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Safe Children:

Reducing Severe and Fatal Maltreatment

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GRAND CHALLENGES FOR SOCIAL WORK INITIATIVE

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Grand Challenge: *Stop family violence*

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Grand Challenges for Social Work Initiative

The Grand Challenges for Social Work are designed to focus a world of thought and action on the most compelling and critical social issues of our day. Each grand challenge is a broad but discrete concept where social work expertise and leadership can be brought to bear on bold new ideas, scientific exploration and surprising innovations.

We invite you to review the following challenges with the goal of providing greater clarity, utility and meaning to this roadmap for lifting up the lives of individuals, families and communities struggling with the most fundamental requirements for social justice and human existence.

The Grand Challenges for Social Work include the following:

- Ensure healthy development of all youth
- Close the health gap
- Stop family violence
- Eradicate social isolation
- End homelessness
- Promote smart decarceration
- Reduce extreme economic inequality
- Build financial capability for all
- Harness technology for social good
- Create social responses to a changing environment
- Achieve equal opportunity and justice
- Advance long and productive lives

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Reducing severe and fatal maltreatment is achievable through an array of methods that are not now consistently, widely, or optimally delivered, or which need to be developed. This paper describes the benefits to children, parents, and society from reducing child maltreatment morbidity and mortality. Mechanisms for achieving a significant improvement—a 50% reduction—in child maltreatment over the next decade are presented. These include implementation of birth match; expansion of safe haven laws; and improved integration of data on birth records, child-welfare involvement, and fatalities. Also included are case reviews that look at severe and fatal maltreatment, the characteristics of the workforce, the conceptualization of the case, and the family. Targets for improvement are identified so that progress toward significant reductions in severe and fatal maltreatment can be ascertained.

Key words: birth match, capture–recapture, Child Fatality Review, child maltreatment, clinical incidence reporting, Grand Challenges for Social Work Initiative, National Violent Death Reporting System (NVDRS), population informatics, safe haven laws

THIS CHALLENGE IS BIG, IMPORTANT, AND COMPELLING

Each incident of severe and fatal maltreatment is unique and tragic, but it also offers insight into how we might better integrate our health and human services to support families and protect children. Importantly, the benefits of an improved understanding of these extreme cases can also extend to less severe cases of maltreatment. The challenge of protecting children and reducing severe and fatal maltreatment builds on nearly a century of successful efforts by social workers to reduce infant mortality (Dickinson & Barth, 2013). These efforts were broad, drew on best practices in epidemiology, included community organizing and public health education, and cut the infant mortality rate by more than half in the early part of the 20th century. Indeed, one of the Children's Bureau's first undertakings was to determine how many children in the United States died before their first birthday. Social workers and volunteers visited more than 20,000 homes of newborns and later formed local programs to address the risk factors they identified. Unfortunately, progress has plateaued in the United States. High rates of child fatalities and near

fatalities persist, though they are distributed unevenly across population subgroups (Leventhal & Gaither, 2012; Wong et al., 2014). The U.S. Department of Health and Human Services (2013) estimates that 1,640 children died from abuse and neglect in 2012. An estimate from the Fourth National Incidence Study is even higher: 2,400 children (Sedlak et al., 2010). Wildeman and colleagues (2014) indicate that one in eight (12.5%) children in the United States will have been victims in a confirmed case of maltreatment by the time they reach 18 years of age. Ensuring the safety and protection of children poses a significant challenge. Efforts to address this challenge should begin with better surveillance of child maltreatment deaths and near deaths (Smith et al., 2011). These efforts must include better methods of risk assessment and better coordination of services.

