	Tribal and/or state laws, P.L. 280
Intake and screening Initial response Initial assessment	Tribal Child Protective Services (CPS), tribal law enforcement, state CPS, county law enforcement, BIA social services, BIA law enforcement, IHS or tribal health care providers	Tribal law, P.L. 280 status, P.L. 93-638 or self-governance status, local agreements or protocols
Civil court actions	Tribal court, state court	Jurisdiction, tribal law, P.L. 280 status, P.L. 93-638 or self-governance status
Treatment <ul style="list-style-type: none"> • Psycho-social assess • Service plans • Family and care services 	Tribal CPS, state CPS, BIA social services, IHS or tribal health care providers	Resources, capacity, P.L. 280 status, P.L. 93-638 or self-governance status

Funding and Resources

Funding is almost non-existent for tribal child abuse prevention, protection, and treatment.

- Title IV-B Subpart 1
 - funds majority of tribes at less than \$10,000 a year.
- Title IV-B Subpart 2
 - not available to all tribes (almost 1/3 receive no funds) and funding amounts are only modestly larger than those under IV-B Subpart 1.

Funding and Resources

- CAPTA
 - Basic CAPTA funding- No tribal Access
 - Community Based Discretionary- 1% shared set aside with migrant populations (2 tribal grants each 3-year cycle - \$270,000 to \$340,000 each)
 - Demonstration and Technical Assistance Discretionary fund- available to tribes but no tribal initiatives yet

Funding and Resources

- ICPFVPA
 - Only tribal specific grants for child abuse prevention and treatment
 - Only twice since 1991 have any funds been requested or appropriated (amounts \$5 million or less - \$65 million authorized)
- ACA
 - Tribal Maternal, Child, Health Home Visit Program
 - First cohort 2012

What is working?

Decolonization, racial healing, and racial equity as a framework

- Collaboration (agreements, service development)
- Promoting and supporting protective factors
- Community-based and located services
- Sharing funds and increasing funding access for tribal and urban Indian communities
- Training

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UNDERSTANDING THE CHILD WELFARE SYSTEM AND ITS INTERSECTION WITH FATAL CHILD MALTREATMENT: EXPERIENCES, LACK OF PREPARATION, AND POSSIBLE REASONS WHY WORKERS MISS WARNING SIGNS

Presented to the Federal Commission to Eliminate Child Abuse & Neglect Fatalities
October 23, 2014 | Burlington, Vermont



Emily M. Douglas, Ph.D.
Bridgewater State University

Funding for research presented today was provided by the Bridgewater State University Presidential Fellows Program

OUTLINE OF PRESENTATION

1. Definition and prevalence rates
2. Characteristics/risk factors for fatal child maltreatment
3. Worker's knowledge and understanding of risk factors
4. Workers who have a child die on caseload
5. How workers may miss warning signs
6. Conclusions

PREVIEW: RECOMMENDATIONS

- Increase training for child welfare professionals about risk factors for fatal child maltreatment
- Integrate assessment for fatal maltreatment across the board from screeners to supervisors/managers.
- Initiate conversations about simultaneously assessing for strengths and risks in a family
- Increase research funding to better understand child welfare practice
 - Relationship to death/serious injuries
 - How strengths and risks are understood, balanced

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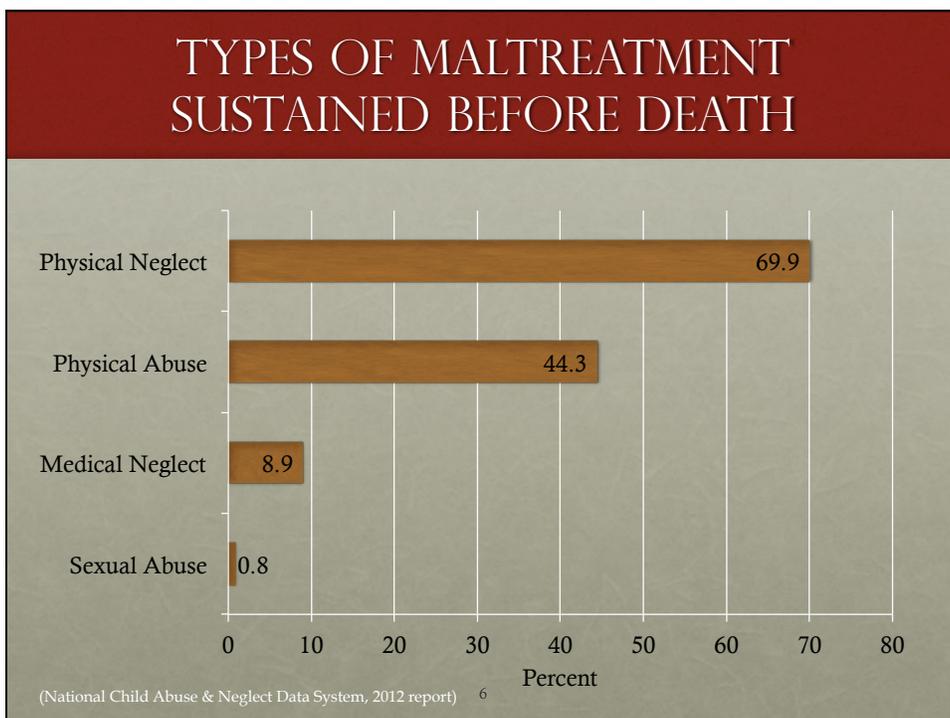
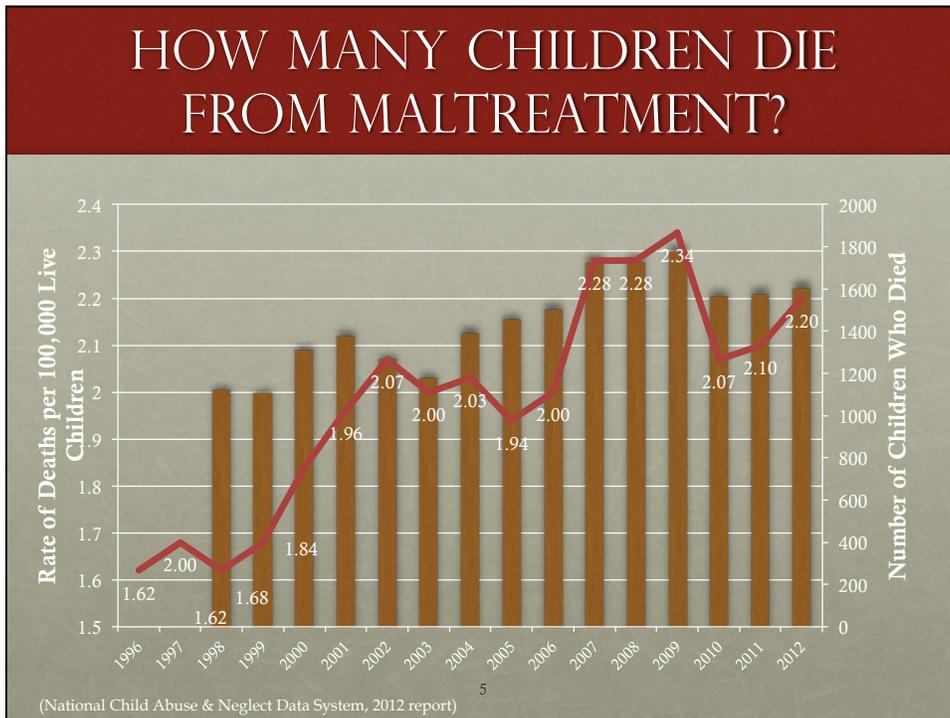
WHAT IS A CHILD MALTREATMENT FATALITY?

- The National Child Abuse and Neglect Data System defines a maltreatment death as:
- *A child dying from abuse or neglect because:*
 1. *The injury from the abuse or neglect was the cause of death, or*
 2. *The abuse and/or neglect was a contributing factor to the cause of death*

CMF = child maltreatment fatality

CWW = child welfare worker

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SOME CAUSES OF DEATH BY *ABUSE*

- Blunt force trauma
- Immersive drowning
- Suffocation/strangulation
- Stabbing/shooting
- Poisoning
- Immersion burns
- Fabricated or Induced Illness by Caretakers (MSBP)

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SOME CAUSES OF DEATH BY *NEGLECT*

- **Supervision**
 - Drowning
 - Hit by car
 - Animal bites
 - Ingestion/poisoning
 - Accidental firearm discharge
 - House fire
 - DUI
 - Falls
- **Physical**
 - Malnutrition/starvation/
Failure-to-thrive
 - Animal bites
 - Unsanitary conditions
 - House fire
- **Medical**
 - Refusal of treatment
 - Failure to seek treatment
 - Overdose

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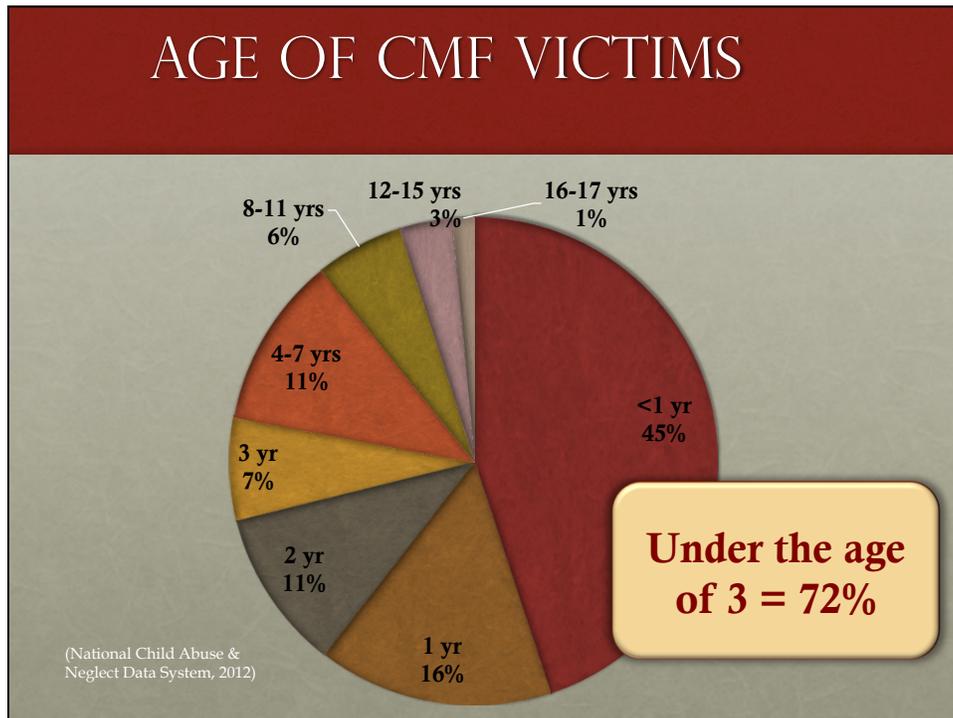
CHARACTERISTICS & RISK FACTORS FOR FATAL CHILD MALTREATMENT

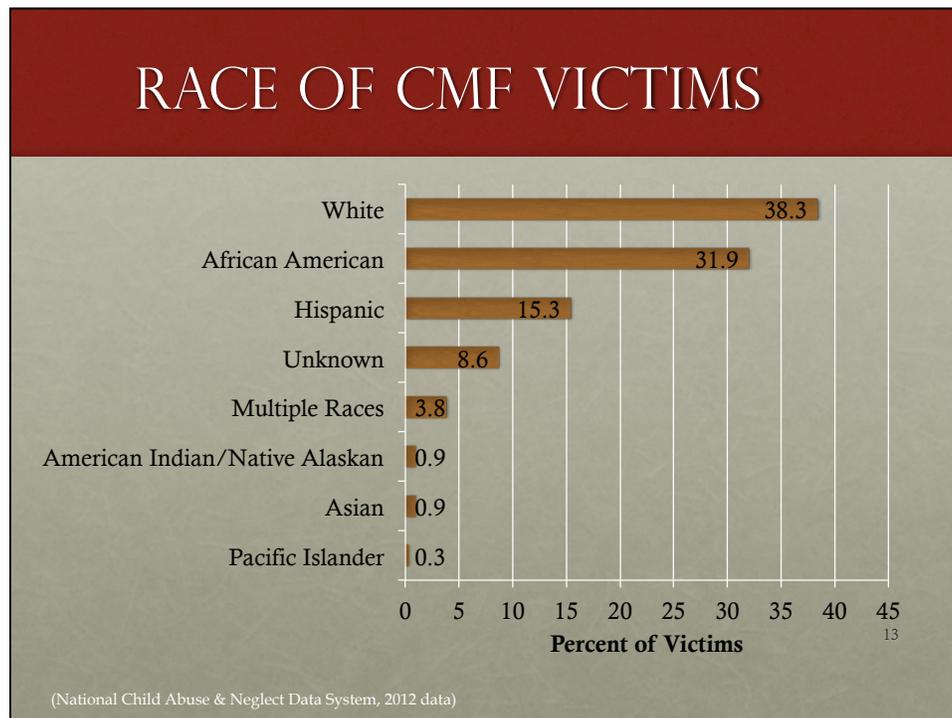
Review of the Literature

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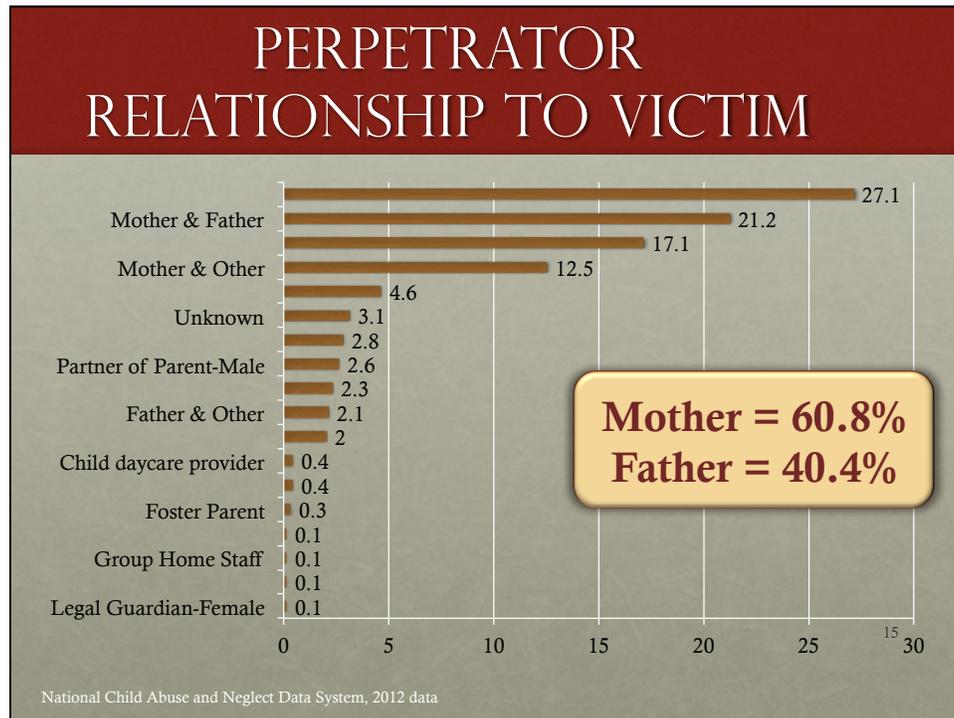
- Child characteristics
- Parent/caregiver characteristics
- Parent-child relationship
- Environmental/situational factors

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- ## CHILD CHARACTERISTICS
- Child age
 - Child gender
 - Behavioral health/”Difficult” child
 - History of out-of-home placement
- 14



- ### PARENT/CAREGIVER CHARACTERISTICS
- Young parents
 - Recent significant stress/major life event
 - Unemployed
 - History of violence in the family/household
 - Mental health concerns
 - Substance abuse
- 16

PARENT-CHILD RELATIONSHIP



- Child is not respectful of parent
- Child engages in “provoking behaviors”
- Low level of parenting skills
- Lack knowledge concerning child development

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ENVIRONMENTAL/ SITUATION FACTORS

- Recent change in household composition
- Non-family members present in the household
- Unemployment in household
- Mobile families/unstable housing
- 30-50% of families known to CPS before death

