Child Maltreatment Fatalities - Risk Factors and Lessons Learned

Presentation by
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Objectives

• Describe the latest national trends related to child maltreatment fatalities

• Understand common risk factors that may contribute to a higher probability of fatal child maltreatment, including: child, parental, household and, environmental variables

• Describe lessons learned and practice recommendations for how child welfare agencies can strengthen practice, child fatality investigations and minimize placing children at risk of extreme harm.
Among child abuse and neglect reports, child fatalities from maltreatment elicit the most confusion and dismay among the general public and the greatest trauma and sense of tragic grief among child welfare professionals.

(Meyer & Comille, 2002)
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
National Child Maltreatment Fatalities (NCANDS)

During FFY 2010-

• **Scope:**
  - 51 States reported a total of **1,537** child deaths
  - Fatalities per 100,000 children: Nationally-**2.07**; California-**1.27**

• **Type of Maltreatment:**
  - Most (**40.8%**) caused by multiple forms of maltreatment
  - **32.6%** attributed to Neglect Only
  - **22.9 %** attributed to Physical Abuse Only

• **Prior CWS Contact:**
  - **12.1%** received CWS in the past 5 years
    • Higher % of cases known from prior referrals or investigations
    • Douglas & McCarthy (2011) cite CWS contact at 30-40% of families
    • In California over 40% of children whose first allegation of maltreatment is evaluated out are subsequently re-reported within 2 years (Needell et al., 2010)

(U.S. Department of HHS, 2011; Douglas & McCarthy, 2011; Needell et al., 2010)
A Combination of Factors are Most Predictive of Fatalities

Risk Factor Domains

Child
- Vulnerability
  - Parental Capacity
Parent/s
Household
- Multifaceted Problems
Environment
- Confounding Issues
Child Risk Factors

Age (2010):

- Four-fifths (79.4%) of all child fatalities were younger than 4 years old.
  - 47.7 percent of child fatalities were younger than 1 year

*Based on data from 44 States (n=1,262)

Child Risk Factors

• **Victims by Gender***:
  - Boys (2010): 60.1%; 2.51 per 100,000
  - Girls (2010): 39.6%; 1.73 per 100,000
  - Supports research indicating boys also have increased risk for maltreatment
    (*Based on data from 44 states)

• **Victims by Race****:
  - 43.6% White
  - 28.1% African-American
  - 16.6% Hispanic
  - 4.4% Two or More Races
  - 5.5% Unknown Race (Unable to Determine or Missing)
    (**Based on data from 42 states)
    (U.S. Department of Health and Human Services, 2011)
Perpetrator Relationship to Victim

*Child Fatalities by Perpetrator Relationship*

- **Total Parents**: 79.2%
- **Total Unknown**: 8.3%
- **Total Nonparents**: 12.5%

- **Mothers involved**: 60.5%
- **Fathers involved**: 40.6%
- **Father**: 17.1%
- **Father & Other**: 1.6%
- **Mother**: 29.2%
- **Mother & Other**: 9.4%
- **Mother & Father**: 21.9%

*Based on data from 40 States (n=1,155)*

CHILD
- Under 4 y/o
- Male
- Unwanted
- Born prematurely
- Illness/disability
- Baby colic
- Challenging behaviors
- Other Siblings under 3 y/o

PARENT/S
- Younger age
- Severe control problems
- Dependency conflicts
- History of abuse/DV
- Psychiatric illness
- Jealousy or rejection by child
- Lack of parenting skills
- Inability to bond

HOUSEHOLD
- Stressful major life event in past year (death, birth, job loss, move, etc.)
- Less education
- Substance abuse
- History of violence
- Lack of job skills
- Criminality
- Especially mobile/frequently move
- Current or prior contact with CWS
- Change in household composition
- Non-family members present

ENVIRONMENTAL
- Living in poverty
- High unemployment
- Increased crime rates
- Geographical locality
- Lack of support systems
- Multiple service providers involved over time
- Seen by physician following onset of abuse
Add to the existing risk factors a “precipitating event or events”
Putnam-Hornstein Study: Population-Level Examination of Maltreatment in CA

• Most rigorous longitudinal analysis of injury mortality following a report to CPS to date

• Recorded linkages between CPS records, 8 years of vital birth records and 9 years of vital death records—over 4.3 million children born in CA (1999-2006) were followed from birth

• Recognizes child maltreatment as a social problem that lends itself to a public health framework of study and subsequent prevention activities

(Putnam-Hornstein, 2011)
Findings (Putnam-Hornstein, 2011)