Ending severe and fatal maltreatment of children in the United States not only will reduce overall child mortality but also will likely reduce other forms of maltreatment. Additional beneficial effects are possible: declines in the incidence of permanent neurological impairment and other cognitive and emotional morbidities, reduced health care costs, greater focus on the far larger number of cases with less severe maltreatment, and decreases in the arrest and incarceration of adults who might not have committed such violence if they had appropriate support and access to other options. The Centers for Disease Control and Prevention (2012) have recently estimated the lifetime cost of child abuse to be more than $210,000 per victim, with most of these costs resulting from the lost potential of child abuse victims rather than from the services they receive. Fang, Brown, Florence, and Mercy (2012) estimate that the total cost of child maltreatment is $124 billion a year. A significant part of that cost is from very serious, nearly fatal assaults such as the violent shaking of babies. A conservative estimate places the costs related to shaken baby syndrome at about $50,000 over the 4 years following the event—the estimate does not include the consequences resulting from the fatalities of 7% of the children in the sample (Peterson et al., 2014).

Severe and fatal maltreatment represents the tip of the maltreatment iceberg; many more children and youth suffer from less-severe abuse and neglect that is still consequential. Neglected children also have an elevated likelihood of death, including death from sudden infant death syndrome and other, sudden, unexplained causes (Putnam-Hornstein, Schneiderman, Cleves, Magruder, & Krous, 2014). Thus, improvements in child welfare responses elevate the possibility of reducing other types of child fatalities. We need to learn from the experiences of all these children; every case review can provide a window on the system (Salomez & Vincent, 2004), enabling the identification of lessons on safeguarding and promoting the safety of children.

We now understand that violent parenting—even when it is not fatal—creates toxic stress, which may result in a range of poor outcomes, including adverse changes to brain architecture, abnormal cortisol levels, and numerous health and behavioral-health vulnerabilities (Shonkoff et

al., 2012). Childhood maltreatment of any intensity has been linked to adult stress and can have an adverse impact on physical health over 30 years after the maltreatment (Widom, Horan, & Brzustowicz, 2015).

Yet, this challenge also persists because of poor practice, policy, and research. Covington and Petit (2013) identified some of the factors that continue to plague child welfare services. These factors include failure to properly assess the well-being of children in the home and to recognize imminent danger, failure to complete safety and risk assessments correctly or at all, failure to remove children subsequently born into a household after the death of a child or after the parent's custodial rights to another child have been terminated, failure to address the mental health needs of parents, and failure to recognize and respond to parents' clear, repeated indications that they do not want their children. Policies that largely fail to follow up with mothers who have previously shown dangerous parenting—mothers whose parental rights to another child have been previously terminated—create an unnecessary risk for children (Shaw, Barth, Mattingly, Ayer, & Berry, 2013). Assessment tools may aid workers in ascertaining the potential for a child to be harmed in the future. The failure to properly invest in and rigorously test such tools also contributes to risk.

THIS CHALLENGE IS LARGELY ACHIEVABLE

Although it is unlikely that we will ever be able to perfectly predict and therefore prevent all child fatalities, we can greatly reduce the number resulting from child abuse. Over the next decade, we can move to markedly improve our understanding of ways to reduce such harms, and we can reduce the remaining incidents of severe and fatal maltreatment by half. New mechanisms must be developed, and promising strategies must be firmed up with stronger research. If shown to be broadly effective, the strategies must be taken to scale. For example, we have a promising array of programs to improve child safety, including programs to provide proper preparation for new parents and for the parents of quickly developing toddlers (e.g., access to improved PURPLE Crying–style programs that aim to prevent violence via baby shaking; Barr, 2012). Specifically, knowledge of common feeding difficulties and their relationship with maternal mental health, and strategies for soothing difficult children in order to feed them calmly, must become more universally known (Hurley et al., 2013).

Reducing severe and fatal child maltreatment requires coordination of vital records (e.g., birth certificate data), child welfare data (to trigger services for the parents of newborns if the parents have prior histories of child welfare involvement), and other data so that early interventions to strengthen families and protect children can be effectively targeted. Information that is now largely uncoordinated with child-welfare service providers and planners could improve the

proper response to reports of child maltreatment. Such information might arise from police departments (e.g., 911 calls), substance abuse treatment programs, hospital emergency departments (see King, Farst, Jaeger, Onukwube, & Robbins, 2015), and health departments (e.g., other information gathered during efforts to provide home visiting programs).