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WORKERS' KNOWLEDGE OF RISK FACTORS

Results of Study

Child Maltreatment Fatalities: Perceptions and Experiences of Child Welfare Professionals – 2010-2011

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PURPOSE OF STUDY

1. To explore workers' understanding of risk for CMFs
2. To learn new information about services received before the fatality
3. To describe the characteristics of children and their families who are known to the system and who die
4. Explore the experiences of child welfare workers in the aftermath of a CMF

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STUDY METHODS

- Collected data mid-September, 2010 – late January, 2011
- Online survey; convenience sample of 452 child welfare workers – frontline or supervisors (CWWs)
- Recruited participants through:
 - Child Maltreatment Research Listserv
 - Direct appeals to child welfare agency directors in all states
 - Online advertising/postings

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PARTICIPANTS

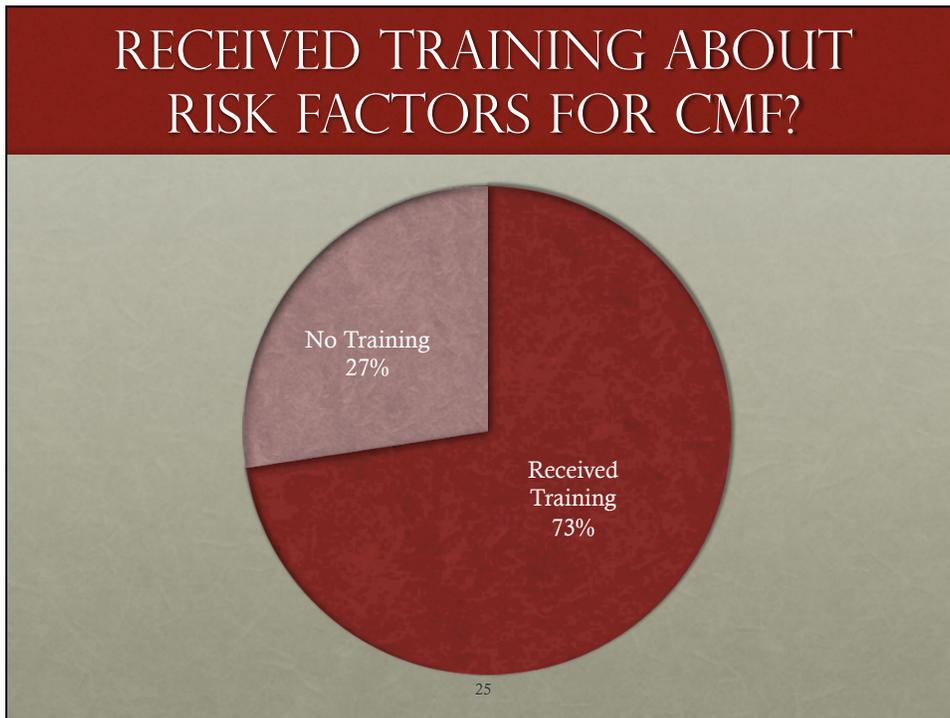
- 452 Participants (child welfare workers or supervisors)
- Present on:
 - 426 participants
 - 129 experienced a CMF on caseload/worked on CMF case
- 90% female
- Education Level
 - 51% - Master's degree
 - 49% - BA/BS
- Field of Education
 - 57% - Social Work
 - 5% - Human Services
 - 32% - Other Social Science Field (CJ, Family studies, Psyc, Soc)
 - 6% - None of the above

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PARTICIPANTS

- Age – 41 years old (mean)
- Race (*not mutually exclusive; sums to > 100%*)
 - American Indian – 2%
 - Asian – 3%
 - African American/Black – 17%
 - Latina/Hispanic – 7%
 - Pacific Islander – 1%
 - White – 76%
- Region of the country work
 - North (CT, ME, NY, PA) – 11%
 - Midwest (IL, MI, ND, OH, WI) – 16%
 - South (AL, DC, GA, LA, MD, NC, OK, TX, VA, WV) – 44%
 - West (AK, CA, CO, OR, WA, WY) – 30%
- Limitations:
 - Convenience sample
 - Participants may have had special interest in fatalities

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PARENT, CHILD, HOUSEHOLD RISK FACTORS FOR CMF PRESENTED TO CWWS

Statement	Accuracy
Mothers are the ones who are most likely to kill their children.	Accurate
Most parents who kill their children do not have mental health problems, diagnosed or otherwise.	False
Most children are usually killed by physical abuse (as opposed to neglect or another type of maltreatment).	False
Children are most likely to be killed by a non-family member (such as mother's boyfriend).	False
Younger children are more at-risk for CMFs than older children.	Accurate
Parents who kill their children often have inappropriate age expectations of their children.	Accurate
Parents who kill their children probably saw their child as "difficult" or ill behaved in general	Accurate
Children are more at risk for a fatality when they have non-family members living in their homes with them.	Accurate
Families that move a lot are more likely to suffer a CMF.	Accurate

KNOWLEDGE OF PARENT, CHILD, HOUSEHOLD RISK FACTORS FOR CMF

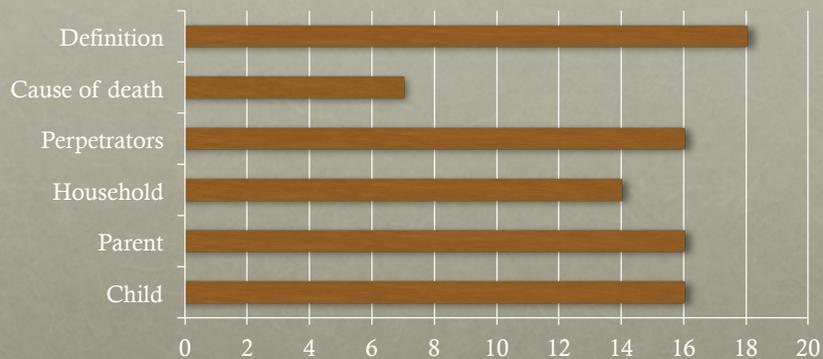
Statement	Accuracy	%Agree
Mothers are the ones who are most likely to kill their children.	Accurate	20.0
Most parents who kill their children do not have mental health problems, diagnosed or otherwise.	False	19.4
Most children are usually killed by physical abuse (as opposed to neglect or another type of maltreatment).	False	58.4
Children are most likely to be killed by a non-family member (such as mother's boyfriend).	False	62.3
Younger children are more at-risk for CMFs than older children.	Accurate	93.6
Parents who kill their children often have inappropriate age expectations of their children.	Accurate	86.0
Parents who kill their children probably saw their child as "difficult" or ill behaved in general	Accurate	71.3
Children are more at risk for a fatality when they have non-family members living in their homes with them.	Accurate	61.4
Families that move a lot are more likely to suffer a CMF.	Accurate	47.0

OPINIONS & PRACTICE CONCERNS REGARDING CMFS

Statement	% Agree
A parent on my caseload once told me that s/he might kill her/his child(ren).	28.2
I worry that a child on my caseload will die.	71.7
When I work with a family, I look for signs that might cause a child to die.	92.5
I am not sure that I know what the risk factors are for a CMF.	14.4
I would like additional training about the risk factors for CMFs.	90.1

WHERE DO WORKERS LEARN ABOUT RISK FOR CMFS?

- Examined 24 social science textbooks about child abuse, families, child development, etc.



(Douglas & Serino, 2013)

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WHERE DO WORKERS LEARN ABOUT RISK FOR CMFS?

- Examined pre-service child welfare training curricula for new child welfare workers
- 20 states
- Only 1 state had section on fatal child maltreatment
- That state did not provide evidence-based information about risk factors

(Douglas, Mohn, & Gushwa – Conditionally Accepted)

WORKERS WHO EXPERIENCE A CMF ON THEIR CASELOADS

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HOW MANY WORKERS ANNUALLY?

- Estimate between 1,062-1,416 child welfare professionals (frontline workers and supervisors) experience death of a child on their caseload due to maltreatment
- Comprises 3.4-4.3% of child welfare workforce
- *What do we know about these workers?*

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REASONS CITED AS CAUSE FOR FATAL MALTREATMENT

Race To The Bottom, Untrained Social Workers, Over Work & More Dead & Suffering Children In Indiana

Published by Mike Tikkonen on February 8, 2012 in Politics and Funding, Public Policy and The States. 8 Comments

Tags: beaten with two by four, bruce greenberg, witch doctors

Invisible Children – Advocacy group to promote change within child welfare system, 2008

REASONS CITED AS CAUSE FOR FATAL MALTREATMENT

The Real Reasons for Child Abuse Deaths

It's easy enough to see how people can leap to the conclusion that the deaths of children "known to the system" must be the result of "family preservation" or the federal law requiring agencies to make "reasonable efforts" to keep families together.

After all, the cases seem so obvious -- especially in hindsight. Often they were not the "tough calls." And almost everyone in the system has a vested interest in promoting the idea that it was the fault of a law or a policy over which they have no control. But the real reasons children "known to the system" die are very different. And those reasons are well within the control of many of those who point the finger at family preservation.

When children known to the system die, it is usually because the system is overwhelmed with children who don't need to be in foster care at all.

In most states, a bachelor's degree in any subject is all that is required to become a child protective worker. After hiring, training generally ranges from minimal to none.

Turnover on the job is constant. The worker who goes to a troubled family is likely to have little experience.

Working conditions can be appalling. In some child protective offices several workers share a phone, in others workers keep files in their cars or piled under their desks.

Caseloads often are enormous, often double, triple or more than the average called for in national standards established by the Child Welfare League of America.

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preserved -- and, contrary to critics'

preservation workers do indeed pla

of the children first.

Child protective workers are

overwhelmed in part because they

investigate so many cases that eith

reports or involve the confusion of

neglect.

CPS officials and frontline

it: 34

From Washington State: "C

- In most states, a bachelor's degree in any subject is all that is required to become a child protective worker. After hiring, training generally ranges from minimal to none.
- Turnover on the job is constant. The worker who goes to a troubled family is likely to have little experience.
- Caseloads often are enormous, often double, triple or more than the average called for in national standards established by the Child Welfare League of America.

National Coalition for Child Protection Reform, 2009

REASONS CITED AS CAUSE FOR FATAL MALTREATMENT



The screenshot shows the Guardian website interface. At the top, the logo 'theguardian' is visible. Below it, a navigation bar includes links for News, US, World, Sports, Comment, Culture, Business, and Environment. A secondary bar highlights 'News' and 'Society'. The main headline reads 'Social workers 'untrained' for violent parents'. Below the headline, it says 'Staff and agencies guardian.co.uk, Friday 20 December 2002 11.00 EST'. A short excerpt of the article is visible at the bottom: 'Vulnerable children are being put at risk because social workers lack adequate training to prevent them from being manipulated by violent and intimidating parents, researchers have warned.'

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REASONS CITED AS CAUSE FOR FATAL MALTREATMENT

constraints facing CA managers accessing qualified candidate pools. The review committee also noted newly hired, inexperienced social workers are assigned CPS investigations after completing their mandatory academy training.

The committee felt assigning high risk investigations to newly hired and inexperienced CPS social workers may present risk issues for CA. Academy training and other mandatory training provided by CA for these social workers cannot by itself compensate for a lack of direct child welfare or investigative experience. Supervisors do not have the time to provide the level of supervision that inexperienced staff require. It was noted the lack of qualified candidates and the

Washington Children's Administration, 2009

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REASONS CITED AS CAUSE FOR FATAL MALTREATMENT

The New York Times
nytimes.com

December 10, 2004

Report on Deaths of 12 Children in New Jersey Faults Child Welfare System

By LESLIE KAUFMAN

An independent review of the cases of the 12 New Jersey children who died of what the authorities suspect was abuse or neglect in 2004 found "shallow and narrow" investigations by child welfare workers. The report also found a breakdown of communications between the caseworkers and supervisors.

The report, released yesterday by the Office of the Attorney General, is based on extensive reviews of medical, police and other state records. It also includes a breakdown of communications between the caseworkers and supervisors. The report found that in many cases, caseworkers did not notify supervisors when they had concerns. In one case, a 4-year-old boy from Asbury Park who was found starved to death in a car, the report said, the caseworker did not notify the supervisor. In another case, a 3-year-old boy from Asbury Park who was found starved to death in a car, the report said, the caseworker did not notify the supervisor.

While the hospital where Jmeir was born had diagnosed him with a rare genetic disorder, child welfare authorities when his mother repeated the diagnosis to them, the report said. Instead, Jmeir's health was taken for granted.

Kevin M. Ryan, the child advocate, said the report is a "wake-up call" for the state's child welfare agency. But, he said, the details of the cases are still being reviewed.

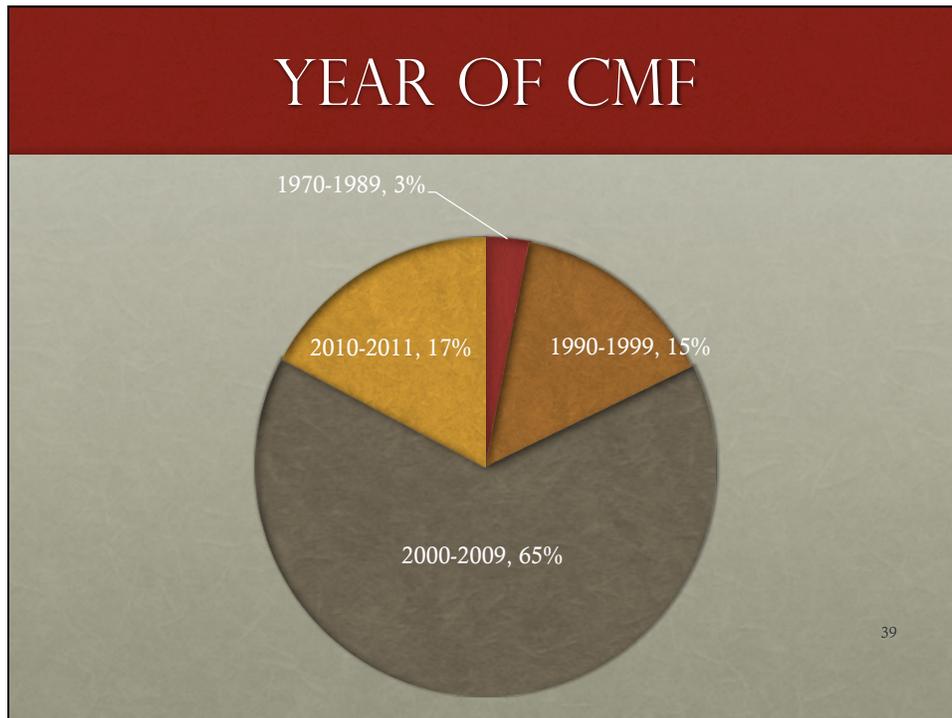
"This office remains unreservedly supportive of the child welfare reform plan," he said, "but we also want to emphasize that some reforms we think need to be made that are not yet being done."

Mr. Ryan said a top priority was to improve training for child welfare supervisors so that they can help inexperienced caseworkers who are stymied in investigating abusive families, as happened in the case of Ajee Anderson.

"...a top priority was to improve training for child welfare supervisors so that they can help inexperienced caseworkers who are stymied in investigating abusive families..."