- **CPS Issues**
  - Strong empirical evidence that a prior allegation to CPS proved to be the strongest independent risk factor for injury mortality before 5 y/o
  - Children with prior allegation of maltreatment die from intentional injuries at a 5.9x greater rate than unreported children, and died from unintentional injuries at 2.5x the rate of unreported children
  - Placement in foster care (for 1 or more days) is protective
  - No evidence that we are able to effectively screen maltreatment allegations over the phone, without an in person investigation
Findings (Putnam-Hornstein, 2011)

• “High Risk” any child with three or more of the following risk factors at birth (from birth records):
  1. Late Prenatal Care (after 1st trimester)
  2. Missing father information
  3. Maternal Education <=high school degree
  4. 3+ children in the family
  5. Maternal age <=24 years

• Children with prior allegation of physical abuse have dramatically higher (38.5x) intentional death rates than unreported children or children reported for all other maltreatment types

• Recommendation: use objective, universally collected data on day of birth to prospectively identify children at greatest risk of maltreatment during first 5 years of life, and target high-risk subsets of children for intervention services prior to first CPS contact
“The real conundrum about fatalities is that predication, preventive intervention, and conceptual models to guide decisions require understanding and scrutiny of myriad risk factors that span parental and child spheres, community supports, and agency practices.”

(Besky, 1993)
System Issues-MACRO

Critical Thinking

Supervision

Assessment Tools/Criteria

Investigation

Worker
Training

Knowledge useful abilities.

backbone of co-
quired for a tr-
today
I’m not sure I know what the risk factors are for CMF.

A parent on my caseload once told me that s/he might kill his/her children.

It could happen of any of our children.

I worry that a child on my caseload will die.

I would like additional training about risk factors for CMFs.

When I work with a family, I look for signs that might cause a child to die.
Belief Systems Can...

- **Skew Perceptions**
  - “See what we want to see and hear what we want to hear.”

- **Influence Clinical Judgment**
  - Confirmatory bias
    - Professional
    - Personal

- **Subvert Accurate Documentation**
  - “Good facts” and “Bad facts”

- **Affect Decision-Making**
  - Viability, Credibility, Logic, Optimism-Pessimism, Attribution of Responsibility, Weight to Evidence and Expert Opinion

(Munro, 1999)
The Challenge of Challenging Beliefs

People consistently avoid exposing themselves to evidence that might disprove their beliefs.

On receiving evidence against their beliefs, they often refuse to believe it.

The existence of a belief distorts people’s interpretations of new evidence in such a way as to make it consistent with the belief.

People selectively remember items that are in line with their beliefs.

(Munro, 1999)
Information Gathering

- As a CW worker, a critical attitude to all evidence is needed
- Always check information and remember “facts” can be inaccurate
- CW workers often rely on people’s testimony rather than written records for information
  - Emphasis often on giving detailed verbal accounts of what happened at this stage, what family members had said and how they reacted to the investigation
  - Past history, written records, abstract theory and research findings tend to be under-used compared with the current, often emotionally charged, factual information gained in interviews
  - Current strategies to help practitioners generally involve checklists and guidelines that give equal emphasis to all areas of information.
- Avoid “start again syndrome”
  - When a family is transient and the caseworker approaches the case as new or simply fails to find the prior history
- When focusing on biological caretaker pay attention to their new relationships

(Munro, 1999)
Decision-Making Errors

- Failure to actually see, interview, examine child
- Selective perception
- Confirmatory bias
- Misattributing causes of behavior
- Poor record keeping/selective documentation
- Developing a vested interest in the outcome
- Groupthink-consensus seeking
- Working with incomplete data
- Tendency to disregard data
- STS/burnout or fear for personal safety & avoidance
- Jumping to conclusions
- Entering into power struggle with client
- Accepting parental withdrawal/“closure”
- Lack of critical thinking or analysis of evidence
- Not questioning “authority” opinions
- Sticking to the same case plan

(Reder, Duncan & Gray, 1993)
Families who “withdraw” and avoid professional attention, intervention and surveillance.

Dale, 2005
• During weekends, holidays and worker’s absences, covering colleagues need to have access to accurate and coherent information about the cases so that they can judge the significance of new reports

• List the chronology of events
  – gives a more complete and vivid picture of the pattern of abuse and its severity

• Draw a genogram of the family

(Reeder, Duncan & Gray, 1993)
Secondary Traumatic Stress (STS) and Caseworker Decision-making
Measurable

Actionable

Concrete

Defensible
“Good decisions do not guarantee good outcomes.”