Achievement of this grand challenge is also likely to require more active engagement and reporting: from primary care providers who see harsh child and parent relationships that could improve with parent education and support; from school personnel who see children behave in aggressive ways that may reflect violence in their homes and who may also see aggression by parents toward children; and from domestic violence services, mental health services, and juvenile services, which will need to work with children's services when they see high-risk pregnancies in order to achieve prompt outreach to those families. If this challenge were solved, there would be fewer serious assaults against children, fewer deaths, less toxic stress, better family relations, and fewer court and administrative expenses associated with the child-welfare system. The educational attainment of system-involved children would be higher, and they would require less medical care.

Parenting skills would improve, and the skills for parenting without violence could foster cooperative problem solving among adult family members. The enhanced collaboration across professions (see discussion below) would have significant value and could be used as a model for reducing other forms of family and community violence.

MEANINGFUL AND MEASURABLE PROGRESS TO ADDRESS THE CHALLENGE CAN BE MADE IN A DECADE

Because of progress made over the last 100 years, the challenge of reducing severe and fatal maltreatment of children can be met and substantially addressed within a decade. Surveillance of child maltreatment is improving and is about to become significantly better. New methodological tools complement interdisciplinary and interorganizational case-review structures (e.g., Palusci & Covington, 2014; Smith et al., 2011).

We are also beginning to better identify and measure some of the factors that predict child maltreatment fatality. Perpetrators of fatal child maltreatment are significantly younger than perpetrators of other child maltreatment (Douglas & Mohn, 2014). Moreover, fatal child abuse is associated with dangerous and inadequate housing as well as with domestic violence in the home. The United Kingdom routinely analyses every fatal and serious child-abuse case that occurs, endeavoring to find patterns of service delivery associated with these events. These reviews serve to focus the profession's attention on risk factors (e.g., Brandon et al., 2008). Because of evidence from the 20-year follow-up, we now know that the Nurse-Family

Partnership home-visiting program has shown a significant reduction in the "all-cause mortality in mothers and preventable-cause mortality in children (sudden infant death syndrome, unintentional injury, and homicide) derived from the National Death Index" (Olds et al., 2014, p. 800).

A positive, invaluable tool in this work will be the Protect Our Kids Act of 2012, which established the National Commission to Eliminate Child Abuse and Neglect Fatalities. The commission is tasked with developing a national strategy and recommendations for reducing fatalities from child maltreatment. It will have recommendations before spring of 2016.

Safe haven laws have also been critical points of progress toward this goal. Under these measures, parents who do not want their newborns may leave them in a safe place (e.g., a police station or fire house) without fear of prosecution for child neglect or abandonment. These cases typically involve young mothers who determine that they are not ready to parent and endeavor to hide their pregnancy and the birth of their babies in ways that result in adverse outcomes to newborns—including death. As yet, there is no definitive evidence on whether safe haven laws are effective in reducing child fatalities, but there is considerable use of the laws. Ideas about best practices are beginning to emerge (e.g., with regard to the age of the child, signage, drop-off stations, and other implementation issues).

Given data indicating that nearly half of all children who die from child maltreatment (about 2,000 children per year) are killed before they complete their first year of life, the age of coverage for safe haven laws should be extended to no less than 1 year of age. This differs significantly from the provisions of the most common safe haven statutes, which limit the period of safe relinquishment to as little as 1 month and only to as much as 6 months. Signage, marketing, and public relations are important because even though some states (e.g., Maryland) properly allow a child to be left with any responsible adult, some signage is still needed to indicate that the program exists. Training is also important, as a recent study shows that even emergency room residents in New York City were largely unaware of this program (Ryan, Caputo, & Berrett, 2014). The Safe Haven program needs to be reconceptualized: It should be understood as a public health intervention to prevent fatal and near-fatal maltreatment, not effort to prevent only neonaticide (i.e., the killing of a child in the first 24 hours of life).