SUBSECTION OF WORKERS – THOSE EXPERIENCING CMF

- 123 experienced a CMF on their caseloads
- 90% female
- Education Level
 - 51% - Master's degree
 - 49% - BA/BS
- Field of Education
 - 57% - Social Work
 - 5% - Human Services
 - 32% - Other Social Science Field (Psys, Soc, Family studies)
 - 6% - None of the above
- Race sums to > 100%
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CWWS EXPERIENCING CMF ON CASELOAD

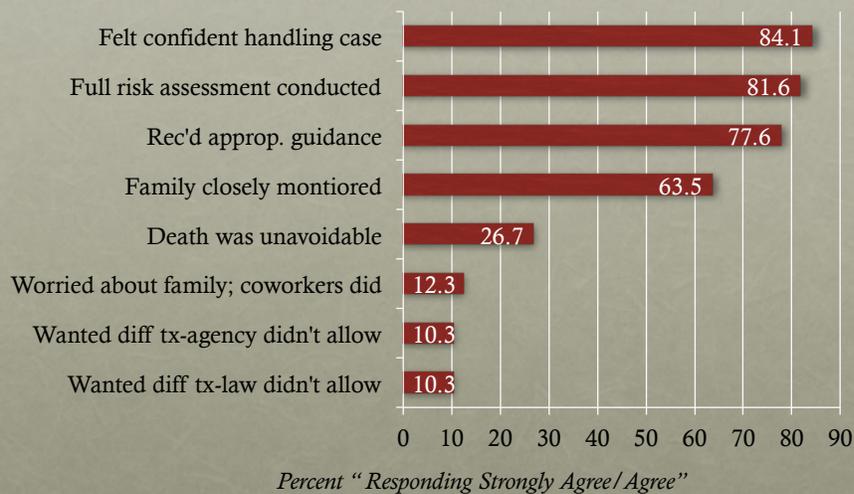
Characteristic	Total CWWs Exp'ed CMF	Frontline CWW Exp'ed CMF	Supervisor Exp'ed CMF
Case Work Info. at Time of CMF			
No. of cases on caseload ¹	25	20	90
No. months on caseload ¹	2	2	3
No. years in CW profession ¹	6	4	13
Worker Characteristics at Time of CMF			
Worker Age at time of death ²	37.6	34.62	41.40
Worker Education: Level			
High school degree	0.9%	0	0.8%
Associate's degree	0.8%	0	0.8%
College degree	45.9%	54.5%	45.9%
Master's degree	52.5%	45.5%	52.5%
Worker Education: Area of Specialization			
Social work	53.7%	42.6%	53.7%
Human services	5.7%	3.7%	5.7%
Other social science	29.3%	48.1%	29.3%
Other area	11.4%	5.6%	11.4%

AT THE TIME OF THE FATALITY

- On average: families involved with CPS for ~10 months
- Workers had seen child ~ 1 week prior to death
- Workers who had seen child in past 4 weeks: 85%

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HANDLING THE CASE BEFORE THE FATALITY



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HOW WORKERS MAY MISS WARNING SIGNS



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BALANCING TWO PERSPECTIVES

- Social work profession based on finding strengths as point of entry for working with clients
- Finding strengths – a necessary & essential component of child welfare practice
- Strengths can never make risk disappear.
- Balancing these two ends of child welfare practice = challenging

STRENGTH-PERSPECTIVE

- Very little research on how a strength-based perspective is integrated into child welfare practice
 - Do workers know what constitutes a strength that can act as protective factor for a child?
 - Workers' attitudes about relationship between strengths and risks
 - Conversations with supervisors about the balance of strength and risk factors in cases?
 - When to intervene even though strengths might be present?

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ASSESSING FOR RISK

- Two basic ways to assess for risk
- *Consensus-based assessment tools*
 - Items included based on consensus (theory, research, practitioner opinion)
 - Do not differentiate between different types of maltreatment
 - Great variation between tools, limited empirical support
- *Actuarial assessment tools*
 - Statistically identified to predict future abuse and neglect
 - Numerically scored, then risk determined based on score
 - Usually have different indices to predict neglect vs. physical abuse
 - Bypass professional knowledge & skills of experienced practitioners

(Gushwa & Chance, 2013)

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LIMITS OF RISK ASSESSMENT TOOLS

- Less experienced workers find tools to be more beneficial than more experienced workers
- Experienced workers believe tools limit ability to use their own professional expertise
- Manipulate scores to align with professional assessments vs. using tools to guide decisions
 - Ex: Lower scores if families do not “seem” to be at risk

(Gushwa & Chance, 2013)

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FURTHER COMPLICATIONS

- Workers’ own attitudes influence their own assessments of families
- Child & Family Service Reviews that are conducted at the state-level for the federal government indicate risk/safety assessments not conducted throughout life of a case
 - Only at initial contact/assessment/investigation
 - Before reunification (if children have been removed)
- Risk and safety should be assessed throughout life of a case
- Lack of research on use of risk/safety tools throughout life of a case

(Gushwa & Chance, 2013)

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FURTHER COMPLICATIONS

- States often adopt new (or old) approaches to child welfare practice
 - For example: differential (alternative) response, family group conferencing
- Swinging pendulum between family preservation and child safety models → Return to family preservation
 - Inadequate resources = lethal outcomes
- Blanket approaches to complex social problems rarely work

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WORKERS AND SUPERVISORS

- Research highlights the importance of supervisors in the workers' experience and job performance
- Exploration of values & biases is necessary to promote effective professional practice
- Supervisors need:
 - To be prepared to help workers use critical thinking skills, in combination with assessment tools
 - To be knowledgeable of risk factors for fatalities
- More and better research
 - About supervisor-worker relationship
 - How worker/agency practices are tied to reducing CMFs

(Gushwa & Chance, 2013)

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CONCLUSIONS & RECOMMENDATIONS

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CONCLUSIONS

- Workers deeply concerned about CMFs
- Not preparing workers especially well for seeing/ understanding risk
- Lack of knowledge of risk factors
- Workers who experience CMF on caseload are not young, unprepared, inexperienced
- Workers may not assess for risk over life of case
- Workers' own attitudes influence their evaluation of risk

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CONCLUSIONS

- Workers need to be trained in risk factors for fatality
- Needs to be priority across the board: legislature all the way down to supervisor
- Discussions around risk factors for fatality – integrated into daily, routine casework
- Open conversations about what constitutes a strength and how strengths and risks cannot cancel each other out

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RECOMMENDATIONS

- Increase training for child welfare professionals about risk factors for fatal child maltreatment
- Integrate assessment for fatal maltreatment across the board from screeners to supervisors/managers.
- Initiate conversations about simultaneously assessing for strengths and risks in a family
- Increase research funding to better understand child welfare practice
 - Knowledge of risk factors
 - Relationship to death/serious injuries
 - How strengths and risks are understood, balanced

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THANK YOU

55

The state of the art of safety assessment in public child welfare

Theresa Costello

Executive Director, ACTION for Child Protection

Commission to Eliminate Child Abuse and Neglect Fatalities Meeting

October 23, 2014

Burlington, Vermont

ACTION for Child Protection

Overview of presentation

- Risk versus safety
- Prevalent safety approaches
- Safety decision points
- Strengths/limitations
- Research
- Safety and fatality prevention

ACTION for Child Protection

Risk Assessment

- Introduced in late 70's
- Created to provide guidelines for practice, optimize the use of available resources and provide a rationale for service targeting
- Risk=likelihood of maltreatment

ACTION for Child Protection

Risk Assessment Tools

Two distinct approaches:

- Actuarial – classification tools
- Theoretical-empirically guided tools

ACTION for Child Protection

Safety as a concept distinct from risk

Introduced in 1985 by Wayne Holder and Mike Corey, ACTION for Child Protection

Edna McConnell Clark Foundation funded first tool development and testing in Anne Arundel County, Maryland

ACTION for Child Protection

Safe and Unsafe

Safe child:

Vulnerable children are safe when there are no threats of danger within the family or when the parents possess sufficient protective capacity to manage any threats.

Unsafe child:

Children are unsafe when:

- threats of danger exist within the family and
- children are vulnerable to such threats, and
- parents have insufficient protective capacities to manage or control threats.

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Key Concept

Threat of Danger?
+
Vulnerable child?
-
Protective Capacity?
=
“unsafe child”

Universal safety threats

- Violent caregivers or others in the household
- Caregiver makes child inaccessible
- Caregiver lack of self-control
- Caregiver has distorted or extreme perception of a child
- Caregiver fails to supervise/protect
- Hazardous living arrangements/conditions
- Intention to harm and cause suffering
- Child provokes maltreatment
- Fearful child
- Caregiver is unwilling/unable to meet immediate needs of child

ASFA: Driving force behind focus on SAFETY

Assess safety at:

Investigation
Placement
Case Plan
Evaluation and Measurement
Reunification
Time Limits!

ACTION for Child Protection

A Safety Intervention System as Defined by ASFA and CFSR

- Timely response for first contact (CFSR)
- Prevent recurrence (CFSR)
- Assess safety at investigation (ASFA and CSFR)
- Expend reasonable efforts to keep children safely in their own homes (ASFA)

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A Safety Intervention System as Defined by ASFA and CFSR

- Provide services to the family to protect children in their own home and prevent removal (CFSR)
- Assess safety in out-of-home placements (ASFA) - at point of placement and throughout the life of the placement (ASFA)
- Prevent maltreatment in out-of-home placement (CFSR)
- Address safety issues in case plan (treatment) plans (ASFA)

ACTION for Child Protection

A Safety Intervention System as Defined by ASFA and CFSR

- Assess safety at reunification (ASFA)
- Time limits for making decisions about permanent placements (ASFA) - safety implication is that there must be precision on the right issues because time is short!
Building protective capacity so kids can be safe in their own homes is the well-being priority.

ACTION for Child Protection

Safety decision points

- Intake/Hotline
- Initial contact
- Investigation conclusion
- Removal/Reunification
- Ongoing cases (in-home and out of home)
- Visitation
- Case Closure

ACTION for Child Protection

Tools at decision points

- Intake/Hotline-response time and differential response decision
- Initial contact (present danger)
- Investigation conclusion (impending danger)
- Removal/Reunification(Step up or step down safety)
- Ongoing cases (in-home and out of home)
- Visitation (supervised or not)
- Case Closure

ACTION for Child Protection

Three safety models/ approaches

- SDM (risk and safety assessment tools)-Children's Research Center
- Signs of Safety (Andrew Turnell)
- SAFE model –ACTION for Child Protection

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Strengths of current safety approaches/ practice

- Consensus on safety threats
- Present danger (happening now) application is widespread
- Implementation is improving (fidelity)
- Increasing emphasis on family engagement
- Hybrids of safety approaches reflect best of each model

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Limitation of current safety approaches/ practice

- Continued confusion on safety versus risk
- Impending danger assessments and planning still lacking
- Safety management function not well understood or practiced
- Reunification decisions not always safety-based

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Challenges

- Implementation historically has been focused on training
- Recent efforts to apply Implementation Science is promising but in early stages
- Multi-year, multi-faceted approach is costly and requires consistent leadership

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Research needed

- Rigorous research on safety models (control group) (One underway)
- Inter-rater reliability analysis
- Construct validity
- Fidelity Assessments (numerous completed)

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Safety assessment tools and sensitivity to serious harm/fatality cases

- Predictive accuracy to prevent maltreatment-related fatalities is not realistic relying strictly on specific tool(s)
- Tools are essential guides and we should strive to improve them as already identified

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- Staff skills at engagement and worker and supervisor critical thinking capacity is essential
- Special protocols for cases of young children/serious harm; safety assessment is one component but protocol involves much more (Hawaii example provided)

ACTION for Child Protection

Discussion/questions

ACTION for Child Protection

Vermont Domestic Violence and Child Safety

Amy Torchia

Children's Advocacy Coordinator,

Vermont Network Against Domestic and Sexual Violence

atorchia1965@yahoo.com; 802-223-1302 X 117; www.vtnetwork.org

VT Network DV Programs

- ▶ 12 DV programs in VT – 9 have shelters; 10 are dual DV/SV
- ▶ Our smallest programs have 3-4 staff; not all have children's staff
- ▶ Services increase since 2009 -
 - ▶ 128% in the number of hotline calls (24,389 in 2013)
 - ▶ 49% in the number of shelter-nights provided to survivors and their children (29,946 in 2013)
 - ▶ 29% in the number of domestic violence victims served (8492 in 2013)
 - ▶ 29% in the number of victims sheltered (827 in 2013)
- ▶ Decrease in Federal and other funds = loss of 20 FTEs in five years
- ▶ Coalition Office – Vermont Network Against Domestic and Sexual Violence

DV and Child Fatality

- ▶ Child Fatality Reviews suggest a 41-43% overlap*
- ▶ We don't always know when they are linked
- ▶ In VT, happens rarely – so when it does, systems pay attention
 - ▶ Adult survivors usually finding safety for themselves and their children
- ▶ VT – December 2013 where a 14 year old boy, Gunnar Schumacher, who was murdered by his father
- ▶ NH – August 2013 where a father killed his 9 year old son, Joshua Savyon, at a supervised visit at a center

**Edleson (1999), Appel & Holden (1998)*

DV Programs consideration and evaluation of child safety

- ▶ When lethality increases for adult victim, it also increases for children
- ▶ Screenings and Intakes
- ▶ Asking more if we hear indicators of lethality
- ▶ Encourage and/or make reports to DCF if there are child abuse concerns
- ▶ Safety Plans
 - ▶ Survivor Parent /Children and Youth
 - ▶ *If there is fighting in your home, Safety Planning with Children*
 - ▶ Outside systems

Two Community Lethality Assessment Programs (LAP)

- ▶ Community response involving Law Enforcement, DV Programs and others
- ▶ Evidence based 11 question survey that helps police quickly access an adult victim's level of danger
- ▶ If the victim meets the high risk criteria, police immediately put them in phone contact with an Advocate
- ▶ **2 indicators/questions that include children**
 - ▶ **Threats to kill adult and/or children**
 - ▶ **Children in the home, particularly who are not biological of perpetrator**
- ▶ Corresponding training for community raised awareness about child safety in relation to adult lethality risk

State work DV/Child Safety

- ▶ Rural Project – collaboration between VT Network and DCF/Family Services
 - ▶ **Purpose:** increase safety for children and adult survivors where DV and Child Abuse coexist AND hold perpetrators accountable (DCF- **Safe and Together**)
- ▶ Law Enforcement Protocol/Training to respond to children at the scene of DV incident
 - ▶ Raise level of expertise in noticing, documenting, and responding to children at DV scenes
- ▶ Chair of DV Fatality Review Commission also sits on the Child Fatality Team; Have considered joint reviews
- ▶ Coalition staff:
 - ▶ DV Fatality Review, VT Citizens Advisory Board to DCF, Public Policy
 - ▶ Training and TA for DV/SV programs on children/youth related advocacy

Safe and Together Model (Mandel and Associates – CT)

- ▶ Model of child protection intervention
- ▶ Perpetrator pattern based, child centered and survivor strengths approach to address domestic violence in child welfare
- ▶ Vermont DCF Family Services - statewide training and local district office training
- ▶ DCF DV/SV Unit continues to implement this model through case consultation and ongoing training.

Critical Components of S&T

- ▶ Perpetrators pattern of coercive control
- ▶ Actions taken by the perpetrator to harm the child
- ▶ Full spectrum of the non-abusive parent's efforts to promote safety and well-being
- ▶ Adverse impact of the perpetrator's behavior on the child
- ▶ Role of substance abuse, mental health, culture and other socio-economic factors

www.endingviolence.com

What would help us...

▶ Tools and resources:

- ▶ To better assess batterer risk to children – similar to the LAP tools
- ▶ For other systems to assess risk to inform their decisions (i.e. courts when awarding protection orders, custody and unsupervised visitation)

▶ Research/data that:

- ▶ Connects DV perpetrator actions with child maltreatment (abusive head trauma/shaken baby?)
- ▶ Links youth suicide with exposure to DV and tools to assess/address
- ▶ Supports the practice of supporting protective parents to support the safety of children/youth

How can the study of near fatalities assist in preventing fatalities?

Joanne N. Wood, MD, MSHP
Assistant Professor of Pediatrics
The Children's Hospital of Philadelphia
Perelman School of Medicine at the University of Pennsylvania
October 23rd, 2014
Burlington VT



The Children's Hospital of Philadelphia®

Today's Talk

1

- What is a near fatality?

2

- What do we know about near fatalities?

3

- Why should we study near fatalities?