Munro, 2010
Support for CPS Workers

• Arizona CPS Worker Exit Interviews (n=460) *(Reinhart, 2012)*
  - Top three exit reasons in 2010: Stress or emotional drain, unmanageable caseloads/workload and a lack of time or ability to serve children and families.
  - Top three exit reasons in 2011: Pay, caseloads/workload and stress or emotional drain.
  - Nearly 60% of those responding to the survey said they left in 2011 because they "felt the administration never or rarely valued the opinions of front-line workers and supervisors."
Supporting Staff Following Fatality

- Crisis debriefing services
  - Typically 24-72 hours after the incident
  - Protect confidentiality
- Primary focus on self-care/stress symptom recognition and reduction techniques
- Confronting the psychological challenges associated with child fatalities

Responding to Risk

Strategies supported by research, to improve intervention efforts:

- Clear decision-making protocols
  - Standardized safety & risk assessment (SDM)*
- Manageable CWS caseloads
- Strong support system for line workers
  - Ask: What is it about this case that is causing you the most stress/fear?
- Maintaining quality and frequent supervision
- Basic and advanced training for professionals
- Integrating evidence-based prevention programs
- Addressing barriers to info-sharing among agencies
- Interagency/ multidisciplinary approach and response
- Participation in CFRTs
Tools

- Structured Decision-Making
- Signs of Safety
- Trauma-informed Care
LA DCFS: Enhancing Safety Reminders

- Address all forms of maltreatment and always assess for signs or symptoms of re-occurrence with every child and family contact (including children in out of home care)
- Access appropriate collateral contacts and actively engage all relevant resources and individuals in the case
- Criminal checks on all parents/adults who reside in the home, and consistently inquire regarding any new individuals who may be in and out the home
- Interview both parents, even if one lives outside the home and gather pertinent information to inform assessment and re-assessment process.
- Locate & contact the reporting party to verify and obtain additional information
- Document thoroughly that worker has interviewed the children individually and privately

(Los Angeles Department of Children and Family Services, April 2010)
Institute for Healthcare Improvement Model: Child Fatality Issues

Environmental Context
(Community/Funders/Media)

Macro/Organizational Context
(Organization Components/Policy and Procedures)

Microsystem
(Departments Within Organizations/Program Managers/Supervisors)

Direct Contact
(Social Workers)
Child Fatality Review Teams

- Multi-disciplinary, multi-agency review of child deaths
- Function at state and local levels
- Assess all deaths to be on a spectrum of potential preventability
- Serve multiple functions: Investigation ➔ Services ➔ Prevention
- Progress in areas of: communication, transparency, information sharing, and data collection
- Six steps to a quality CDR that address the maximum number of issues involved in children’s fatalities:
  - Share, question, and clarify all case information
  - Discuss the investigations
  - Discuss the delivery of services
  - Identify risk factors
  - Identify barriers and recommend system improvements
  - Identify and take action to implement prevention recommendations

(National MCH Center for CDR, 2005; Covington, et al., 2007; Douglas and Cunningham, 2008)
Selection of CFRT Risk Reduction Recommendations

- More attention to risk factors/comprehensive risk assessments
- Assess for signs of caretaker MH issues (screen and refer)
- Provide advisory on mandated reporting of child abuse/neglect to local HSAs, hospitals and physicians
- Increased case management, referrals & follow-up for infants sent home with serious health or developmental problems
- Media campaigns to inform the general public on known fatality-producing behaviors (e.g. SIDS: Back to Sleep; Shaking)
- Crisis nurseries to serve as havens for parents “on the edge”
- Intensive home-visiting services to parents of at-risk infants
- Implement evidence-based intervention programs for parents (CEBC- http://www.cebc4cw.org)
- Train hospital ER room staff to improve identification and reporting of child abuse fatalities to appropriate agencies

(National MCH Center for Child Death Review, 2005)
Complexity of Change

Developed by Charles A. Wilson, Senior Director, Chadwick Center for Children & Families, San Diego, CA
Children most likely to be protected when:

- Agencies communicate effectively, frequently and honestly
- Agencies give greater attention to process issues and a stronger emphasis on translating learning into practice
- Records are well done
- Workers are in frequent contact with the family AND child
- Worker egos are not wrapped up in the decisions
- Workers are well trained in child protection and have access to needed specialty resources
- Services used are based on evidence-based practices
- Workers are well supported with effective supervision
- There is recognition that even the best work will not avoid all deaths

(Peter Choate, 2010; Devaney, Lazenbatt & Bunting, 2011)
Bibliography/References

- Please see accompanying attachment
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