Another innovation, birth match, is now available in four states: Maryland, Michigan, Minnesota, and Texas. This program enables officials to match the birth records of newborns to information on parents previously found to have harmed their children, and the search for a match is conducted in real time. If a match is found, officials can check on the newborn at an early point and assess whether protective intervention is warranted (Shaw et al., 2013). This program is now undergoing evaluation, which may help it to expand. Texas has expanded the program to offer voluntary-care coordination services to former foster youth who give birth so

that they can get the help they need in a timely way; the uptake by youth who are contacted is reported to be higher than 50% (C. Rogers, Texas Department of Family and Protective Services, personal communication, November 12, 2014).

THE CHALLENGE IS LIKELY TO GENERATE INTERDISCIPLINARY OR CROSS-SECTOR COLLABORATION

A wide array of professionals is already engaged in efforts to reduce child deaths. Nearly a decade ago, Friedman, Horwitz, and Resnick (2005) called for psychiatry, public health, and the social sciences to collaborate across the traditional disciplinary boundaries by sharing approaches and resources that would improve our knowledge of the determinants of filicide by mothers. They asserted that these efforts should include research with follow-up of cohorts of mentally ill mothers and should inquire about filicidal intentions. They concluded that preventive interventions could not be developed without additional data on who is at risk. Public health data are still lacking on targets for intervention to prevent filicide (data on neonaticide are an exception), but recent additions enable us to identify populations of parents whose children are at risk of early death—perhaps, especially, teenage mothers who have previously been involved with child welfare services because they needed protection. These mothers have an exceptionally high likelihood of subsequent involvement with child welfare services (Putnam-Hornstein Cederbaum, King, Eastman, & Trickett, 2015).

Work with health care providers, transportation controllers, public health specialists, criminal investigators (e.g., Shelton, Corey, Donaldson, & Dennison, 2011), engineers (e.g., Chuang & Howley, 2013), economists, and mathematicians (e.g., Camasso & Jagannathan, 2013) will help to determine the optimal integration of predictive analytics, qualitative case reviews, risk control formulation, and other methods for preventive and interventive approaches (Nicolini, Waring, & Mengis, 2011). In pursuing this grand challenge, we can also learn from parallel work in Australia (De Bortoli, Coles, & Dolan, 2013), New Zealand (Vaithianathan et al., 2012), Sweden (Lysell, Runeson, Lichtenstein, & Långström, 2014), and the United Kingdom (Brandon et al., 2008). The totality of this interdisciplinary work could yield innovations in other branches of health and safety services.

At the policy level, more needs to be done to engage the vast resources of our health care programs in the prevention of child maltreatment. Many state and local health departments do not include child abuse prevention as one of their top priorities—or mention it at all. Given what we know about the short- and long-term impacts of child maltreatment on health and behavioral health, this is a huge area of possibility for public health. State and local policies are most likely to accelerate improvements in the rates of fatality and near fatality if they facilitate information

sharing about child abuse risk, establish child-abuse review processes for cases involving fatalities and near fatalities, and give priority to child abuse prevention.

SOLUTIONS TO THE CHALLENGE REQUIRE SIGNIFICANT INNOVATION

Reducing severe and fatal maltreatment of children will require social work to engage more broadly in the mastery of new fields and skills. These innovations will likely stimulate advances in other human-service sectors.

Development of Linked Data on Violent Child-Abuse Deaths

Although current state and national databases link infant birth and death records, there is no current, consistent linkage of birth and death records for children over the age of 12 months. Nor is information on the homicide perpetrator linked to those records. The Centers for Disease Control and Prevention (2015) are developing the National Violent Death Reporting System (NVDRS), which is funded in more than 30 states. When this system is operational in a state, it links coroner, judicial, and law enforcement records, facilitating understanding in this area of homicide. Ironically, however, child welfare records are not included in the NVDRS. Nor are there plans for this system to be expanded to track near deaths. Better integration between groups reviewing child deaths and near deaths would optimize the use of resources and, very possibly, save lives.

Although many states continue to be ambivalent about or averse to linkages among birth records, death records, and data in other systems, innovations in California provide hope that this useful strategy can be implemented more broadly (Putnam-Hornstein & Needell, 2011; Putnam-Hornstein, Needell, & Rhodes, 2013). Another important innovation is the implementation of a system that enables officials to identify matches between birth records and registries of individuals whose parental rights have been terminated in the past.