4

- How can we study near fatalities?
 - Opportunities, challenges and recommendations

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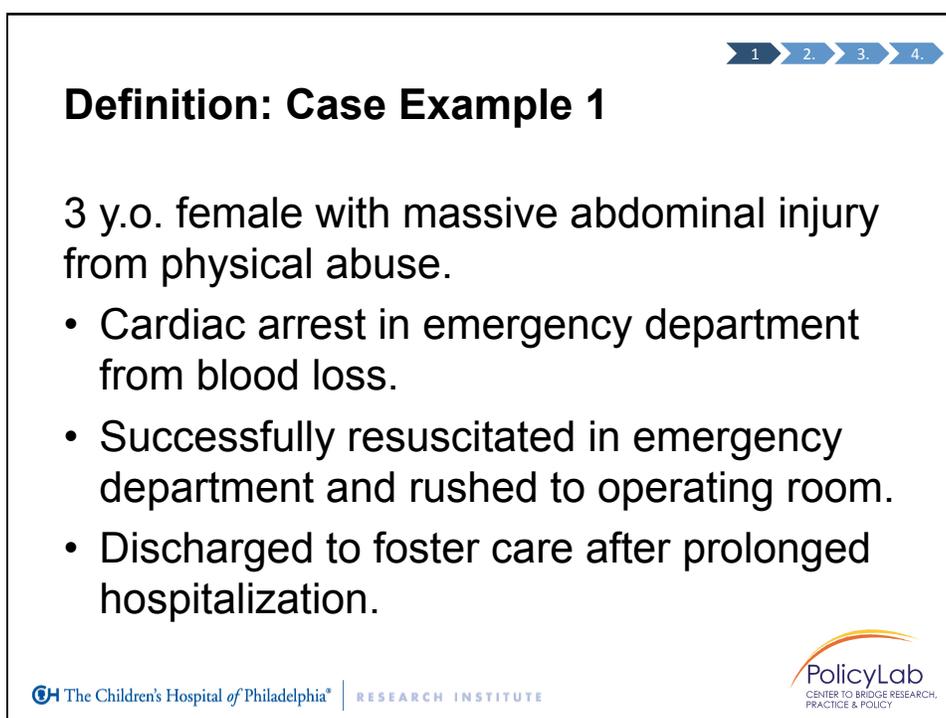
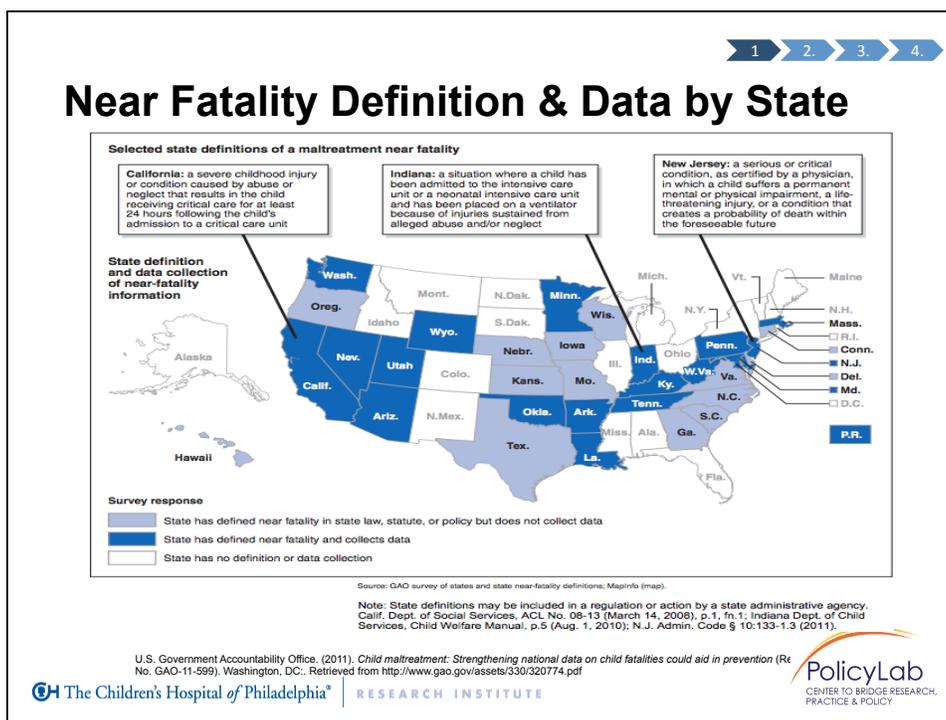
1 2 3 4

Near Fatality Definition:

CAPTA: “An act that, as certified by a physician, places the child in serious or critical condition.”

Medical definition: none

- Near fatality is **not** a medical term
- Lack of clear consensus regarding serious or critical condition
- Physicians may be hesitant to certify that **act** of abuse caused the serious or critical condition



1 2 3 4

Definition: Case Example 2

18 m.o. boy with heroin ingestion.

- EMS found child unresponsive with pinpoint pupils. Naloxone administered by EMS.
- At hospital child awake and alert. Admitted for further evaluation and treatment but does *not* require admission to the intensive care unit.

1 2 3 4

Definition: Case Example 3

2 m.o. male admitted for evaluation of traumatic brain injury and fractures. All injuries are healing.

- No acute medical intervention needed.
- Concern for long term impact on infant's development due to brain injuries.

1 2 3 4

Are our cases near fatalities?

Depends on . . .

- Which state you live in
- Which physician you ask

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana			

Indiana → A situation where a child has been *admitted to the intensive care unit* or a neonatal intensive care unit *and has been placed on a ventilator* because of injuries sustained from alleged abuse and/or neglect

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	X	X

Indiana → A situation where a child has been *admitted to the intensive care unit* or a neonatal intensive care unit *and has been placed on a ventilator* because of injuries sustained from alleged abuse and/or neglect

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	X	X
California			

California → A severe childhood injury or condition *caused by abuse or neglect* which results in the child *receiving critical care for at least 24 hours* following the child's admission to a critical care unit

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	✗	✗
California	✓	✗	✗

California → A severe childhood injury or condition **caused by abuse or neglect** which results in the child **receiving critical care for at least 24 hours** following the child's admission to a critical care unit

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	✗	✗
California	✓	✗	✗
Pennsylvania			

Pennsylvania →

2006: An **act** that, as certified by a physician, places the child in serious or critical condition.

2014: A child's **serious or critical condition**, as certified by a physician, where that **child is a subject of the report of child abuse**.

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	✗	✗
California	✓	✗	✗
Pennsylvania	✓	?	?

Pennsylvania →

2006: An **act** that, as certified by a physician, places the child in serious or critical condition.

2014: A child's **serious or critical condition**, as certified by a physician, where that **child is a subject of the report of child abuse**.

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	✗	✗
California	✓	✗	✗
Pennsylvania	✓	?	?
New Jersey			

New Jersey → A serious or critical condition, as certified by a physician, in which a child suffers a **permanent** mental or physical **impairment**, a **life-threatening injury**, or a condition that creates a **probability of death within the foreseeable future**

1 2 3 4

Are our cases near fatalities?

State	3 y.o. with massive abdominal trauma	18 m.o. heroin ingestion	2 m.o. with AHT
Indiana	✓	✗	✗
California	✓	✗	✗
Pennsylvania	✓	?	?
New Jersey	✓	✗	✓

New Jersey → A serious or critical condition, as certified by a physician, in which a child suffers a **permanent** mental or physical **impairment**, a **life-threatening injury**, or a condition that creates a **probability of death within the foreseeable future**

1 2 3 4

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How common are near fatalities?

Near fatality cases substantiated by CPS¹

- National estimates: not available
- Individual states (7):
 - 0.9 to 2.7 near fatalities per 100,000 children
 - 0.9 to 6.3 fatalities per 100,000 children

Data on children with serious injuries from abuse²

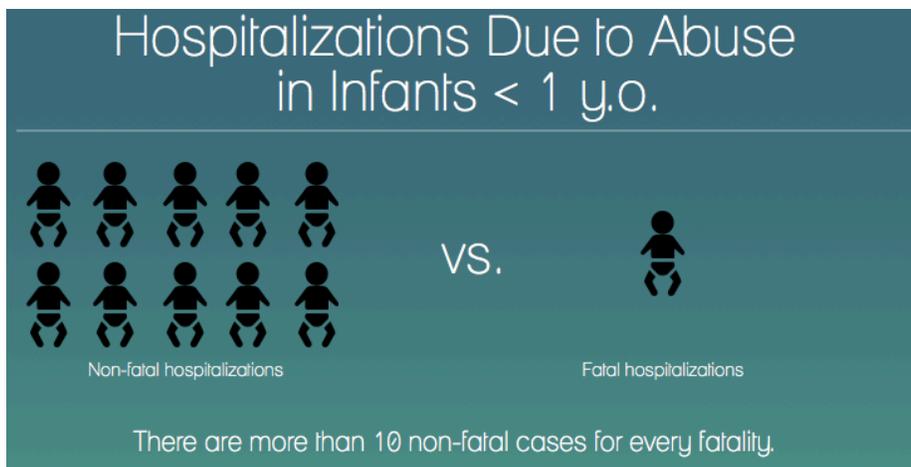
- National estimates:
 - 6.4 hospitalizations per 100,000 children

1. Calculated from reports released by individual states.

2. From Leventhal JM, Gailther JR. Incidence of serious injuries due to physical abuse in the United States: 1997 to 2009. Pediatrics 2012;130(5):e847-52.



How common are near fatalities?



Leventhal JM, Martin KD, Gailther JR. Using US data to estimate the incidence of serious physical abuse in children. Pediatrics 2012;129(3):458-64.

1 2 3 4

How common are near fatalities?

Abusive Head Trauma in Infants < 1 y.o.



Non-fatal AHT

VS.



Fatal AHT

There are more than 5 non-fatal cases for every fatality.

Parks SE, Kegler SR, Annett JL, Mercy JA. Characteristics of fatal abusive head trauma among children in the USA: 2003-2007: an application of the CDC operational case definition to national vital statistics data. Inj Prev 2012;18(3):193-9.
Parks S, Sugerman D, Xu L, Coronado V. Characteristics of non-fatal abusive head trauma among children in the USA, 2003-2008: application of the CDC operational case definition to national hospital inpatient data. Inj Prev 2012;18(6):392-8.




1 2 3 4

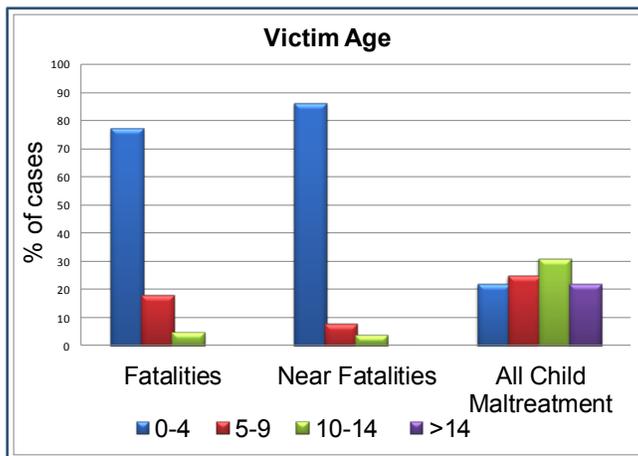
How are near fatalities and fatalities similar?

- Child characteristics
- Perpetrator characteristics
- Risk factors




Age of Substantiated Cases of Maltreatment

1 2 3 4



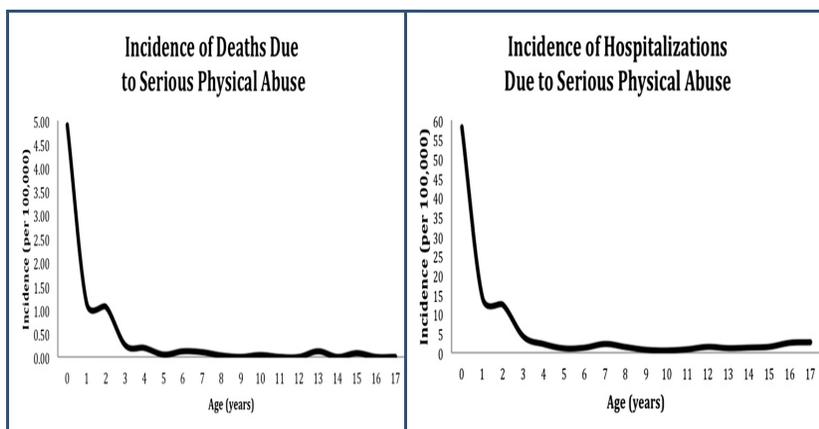
PA Data for 2013

The Children's Hospital of Philadelphia® RESEARCH INSTITUTE

PolicyLab
CENTER TO BRIDGE RESEARCH,
PRACTICE & POLICY

Age of children hospitalized due to serious physical abuse

1 2 3 4



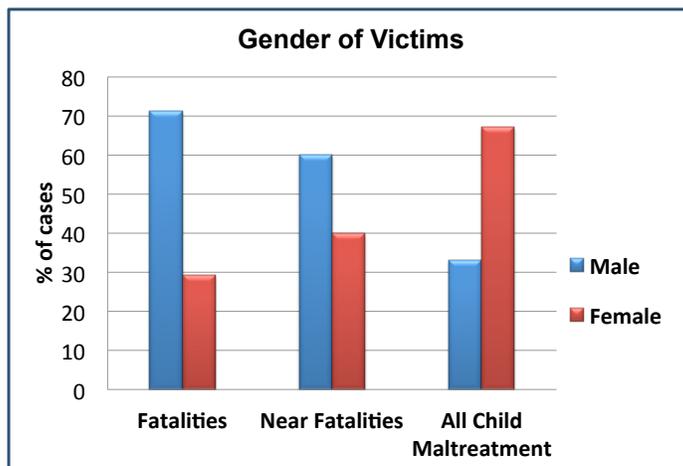
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1 2 3 4

Gender of Substantiated Cases of Maltreatment



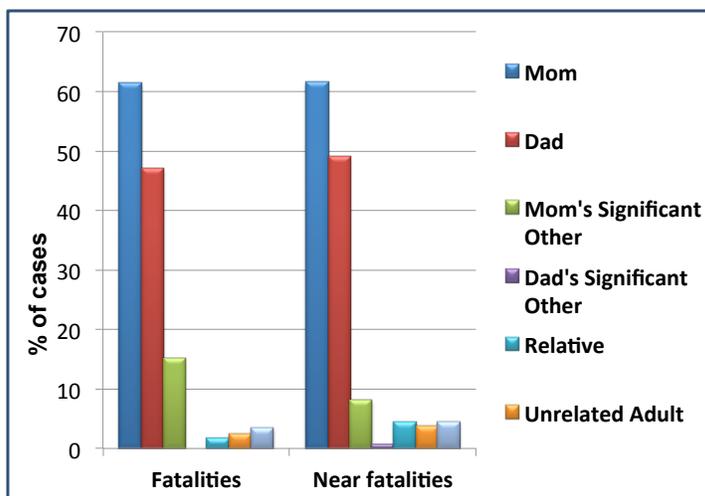
PA Data for 2013

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1 2 3 4

Perpetrator Relationship to Child

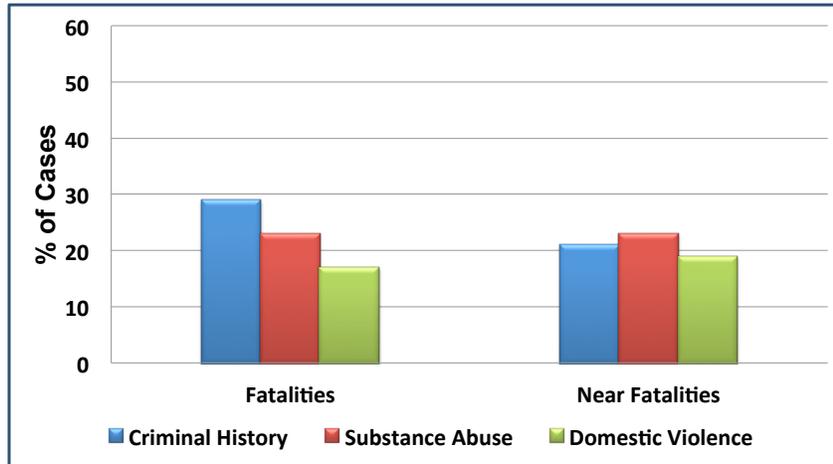


CA Data for 2011

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Risk Factors: Near fatalities and fatalities



PA Data for 2013

The Children's Hospital of Philadelphia® RESEARCH INSTITUTE



Today's Talk

- 1 • What is a near fatality?
- 2 • What do we know about near fatalities?
- 3 • Why should we study near fatalities?
- 4 • How can we study near fatalities?
• Opportunities, challenges and recommendations

1 2 3 4

GAO Report

Findings:

- States increasingly interested in collecting and using data on near fatalities.
- States indicated need for assistance in collecting near fatality data.

Recommendation:

- “Estimate the costs and benefits of collecting national data on near fatalities...”

1 2 3 4

Why study near fatalities?

- Near fatalities are as common if not more common than fatalities
- Near fatalities and fatalities share similar child, perpetrator and risk factor profiles

=> Increase number of cases available to study:
overall and subpopulations.

1 2 3 4

Why study near fatalities?

1. Increased accuracy of estimates of incidence and prevalence of severe child abuse & neglect
 - Monitoring of trends over time
 - Comparison across localities
 - Assess response to prevention efforts
2. Increased power to understand risk factors for subpopulations of severe / fatal maltreatment
 - Guide development of prevention programs
3. Inform policy and practice change to reduce the likelihood of future near fatalities and fatalities related to child abuse and neglect

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- Opportunities, challenges and recommendations

How can we study near fatalities?

1. State near fatality data
2. Serious injury from abuse data



State Near Fatality Data: Opportunities

- Near fatality data collected by over 20 states
- Data reporting by subset of states:
 - Aggregate data and / or individual case summaries
- Some states collecting rich data through near fatality reviews
 - Case example: PA Act 33 Reviews (2008)

1 2 3 4

State Near Fatality Review Data: Example - PA Act 33 (2008)

Local Review	<ul style="list-style-type: none"> • Convened no later than 31 days after child abuse near fatality / fatality report received if substantiated or a decision has not been made. • Final report issued to CPS commissioner, mayor, and state department of public welfare within 90 days.
State Response to Local Team	<ul style="list-style-type: none"> • 45 days after a local near-fatality review team submits its final reports, the state prepares a response to the local report.
Final Report	<ul style="list-style-type: none"> • As soon as possible, but no later than 6 months the state issues reports on all fatalities/near-fatalities that were suspected as child maltreatment.

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1 2 3 4

State Near Fatality Review Data: Example - PA Act 33 (2008)

- Over 400 cases reviewed to date in PA
- Over 140 recommendations made in Philadelphia County alone
 - Majority implemented, remainder in progress
- Examples of Implemented Recommendations:
 - Developed policy and protocols for consults with CPS psychologists and nurses
 - Memorandum of understanding developed with local CPS, police, district attorney's office
 - Developed definitions and protocols for supervised visits
 - Expanded requirements for pre-placement background checks

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1 2 3 4

State Near Fatality Data: Challenges

1. National data not available
 - NCANDS does not have a specific data field that identifies the case as a near fatality from maltreatment
2. Variation in definition of near fatality across and within states
3. Not all states collecting or reporting near fatality data
4. Lack of collection of core common data elements across states
5. Reports may contain limited data elements or be heavily redacted

1 2 3 4

State Near Fatality Data: Recommendations

1. Clarification of near fatality definition at federal level
2. Collection and reporting of near fatality data including core data elements by all states
3. Support states (and counties) in conducting near fatality reviews

State Near Fatality Data: Recommendations

1 2 3 4

1. Clarification of near fatality definition at federal level (Children's Bureau)
 - Guidance on definition of serious/critical condition
 - Clarification of role of physician certification:
 - Certification of serious/critical condition in child who is a subject of report for suspected abuse and neglect (e.g. PA)
 - Development of tools to assist in certification (e.g. KY tip sheet)

State Near Fatality Data: Recommendations

1 2 3 4

2. Collection and reporting of near fatality data including core data elements by all states
 - Near fatality numbers (CPS data)
 - Core data elements
 - Potential source: near fatality reviews
 - Consider CDC recommended data elements*
 - Coordinate with child death reviews

*Leeb RT, Paulozzi L, Melanson C, Simon T, Arias I. Child Maltreatment Surveillance: Uniform Definitions for Public Health and Recommended Data Elements, Version 1.0. Atlanta (GA): Centers for Disease Control and Prevention, National Center for Injury Prevention and Control; 2008.

State Near Fatality Data: Recommendations

3. Support states in conducting near fatality / fatality reviews*
 - Guidelines or tool kits for implementing local near fatality / fatality reviews
 - Support in utilizing reviews to inform local practice and policy
 - Coordination with other local reviews including child death reviews

*Impact of local near fatality reviews / fatality reviews in improving practice and preventing future near fatalities and fatalities needs evaluation

How can we study near fatalities?

1. State near fatality data
2. Serious injury from abuse data

1 2 3 4 Serious Injury from Abuse Data: Opportunities

- Multiple available sources:
 - Hospital administrative data
 - Medical claims data
 - Research networks / databases
- National data available
- Based on medical diagnosis of abuse
 - Independent of differences in CPS policy and practice across localities and time

1 2 3 4 Serious Injury from Abuse Data: Example

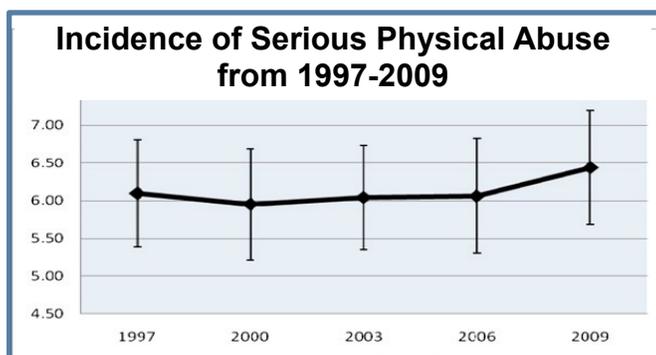


Figure: Incidence per 100 000 children of hospitalizations of children aged 0 to 18 years with serious injuries due to physical abuse.

Leventhal JM, Gaither JR. Incidence of serious injuries due to physical abuse in the United States: 1997 to 2009. *Pediatrics* 2012;130(5):e847-52.

1 2 3 4

Serious Injury from Abuse Data: Challenges

1. Primarily limited to physical abuse
2. Variation across hospitals in utilization of and accuracy of diagnosis codes for abuse
3. Limited number of data elements routinely captured and reported in existing datasets
 - Not specific to child maltreatment

1 2 3 4

Serious Injury from Abuse Data: Recommendations

1. Development and validation of standardized definitions for abuse related serious injuries for use with medical data
 - e.g. CDC fatal and non-fatal abusive head trauma definitions
2. Standardization of utilization of child maltreatment diagnosis and cause of injury codes by hospitals
3. Collection and reporting of core data elements for cases of serious injury from abuse
 - Adding core data elements to existing databases vs. creation of child maltreatment specific databases

Summary

Study of near fatalities can aid in our understanding and prevention of fatalities but standardization of definitions, data collection, and data reporting needs to occur.



Recommendation Summary

State Near Fatality Data

1. Clarification of near fatality definition at federal level
2. Collection and reporting of near fatality data including core data elements by all states
3. Support states (and counties) in conducting near fatality reviews

Serious Injury from Abuse Data

1. Development and validation of standardized definitions for abuse and neglect for use with medical data
2. Standardization of utilization of child maltreatment diagnosis and cause of injury codes by hospitals
3. Collection and reporting of core data elements for cases of serious injury from abuse

Thank You



Preventing Child Maltreatment Fatalities

Sally Fogerty
October 23, 2014

Tip of the Iceberg



“No epidemic has ever been resolved by treatment of the affected individual.”

- George Albee

3

Changing the Paradigm –

Continuum of Prevention

***Individual and Community
Focused Efforts***

4

Moving Upstream

“We are standing on the bank of the river, rescuing people who are drowning. We have not gone to the head of the river to keep them from falling in.”

- Gloria Steinem, 2002

5



Public Health Approach

- ❑ Uses surveillance data to understand problem and target interventions.
- ❑ Uses data driven, evidence-informed interventions
- ❑ Focuses on population and community based strategies as well as strategies to influence individual behaviors
- ❑ Identifies risk, protective factors and resiliency (and interplay)
- ❑ Understands influence of biological, environmental and social factors
- ❑ Uses social marketing to increase public and professional awareness including understanding of life long consequences

Child Maltreatment Prevention and State Public Health Agencies, 2009

- ⦿ 82% indicated that child maltreatment is considered to be very important or important to their agency
- ⦿ 69% strongly agreed or agreed that their agency considers child maltreatment a public health issue
- ⦿ 37% reported that their state had a statute, law, or executive order mandating that the state public health agency participate in state child maltreatment prevention efforts

Public Health Leadership Initiative, CDC Foundation, 2009

Top Five Roles State Public Health Agencies Believe They Should Play

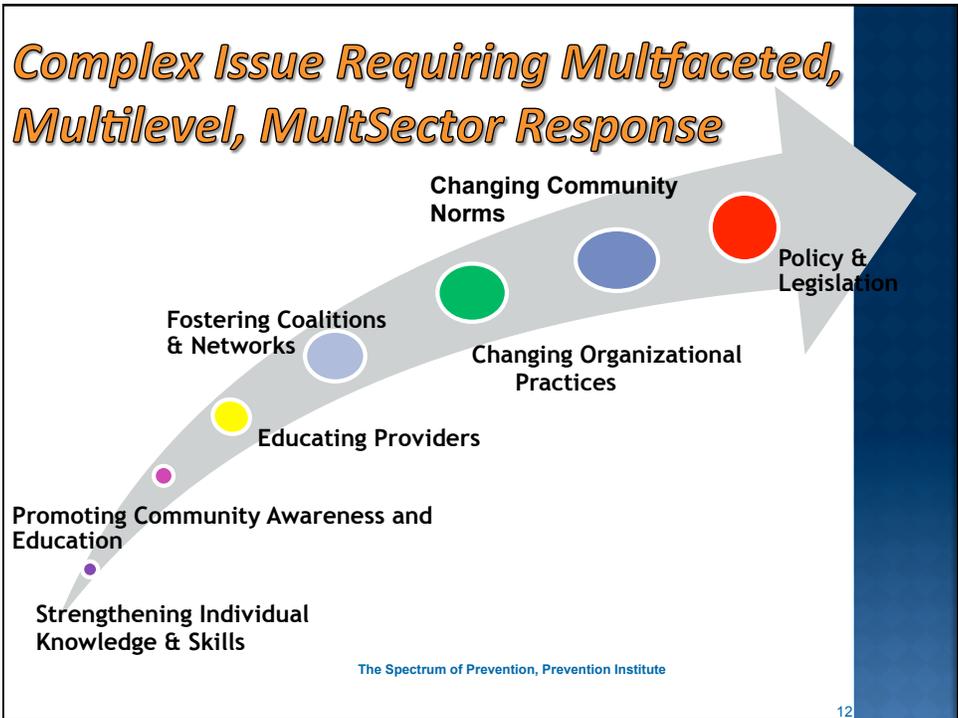
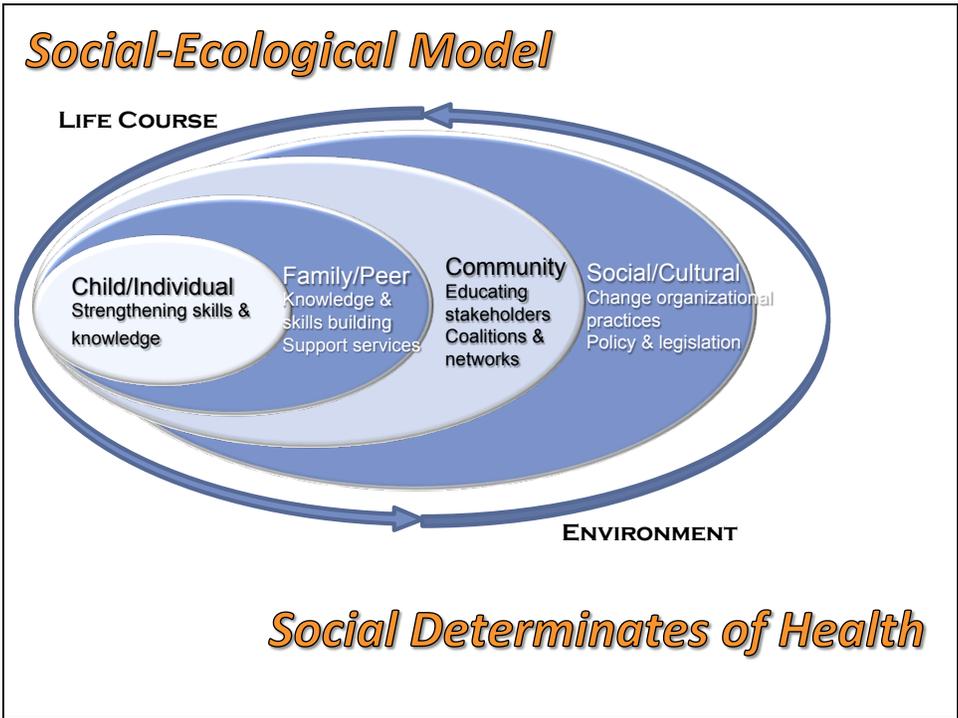
- ◉ 90% Making referrals to external child maltreatment resources
- ◉ 88% Identifying and targeting at-risk populations
- ◉ 84% Communicating best practices, funding, and training for child maltreatment prevention
- ◉ 84% Building capacity for child maltreatment efforts within the state public health agency
- ◉ 78% Conducting surveillance of child maltreatment risk and protective factors

Public Health Leadership Initiative, CDC Foundation, 2009

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Public Health Provides at a Minimum Access to a Broad Array of Programs:

- Teen Pregnancy Prevention
- School Health
- Child Care
- Lead Prevention
- WIC
- Home Visiting
- Adolescent Health Care
- Prenatal Care
- Pediatric Primary care
- Early Childhood
- Early Intervention
- Prenatal care
- Children with Special Health Care Needs
- Injury and Violence Prevention



What Do We Need To Do -

- ◉ Strengthen population and community-based efforts
- ◉ Assure mental health and substance abuse services for families and children
- ◉ Continue support for diverse array of services including targeted efforts such as home visiting programs & parenting education
- ◉ Increase evaluation and research efforts to identify evidence-informed prevention efforts

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What Do We Need To Do -

- ◉ Design funding and programs to allow states and communities to move out of “siloed” efforts and create coordinated and integrated efforts including braiding of funding
- ◉ Engage more systems and professionals in child maltreatment prevention
- ◉ Recognize importance of need for strong infrastructure
- ◉ Increase coordination, collaboration and integration of services
- ◉ Find right balance between community and individual based initiatives and services

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Nation's and Community's Health & Well-being Depend on Our Children Having A:



GOOD START

GOOD FUTURE

GOOD CARE

GOOD SUPPORT

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Contact Information

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Child Maltreatment Fatality Prevention and Public Health

Breena Holmes, MD
Maternal and Child Health Director
Vermont Department of Health
October 23, 2014



Objectives

- Highlight several public health programs with child maltreatment fatality prevention strategies and evidence
- Review federal Maternal and Child Health funding for injury prevention, including maltreatment

Maternal and Child Health

- WIC
- School Health
- Early Periodic Screening Diagnosis Treatment
- Children with Special Health Needs
 - Child Development Clinic
 - Financial technical assistance
 - Medical social workers/care coordination in medical home
 - Palliative Care, Personal Care, Hi Tech Nursing

Vermont Department of Health

Maternal and Child Health

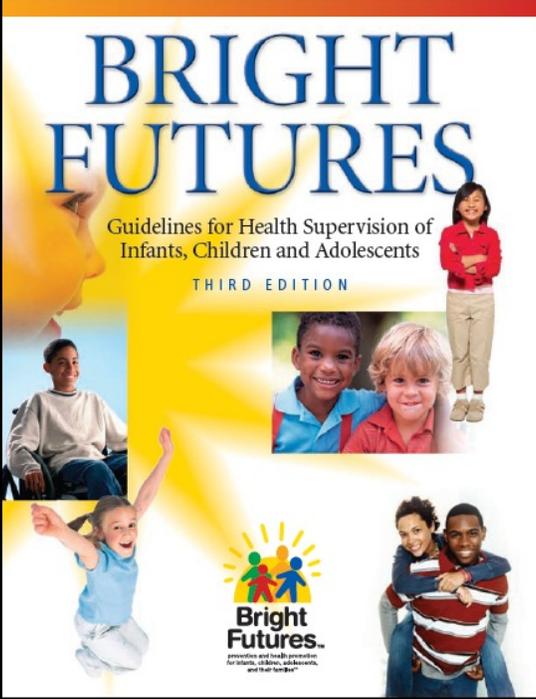
- MCH Planning
 - Home Visiting
 - Preventive Reproductive Health
 - Domestic Violence and Sexual Violence Prevention
 - Childhood Injury Prevention
 - LAUNCH

Vermont Department of Health

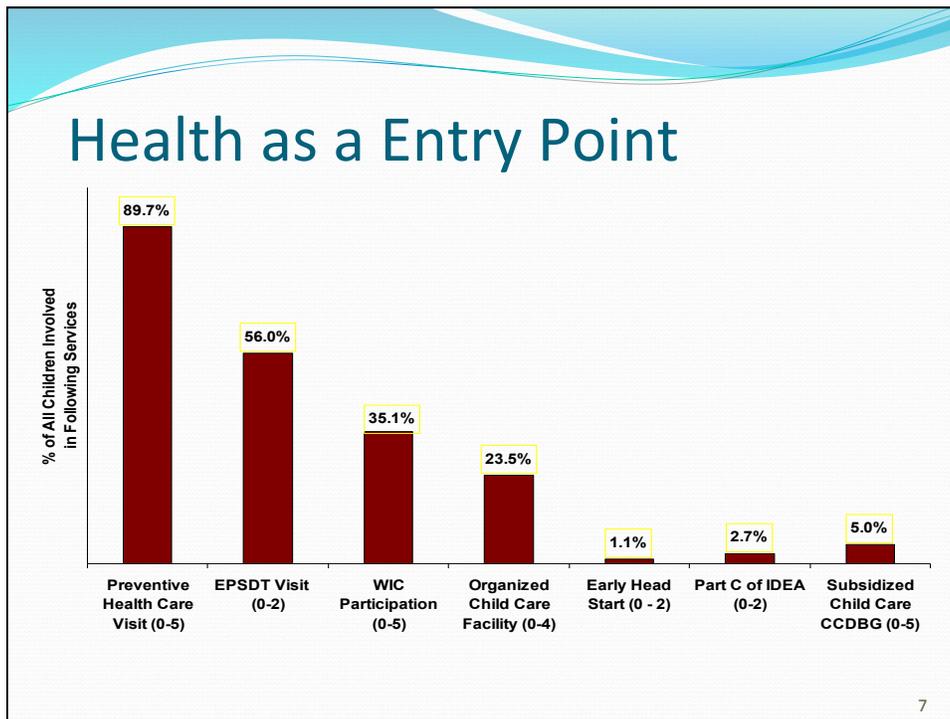
Maternal and Child Health Examples

- Bright Futures Guidelines
 - Health supervision for all children
- Home Visiting
- Help Me Grow
- Strengthening Families

Vermont Department of Health



...is a set of principles, strategies and tools that are theory - based, evidence - driven, and systems - oriented, that can be used to improve the health and well-being of all children through culturally appropriate interventions that address the current and emerging health promotion needs at the family, clinical practice, community, health system and policy levels.



Maternal Infant Early Childhood Home Visiting

- Affordable Care Act 2010
- Nurse Family Partnership

Vermont Department of Health

Home Visiting Alliance

- Vermont Business Roundtable
- Pew Center for the States
- State and community partners met monthly for 2 years
- Home Visiting statute, rules and manual

Vermont Department of Health

Early Learning Challenge-Race to the Top

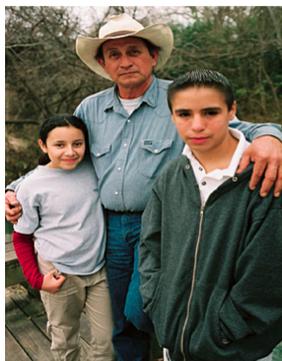
- Evidence based Home Visiting
 - Parents as Teachers
 - Maternal Early Childhood Sustained Home Visiting (MESCH)
- Strengthening Families
- Help Me Grow
 - Universal Developmental Screening
 - Health and Safety consultation in early care and education

Vermont Department of Health

Strengthening Families

FIVE PROTECTIVE FACTORS

PARENTAL RESILIENCE
 SOCIAL CONNECTIONS
 KNOWLEDGE of PARENTING
 and CHILD DEVELOPMENT
 CONCRETE SUPPORT in
 TIMES of NEED
 SOCIAL and EMOTIONAL
 COMPETENCE of CHILDREN



CENTER FOR THE STUDY
OF SOCIAL POLICIES
strengthening families
A PROTECTIVE FACTORS FRAMEWORK

Help Me Grow

- HMG serves as an umbrella for coordinating early childhood health, social and educational services, ensuring that all programs and sectors are benefiting from an integrated approach to meeting children's needs.
- HMG is a systems change strategy which increases effective collaboration across child-serving settings in order to improve access to existing services and resources.
- HMG has been designed with an emphasis on helping families navigate the different agencies and partners in the sector, and coordinating systems for referral and follow up to ensure complete coverage. Through the use of a centralized telephone access point, this evidence-based model provides coordination across early learning and development programs while strengthening the effectiveness of child health practices as medical homes.

Vermont Department of Health

Opportunities

- Federal funding in Vermont
 - MIECHV
 - Title V (MCH Block Grant)
 - Early Learning Challenge-Race to the Top
 - Linking Action for the Unmet Needs in Children's Health (LAUNCH)

Vermont Department of Health

What do we need?

- Commitment to primary prevention
- Health reform efforts to include family services in child health medical home
- Sustainable funding for evidence based home visiting
- Sustainable funding for Strengthening Families

Vermont Department of Health

 VERMONT
Department of Vermont
Health Access

 VERMONT
Blueprint for Health
Smart choices. Powerful tools.

Vermont Public Health Infrastructure:
Medicaid, Blueprint For Health, Addictions
Treatment, & ACES

Commission to Eliminate
Child Abuse and Neglect Fatalities

October 23, 2014
South Burlington, Vermont

Beth Tanzman, Assistant Director
Vermont Blueprint for Health
Beth.Tanzman@State.vt.us

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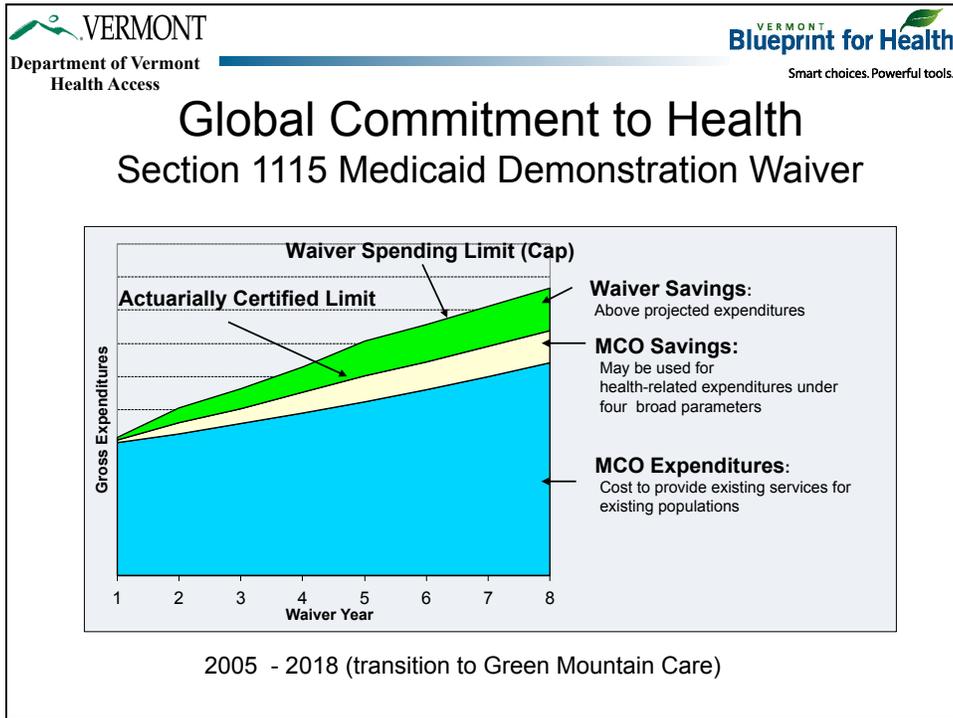
 VERMONT
Department of Vermont
Health Access

 VERMONT
Blueprint for Health
Smart choices. Powerful tools.

Objectives

- ✓ Medicaid Plan for Health Service Infrastructure
- ✓ Exemplar Approaches & Potential to Reduce Fatalities
 - Blueprint for Health
 - Hub & Spoke Initiative for Medication Assisted Treatment
- ✓ ACES Study: Preliminary Findings for Vermont
- ✓ Ideas for Recommendations at Federal Level

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-
-
- ## VT Global Commitment: Purpose
- Promote universal access to affordable health coverage
 - Build public health approaches to meet needs of individuals and families
 - Develop innovative quality and outcome payment approaches
 - Enhance coordination of care across providers and delivery systems
 - Unified management for program & budget across Agency of Human Services
 - Control program cost growth
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Objectives

- ✓ Medicaid Plan for Population Health Infrastructure
- ✓ Exemplar Approaches & Potential to Reduce Fatalities

Blueprint for Health

Hub & Spoke Initiative for Medication Assisted Treatment

- ✓ ACES Study: Preliminary Findings for Vermont
- ✓ Ideas for Recommendations at Federal Level

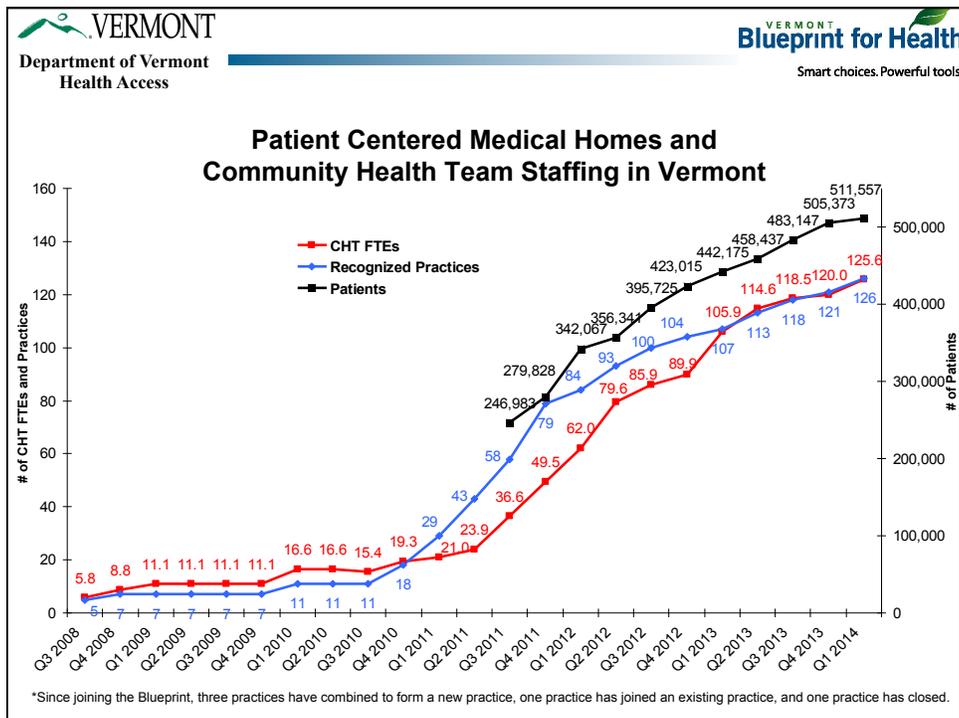
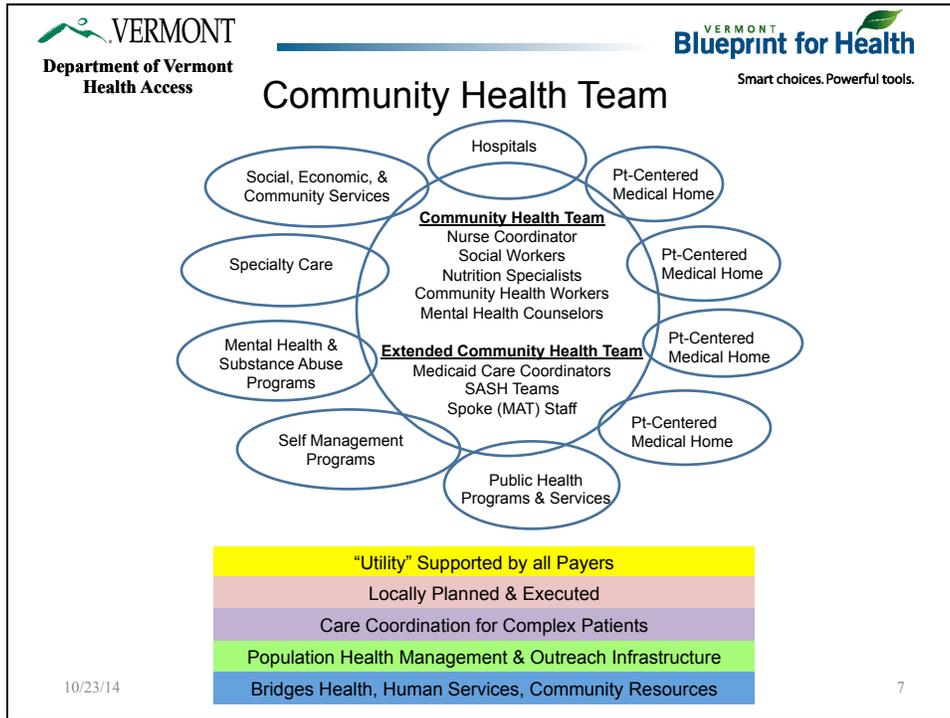
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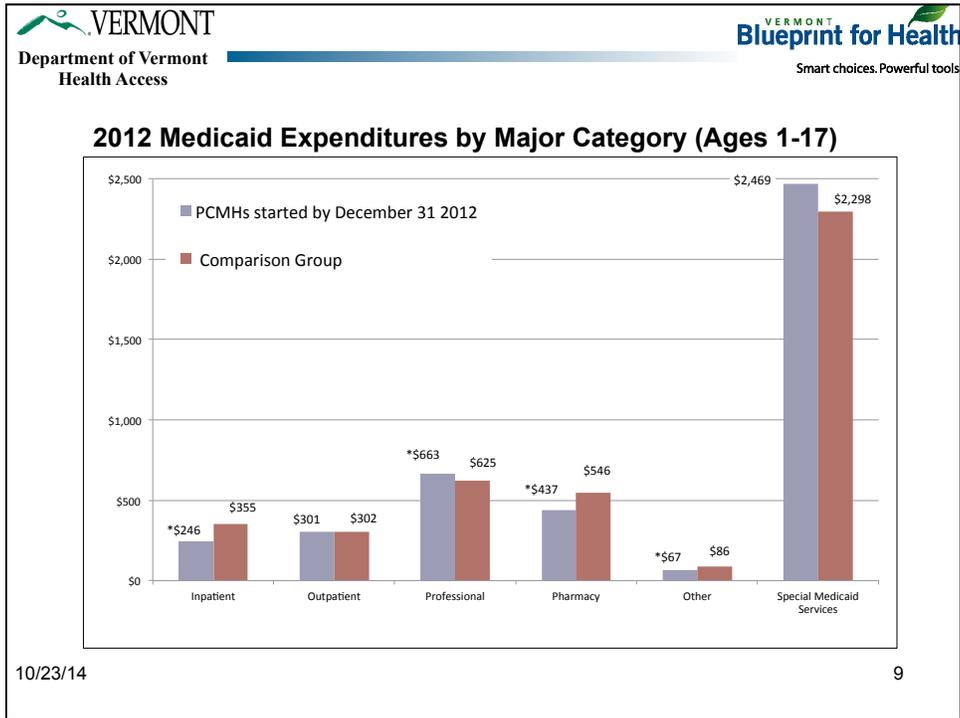



Patient Centered Medical Homes: Joint Principles

American Academies of Family & Pediatric Physicians,
College of Physicians, Osteopathic Association

Personal Physician ongoing relationship for continuous & comprehensive care
Physician Directed team who collectively take responsibility for ongoing care
Whole Person provide or arrange for all a patient's health care needs
Care is Coordinated & Integrated across all elements of health care system and community. Care is facilitated by registries and health information exchange.
Quality & Safety care planning process based on partnership with patients, evidence-based medicine, accountability for CQI, voluntary recognition process
Enhanced Access open scheduling, expanded hours, electronic communication
Payment recognizes the added value to patients including for coordination of care





Savings Compared to Investment in 2012

Study Groups	# People	Amount Saved Per Person in 2012*	Total Saved in 2012	Total Invested in 2012**	2012 Gain/ Cost Ratio***
Commercial (Ages 1-17 Years)					
Blueprint 2012	30,632	\$386	\$11,823,952	Commercial \$5,905,166	15.8
Blueprint 2012	138,994	\$586	\$81,450,484		
Medicaid (Ages 1-17 Years) Excluding SMS					
Blueprint 2012	32,812	\$200	\$6,562,400	Medicaid \$2,883,525	8.2 excludes ****SMS
Blueprint 2012	38,281	\$447	\$17,111,607		
Medicaid (Ages 1-17 Years) Including SMS					
Blueprint 2012	32,812	\$29	\$951,548	Medicaid \$2,883,525	2.2 includes SMS
Blueprint 2012	38,281	\$142	\$5,435,902		

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*Difference in 2012 total expenditures per person for Participants vs. Comparison Group.
 **Includes 2012 totals for Patient Centered Medical Home and Community Health Team payments.
 ***Calculated as Total Saved divided by Total Invested.
 ****Special Medicaid Services (SMS) include Transportation, Home and community-based services, Case management, Dental, Residential treatment, Day treatment, Mental health facilities, School-based and Department of Education Services




Summary – Results from 2012 Claims Data

PCMH+CHT patients vs. their respective comparison groups

- Improved healthcare patterns
- Reduced medical expenditures per capita
- Linking Medicaid population to non-medical support services
- Similar or higher rates of recommended assessments

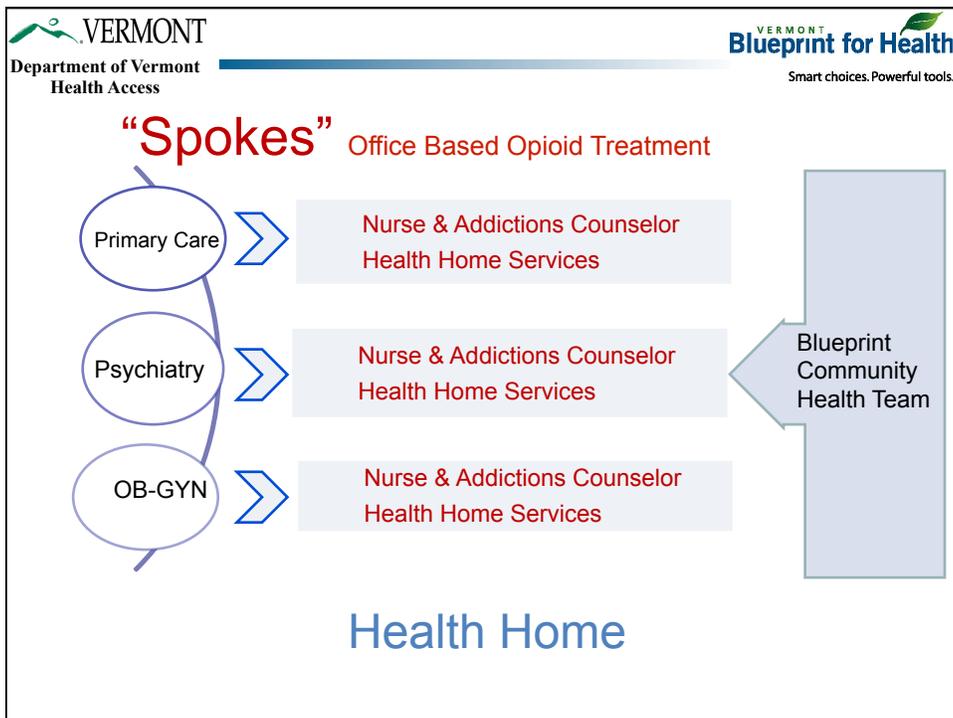
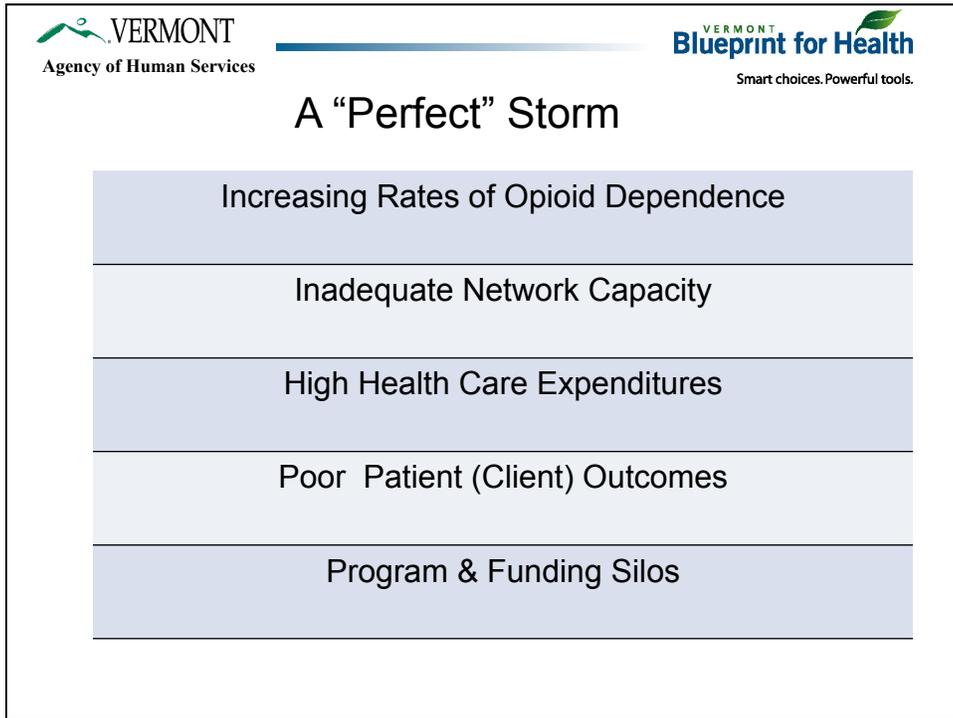
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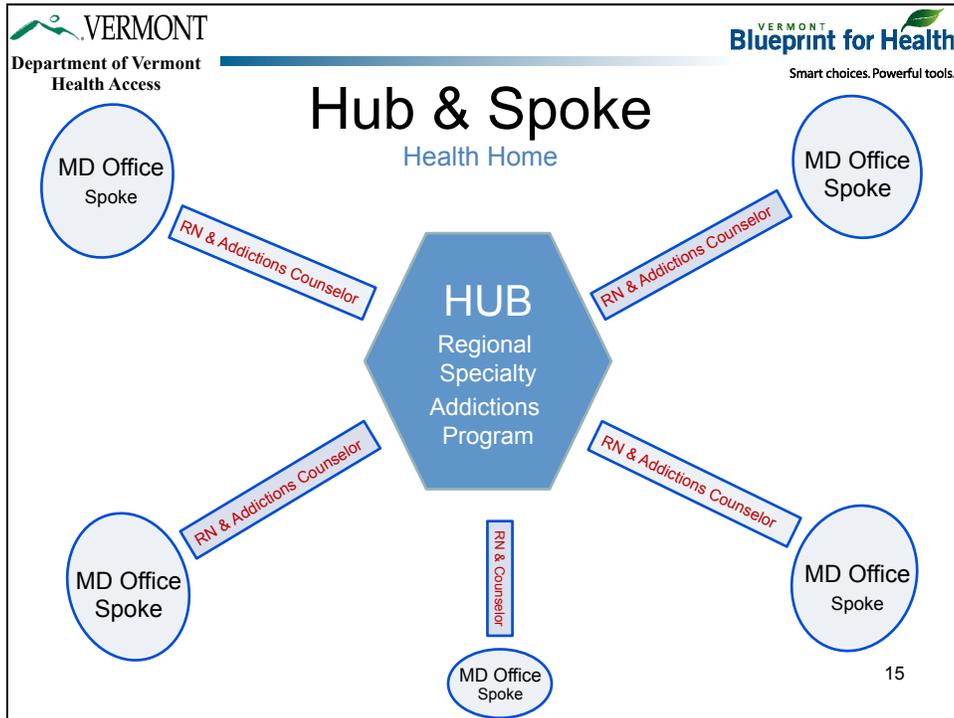



Objectives

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- VERMONT Department of Vermont Health Access
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 - ✓ Recommendations Federal Level
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Preliminary Observations on ACES

- Many points of identification and intercept for families and individuals with high ACES burden
- Service silos remain; difficult to organize proactive response to need
- Families at greatest risks may be difficult to engage with current models
- Support practice improvement & pathways to care
- Both universal & targeted approaches to break inter-generational cycle

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Objectives

- ✓ Medicaid Plan for Population Health Infrastructure
- ✓ Exemplar Approaches & Potential to Reduce Fatalities
 - Blueprint for Health
 - Hub & Spoke Initiative for MAT
- ✓ ACES Study: Preliminary Findings for Vermont
- ✓ Recommendations: Federal Level

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Recommendations

Federal policies that support timely exchange of information among providers (Child Welfare, Addictions Treatment 42-CFR)

Universal access to health care services (including parity for MH/SA conditions)

Accelerate use of “Big Data” & predictive analytics to ID risk for child fatalities

Develop the evidence base for effective interventions

Align related initiatives

CHARM

Children and Recovering Mothers

***A Model for Prevention:
Collaborative Approach to
Services for Opioid-Dependent Pregnant and
Postpartum Mothers and their Babies in Vermont***

Commission to Eliminate Child Abuse and Neglect Fatalities

Burlington VT

October 23, 2014

Sally Borden, M.Ed., KidSafe Collaborative

What is CHARM?

- CHARM is an **inter-disciplinary and cross-agency team** which **coordinates care** for pregnant and postpartum mothers with a history of opiate dependence, and their babies.
- **Model collaborative approach**





CHARM Goal:

to improve the **health and safety outcomes of babies** born to women with a history of opiate dependence by **coordinating** medical care, substance abuse treatment, child welfare, and social service supports.



CHARM: Promising Prevention Model

Prevention of substance abuse-related child maltreatment and child abuse and neglect fatalities - **Key Elements:**

- Pregnancy: Opportunity for Change
- Early Access to Prenatal Care and Substance Abuse Treatment
- Early child welfare involvement, assessment and develop plans of safe care *prior to birth*
- Coordinated Services and Supports
- Systems for collaboration: information sharing to support health/safety of moms and infants

Background: Pregnancy and Prescription Opioid Abuse Among Substance Abuse Treatment Admissions

Nationally, from 1992 to 2012:

- Admissions of **pregnant women reporting prescription opioid abuse** increased substantially from 2% to **28%**
Overall proportion of pregnant admissions remained stable at 4%.
- Pregnant treatment admissions for prescription opioids as the **primary substance** of abuse increased from 1% to **19%**

Martin, C.E., et al., Recent trends in treatment admissions for prescription opioid abuse during pregnancy. *Journal of Substance Abuse Treatment* (2014), <http://dx.doi.org/10.1016/j.sat.2014.07.007>

Background: Pregnancy and Prescription Opioid Abuse - Vermont

- Vermont has the second highest rate of admissions to state-funded substance abuse treatment programs in the U.S.
- In Vermont, the vast majority of opioid dependent pregnant women are in treatment. *Four out of five opioid exposed infants were born to women in treatment.*



http://healthvermont.gov/research/documentsopioid_expos_infants_4.18.14.pdf

Early Intervention = Healthy Outcomes

- Medication-assisted treatment with methadone or buprenorphine is the **standard of care** for pregnant opioid addicts, both for the **health of the mother** *and* the **health of the fetus**.
- *“One cannot talk about the health [and safety] of the fetus or newborn without addressing the health care needs of the mother.”*

Dr. Anne Johnston, Neonatologist

Vermont Children’s Hospital at Fletcher Allen Health Care

CHARM Partners: How it Works

Partner	Service(s) Provided	Collaborative Role
Hospital: High Risk Obstetrics Clinic	Intensive prenatal care, Initiation on Medication Assisted Treatment, script; Postnatal care (mother)	Obtains Release of Information; Provides patient updates
Hospital Neonatology; Neonatal Medical Follow-up Clinic	Prenatal consults with mother; NAS: Neonatal Abstinence Syndrome scoring; Infant care and treatment; Developmental assessment	Maintains listing of CHARM families, Releases of Info.; Provides patient updates
Community-based Substance Abuse and Mental Health Agency	Medication Assisted Treatment; Opioid Care Alliance case management	Provides client progress updates re MAT, counseling

CHARM Partners: How it Works		
Partner	Service(s) Provided	Collaborative Role
Child Welfare: VT Department of Children and Families	Child safety and risk assessments; Ongoing services for high risk families.	Consultation on child safety Issues; Child welfare and court case status
Public Health: Maternal and Child Health	WIC; Access to home visiting, Children's Integrated Services	Referrals to MCH services; Updates and follow-up
Public Health: Substance Abuse	State Opiate Authority; Care Alliance for Opioid Addiction	Information on treatment options and standards, coordination
Hospital OB and Pediatric Social Work	Assessment and intensive support	Provides patient updates

CHARM Partners: How it Works		
Partner	Service(s) Provided	Collaborative Role
Home Health Agency	Home visiting services:	Client referrals and provide updates
Community-based Substance Abuse Treatment and Social Services Agency	Residential care (pregnant/moms and babies); Substance abuse treatment; Parent support	Client treatment updates; Referrals for residential care and outpatient
VT Department of Corrections - Health Care	Health care for incarcerated pregnant women	Patient status updates and follow-up
VT Healthcare Access (Medicaid)	High risk pregnancy support program	Information on Medicaid, services
Community-based organization		Facilitator; MOU

Key Elements of CHARM Collaboration

- **A Shared Philosophy:** Improving care and supports for mothers is the most important factor in helping to ensure healthy and safe infants
- **Shared Information** improves child safety and healthy outcomes
- **Memorandum of Understanding:** provides an important framework for sharing information and coordinating services



Framework for Collaboration

- **Memorandum of Understanding:** provides an important framework for sharing information and coordinating services
- **Consent to Release Information:** Majority of patients sign consent; information sharing is in their best interest
- **Vermont Law:** “Empanelled” as a **multi-disciplinary “child protection” team** under VSA Title 33 §4917

Provides for information sharing among team members for case coordination to identify and treat suspected child abuse/neglect

Prenatal Care

- ❖ **Comprehensive Assessment:** Confirm Pregnancy, Assess for Opioid Dependency. Obtain Release.
- ❖ **Medication Assisted Treatment** during Pregnancy
 - **Enhanced Prenatal Care:** Frequent Prenatal Visits & Monitoring; Urine Drug Tests; Dose Adjustment
 - **Substance Abuse Counseling:** Required for all Women Receiving MAT
- **Residential** program for moms and babies
- **Case Management and Referrals:** WIC, Visiting; social support services

❖ = point of entry



Neonatology Antenatal Visit(s)

- **Establishing a Connection**
- **Alleviation of fear**
 - *Our Care Notebook*
 - You are not alone...
- **Education**
 - Provide information and resources: Neonatal Abstinence Syndrome, screening, treatment, newborn care
- **Respect**
 - “What are your dreams / goals?”
 - Listen actively, reserve judgment; allow the story to change
 - Recognize strengths and accomplishments



Child Protection

- Federal CAPTA Assurances
- Mandated Reporting: “Reasonable cause” to believe a child has been harmed or at risk of harm
- Vermont Department for Children and Families (DCF)- Family Services Division - **Policy 51**
 - DCF-FS may respond to a report of suspected maltreatment by conducting a child safety intervention.
 - **An assessment may begin approximately one month before the due date** or sooner if medical findings indicate that the mother may deliver early.

<http://dcf.vermont.gov/sites/dcf/files/pdf/fsd/policies/51%20%28Screening%20Reports%20%20CAN%29%208-12-2011%20-%20Final.pdf>

Child Protection

An DCF assessment may be conducted when:

- Illegal substance or non-prescribed prescription medication use **during the last trimester of pregnancy.**
- **Newborn positive toxicology screen** for illegal substances or prescription medication not prescribed or administered by a physician
- A newborn has Fetal Alcohol Spectrum Disorder, or **Neonatal Abstinence Syndrome** ...as the result of **maternal use of illegal substances or non-prescribed prescription medication.**

Child Protection: Implications for Prevention

DCF Policy 51: assessment initiated one month before the due date when:

- serious threat to a child's health or safety,
- mother's substance abuse during pregnancy,

Innovative approach:

- allows time for family engagement prior to birth
- planning for safe environment for the infant
- **child maltreatment prevention:** earlier indication of risk/parent is unable to parent safely
- avoid unnecessary placement crisis at birth

Outcome: significant reduction in the number of child protection emergency "pick up orders" at hospital

Birth and Post-natal Care

Neonatal Abstinence Syndrome (NAS) screening

If indicated, **Pharmacological Treatment** for infant.

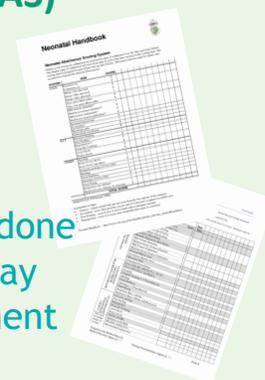
Outpatient treatment with methadone

Shortened hospital length of stay

Promotes bonding and attachment

Facilitates family support

Promotes breastfeeding (attachment)



Outcome: Decreased % of infants require medication (15-20%). National average: approximately 50%

Birth and Post-natal Care

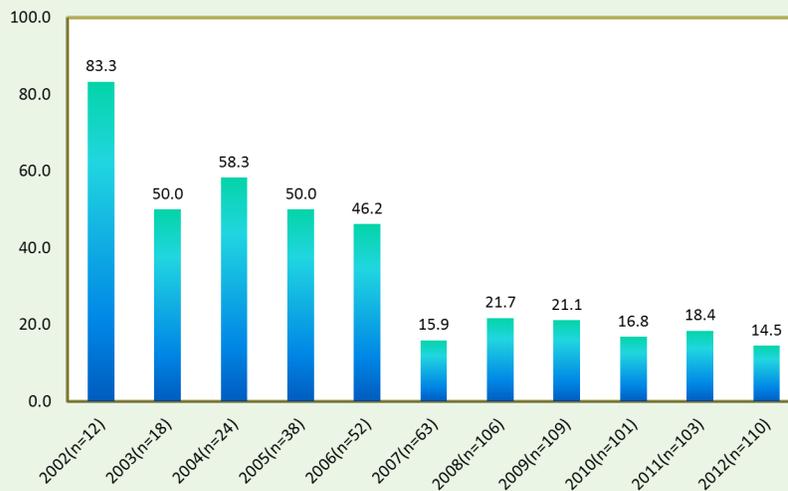
NeoMed Followup Clinic:

- Initiate treatment for infant in hospital
- Provide family/caregiver education regarding methadone administration and storage
- Monitor infant's taper
- 24/7 On-call Support
- Follow-up visits for all opioid-exposed infants and their parents/caregivers
- Home Visiting and Family Support Referrals



Outcome: Mean length of stay (LOS) for infants discharged on methadone treatment: 6.3 days.
National LOS for infants treated with morphine: 16 days

Vermont Children's Hospital % Infants who received outpatient pharmacologic therapy



CHARM: Case Review

At each monthly meeting the CHARM team reviews a list of current cases, and prioritizes cases for discussion:

- All **pregnant** patients due in upcoming month
- Prioritized **high risk prenatal** patients
- All **new pregnant** patients
- All **new babies** / post-partum patients
- Prioritized **high risk post-partum patients** and their babies

Information Sharing at CHARM Meetings

- Treatment: Methadone or Buprenorphine, (dose); consistency of treatment; provider; problems
- Attendance at prenatal, postpartum appointments, Neomed appointments
- Participation in substance abuse counseling
- Child welfare involvement and status
- Relevant medical and mental health information
- General psychosocial information and barriers to successful treatment: transportation, housing, family/ household members using substances



CHARM: Key Elements of Patient Success

- ❖ Start prenatal care early in pregnancy
- ❖ Pregnant women receive pharmacological treatment for opiate dependence
- ❖ Engaged in substance abuse counseling
- ❖ Attend prenatal care appointments
- ❖ Attend Neomed Clinic appointments
- ❖ Family and social supports, stable housing



CHARM: Key Elements of Patient Success

continued



- ❖ Partner: stable, safe, in treatment or no substance abuse
- ❖ Post-partum treatment plan
- ❖ Nurse home-visiting services
 - ❖ WIC, Other supports
 - ❖ Breastfeeding - attachment
- ❖ Earlier assessment of ability to provide safe care of infant; child safety risk



CHARM Outcomes

- More pregnant women are in treatment earlier with better prenatal care
- Fewer premature births; fewer small birth weight infants
- DCF policy change: Support services and plans of safe care developed prior to birth. Fewer emergency custody orders at time of birth.
- Improved collaboration = safer babies
- Less than 20% of exposed infants need medication treatment for NAS
- Lower hospital length of stay for treated infants
- Infants followed by Neomed Clinic have no increased developmental delay at ~12 months of age

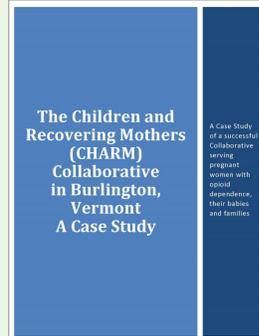


Challenges

- Collaboration - requires ongoing attention
- Complex lives: need high level of *ongoing* support
- Best practice: Home Visiting for *all* pregnant/new parents
- Recent cases: review of child welfare policies and practices regarding substance abusing parents to ensure child safety
 - Will practice changes result in pregnant women not seeking prenatal care?
- Memorandum of Understanding - need to expand and update to include all agencies
 - Confidentiality/limits to information sharing
- Area for further study: substance abuse/child welfare outcomes: child fatality risk related to CHARM

❖ **The Children and Recovering Mothers (CHARM) Collaborative in Burlington, Vermont A Case Study**

National Center on Substance Abuse and Child Welfare <http://www.ncsacw.samhsa.gov/>



❖ **Vermont Health Department - Alcohol and Drug Abuse Programs: Care Alliance for Opioid Addiction:**

<http://healthvermont.gov/adap/treatment/documents/CareAllianceOpioidAddiction.pdf>

❖ **University of VT - VCHIP: Improving Care for Opioid-exposed Newborns (ICON):**

<http://www.uvm.edu/medicine/vchip/?Page=ICON.html>

Sally Borden, Executive Director
KidSafe Collaborative

www.kidsafevt.org sallyb@kidsafevt.org 802.863.9626



Purpose of Counting

- To understand the scope of fatalities
- To measure if our interventions work
- To garner attention/financial support



Where Child Maltreatment Deaths are Registered and Counted



- Death Certificates
- State Child Abuse Reports Submitted to NCANDS
- Police Records to Uniform Crime Statistics
- State Child Death Review Data
- Individual State Reporting Sources

Current National Count is Focused on CPS

- Deaths reported in case and agency file in NCANDS

“Forty-nine states reported a total of 1,593 fatalities. Of those 49 states, 44 reported case-level data on 1,315 fatalities and 41 reported aggregate data on 278 fatalities. Fatality rates by state ranged from 0.00 to 4.64 per 100,000 children in the population.”

State Notes in NCANDS

- Florida Fatality counts include any report closed during the year, even those victims whose dates of death may have been in a prior year. Only verified abuse or neglect deaths are counted.
- Georgia: The state relies upon partners in the medical field, law enforcement, Office of the Child Advocate, and other agencies in identifying and evaluating child fatalities. Since late 2011, the state has expanded the review process to better identify possible commonalities that will aid in our practice.
- .
- Nebraska: The state continues to work closely with the state's Child Death Review Team (CDRT) to identify child fatalities that are the result of maltreatment, but are not included in the child welfare system. When a child fatality is not included in the Child File, the state determines if the child fatality should be included in the Agency File.

- Iowa: The state Child Death Review Board reviews all child deaths in the state. Child fatalities reported to NCANDS are child deaths as a result of maltreatment. Reviews completed by the state child death review are completed after all the investigations, medical examiner's results and any other information related to the death is made available.
- Michigan The state doesn't report on non-CPS child fatality cases.
- Montana: There were no child fatalities for children in care of Child and Family Services. However, according to the Department of Justice there were two child deaths as the result of abuse in the state in FFY 2012. These are reported in the Agency File.

- Hawaii: CWS works collaboratively with the Medical Examiner's office, local law enforcement and our Kapiolani Child Protection Center (Multidisciplinary Team-MDT) who conducts our Child Protection Review Panel (CPRP) on death or near fatality cases as a result of acts or omissions of the child's legal caretaker.
- Illinois: The state only uses data from our Statewide Automated Child Welfare Information Systems (SACWIS) system when reporting child deaths to NCANDS

Typical “Missed” Cases

Baby Albert

- 4 month old baby boy, born drug exposed.
- Sleeping on couch with mom and dad, found at 2 am not breathing.
- EMS responded, found both parents intoxicated and drug paraphernalia.
- 8 year CPS history on both parents, rights terminated on 4 other children.
- Mother lost 2 children in a fire when a drug deal went bad-house was firebombed.

Death Certificate: Natural, SIDS

Law Enforcement: No report

CPS: Not notified

CDR: Accidental suffocation and neglect

Baby Steven

- Child born drug exposed to opiates.
- Birth mother had 10 other children removed at various points.
- At two months, baby died due to respiratory distress, conditions related to perinatal conditions.
- Baby severely underweight for age.
- Baby had not had any other medical appointments since leaving hospital.
- Mother actively using.

Death Certificate: Natural, related to perinatal conditions.

Medical Examiner: not notified

Law Enforcement: no report

CPS: Not reported

Blake, Chris and Joyce

- 3 siblings, ages 2, 4, and 6.
- Oldest had a history of playing with fire and had been beaten by Mom for starting a small fire in garage.
- Fire started in upstairs bedroom where all children were-believed to have been caused by a lighter.
- Mother was two houses down visiting neighbors.
- 3 unsubstantiated CPS referrals for abuse and neglect-neighbors reported mother would leave children to go to store or visit neighbors. One call came in after mom beat Blake for playing with matches.

Death Certificate: Accidental-Fire

Law Enforcement: Accidental but reported to CPS

CPS: Neglect

CDR: Accidental Fire and Neglect

Darrin

- 14 month old baby boy in bathtub, fell over and drowned in 12 inches of water.
- Mom a middle income, licensed day care provider, had one infant at time, asleep.
- Mom went to answer doorbell at time Darrin was in tub. Talked for a few minutes with neighbor. Went into kitchen to make coffee and read newspaper.
- Remembered Darrin and ran upstairs.

Death Certificate: Accidental,
drowning

Law Enforcement: Accidental
Drowning

CPS: Not reported

CDR: Accidental drowning, but neglect

Chalene

- 13 month old old died from inflicted head trauma-beaten by her mother's boyfriend while mother was at work. He was convicted and sentenced to prison.
- Mother had been counseled by CPS not to leave baby with boyfriend because of his known violent history and domestic violence with mother.

Death Certificate: Homicide

Law Enforcement: Homicide

CPS: Undetermined for mother

CDR: Homicide/Neglect

Tyler

- 7 year old boy wandered from his trailer home and drowned in the trailer park pool.
- Child had mild autism.
- Both parents were home and working outside at time.
- Neighbor had called trailer park owner several months earlier to ask that gate to pool be locked-reported “worried that the little boy next door wanders around alone and could get in and drown.”
- Multiple calls to CPS for poor supervision, “this boy is going to drown one day.” No reports accepted for investigation.

Death Certificate: Accidental drowning

Law Enforcement: Accident

CPS: Undetermined

CDR: Child neglect, drowning

CDC Maltreatment Surveillance Project: Combine multiple sources of data

- Expanded CM case definition.
- Expanded case finding and collection of additional information.
- Multiple sources of data
- Case by case review.

Michigan

Medical Examiner: manner homicide on death certificate	0
Medical Examiner: Cause maltreatment on death certificate	0
Law enforcement Crime report	0
CPS reported as neglect	22
Charges filed for 2 nd or 4 th degree abuse	7
Work group consensus of gross negligence	76

Officially Reported Child Maltreatment Deaths

	1994	1995	1996	1997	1998	1999	2000	2001
Michigan Vital Stats	14	16	13	13	14	16	19	15
State MDT review					40	48	76	107
NCANDS Data	0	0	0	0	40	48	52	53



Comprehensive Review

California:

Child Maltreatment Deaths Reported to Multiple Data Sources, 2000-2005

Data Source	Year					
	2000	2001	2002	2003	2004	2005
FCANS Reconciliation Audit	129	133	140	Not conducted	Not conducted	185
Vital Statistics Death Statistics Master File	21	30	23	30	20	21
Supplemental Homicide File	79	77	78	90	76	82
Child Abuse Central Index	34	24	30	18	36	59
Child Welfare Services/Case Management System	21	50	59	Not included	Not included	Not included
Child Death Review Teams - FCANS	62*	116	105	134	107	124

Comprehensive Review

Las Vegas

79 deaths identified by state as possibly due to abuse or neglect. Only 6 were coded on death certificates as maltreatment-from physical abuse. Only 9 has been substantiated as maltreatment by CPS. 37 more substantiated after MDT review.

Type of Death	Manner				Total
	Natural	Accidental	Homicide	Udtmed	
Fetal Demise with Drug Intoxication	-	8		1	9
Other Fetal Demise			1	1	2
Perinatal Condition, Drug Intoxication	2	4	-	-	6
Medical Condition	16	-	1	-	17
Physical Abuse	-	-	6	-	6
Drowning	-	4	-	1	5
Left in Car on Hot Day	-	7	-	-	7
Car Crash	-	1	-	-	1
SIDS	7	-	-	-	7
Infant Asphyxia While Sleeping	-	10	-	4	14
Infant Undetermined While Sleeping	-	-	-	4	4
Undetermined	-	-	-	1	1
Total	25	34	8	12	79

Where most cases were missed

Neglect

- Poor supervision.
- Drug-exposed or FAS infants.
- Failure to thrive.
- Failure to use safety devices (car seats, smoke detectors, pfd).
- Allowing developmentally inappropriate activities.
Suffocation by overlay or positional asphyxia.
Deaths occurring while caregiver is intoxicated.
Caregivers with disabilities, impairments.

Neglect

- “Classification of deaths due to neglect is problematic because of a lack of consistent definitions. Each agency and each investigator may have different views of the societal norms that draw the line between minimally adequate care and supervision and serious/life threatening neglect.”
- Bias related to income, race, etc. likely

Air Force Project

- Amy Slep and Richard Heyman developed and validated specific, operationalized substantiation definitions. They developed a computerized system that allowed community decision boards to make determinations.
- Now used throughout all branches of DOD.

National CDR Case Reporting System

Comprehensive case data entered after reviews.

Teams determine omissions or commission's including abuse, neglect, poor supervision.

43 states enrolled voluntarily.

Recommendations

- Develop a national system of surveillance which is based on a public health model.
- Develop and field-test uniform definitions for child maltreatment with process for obtaining high reliability. Consider DOD model and/or CDC definitions.
- Clearly determine the role of federal and state agencies in leadership and in funding the development and sustainability of the new system

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- Strengthening the existing network of state and local CDR teams for the purpose of creating a national system for public health surveillance of fatal CM.
 - Determine which data systems are most cost-effective to invest in - NCANDS, NCDR-CRS and death certificates are critical.

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- Incorporate uniform definitions into the CDR Case Reporting System and NCANDS systems.
 - Standardize how states report deaths into NCANDS.
 - Improve the identification of fatal CAN from vital records/death certificates by adding a check box to indicate child maltreatment,

Improve the quality of death investigations

- Develop a nationally-standardized child death investigation tool.
- Resource medical examiners/coroners to use this tool.
- Contract only with forensic pathologists to perform autopsies in child and infant death cases.
- Defer to the forensic pathologist in determining cause and manner of child deaths.
- Transition coroner systems to medical examiner systems.