Innovative Research Methods

Reducing severe and fatal violence against children will require better methods for surveillance, better modeling of risk and protective factors, and better skill in crafting strategies that lift up child fatalities as a national public-health issue (FrameWorks Institute, 2002). To improve surveillance, it is necessary to adopt techniques like capture–recapture, which helps to confirm the accuracy of estimates of child deaths from different sources of information (Palusci, Wirtz, & Covington, 2010). Modeling can be improved by expertise with population informatics (Kum, Krishnamurthy, Machanavajjhala, & Ahalt, 2014). Such expertise will follow the emergence of

databases that integrate city, county, and state records. This integration will produce a social genome that includes the birth, child-welfare, and health records of children as well as the health, juvenile-services, family-court, corrections, and child-welfare records of their parents (FrameWorks Institute, 2002). By expanding use of signal detection theory and its application to child deaths, those working on this challenge may create additional opportunities for learning (Mumpower & McClelland, 2014).

Progress on the challenge of reducing severe and fatal maltreatment of children is impeded by an important barrier: the absence of a standardized definition of what constitutes severe maltreatment (Litrownik et al., 2005). Without this, we lose the power to aggregate data across jurisdictions within a single surveillance system. Yet, Litrownik and colleagues (2005) argue that severity measures are only good predictors of case outcomes when they are used within types of maltreatment (e.g., physical abuse) rather than across types. Consistent with that conclusion, Damashek, Nelson, and Bonner (2013) have looked separately at child maltreatment fatalities resulting from physical abuse (Damashek, Nelson, & Bonner, 2013) and those resulting from inadequate caregiver supervision, finding that the latter account for nearly half of all child maltreatment deaths in their study. The field can advance if we can find agreement on those categories. Some work has been done in the first wave of the National Survey of Child and Adolescent Well-Being to close-end the open ended categories (Dowd, Kinsey, Wheeless, Suresh, & NSCAW Research Group, 2002) developed in the seminal Maltreatment Classification System (Barnett, Manly, & Chicchetti, 1993). This work could be considered, improved, and operationalized.

Additional work has been done to code near-fatal abuse according to severity (Litrownik et al., 2005). If a consistent definition were adopted, researchers would have a more meaningful dependent variable for efforts to explain or predict fatalities. Putnam-Hornstein, Wood, Fluke, Yoshioka-Maxwell, and Berger (2013) argue forcefully that linking multiple data sources to study severe and fatal maltreatment offers the most promising path to well-designed prevention programs.

Innovation in Review Procedures

Addressing this challenge will also require improvements in the processes and procedures for reviewing maltreatment events. Mechanisms are emerging to facilitate review of child fatalities and to draw information for prediction and prevention. All 50 states have child fatality review teams. In Ohio, for example, an interdisciplinary team evaluates the deaths of children under age 18 years and examines factors that may relate to prevention. However, the teams are not required to investigate the child's death until after the perpetrator has been prosecuted. That could delay review of many maternal filicide cases. Although some delays may improve the quality of

information, delays undermine the important task of collecting fresh information that can inform the prevention of child fatalities.

The advent of the serious-case review process in the United Kingdom has been associated with a decline in the proportion of children who were subjects in reviewed cases and had child protection plans in place. The overall number of cases with such plans has risen, and the decline among children in reviewed cases suggests that the process has improved the effectiveness of child protection plans. Another possible sign of improvement is the decreasing proportion—from 46% to 36%—of all reviews undertaken for cases concerning infants (Brandon et al., 2008, 2012).

Innovation of Workforce Training and Support

Professionals are not well trained to understand the factors that heighten a child's risks for serious maltreatment and fatality. Turnell, Munro, and Murphy (2013) stress the importance of identifying staff performance errors in order to improve social work practice and promote accountability. They also point to system functioning errors and features that contribute to mistakes leading to severe and fatal maltreatment. Such elements include the lack of structures to grow practice wisdom, unmanageable workloads, poor supervision, and scant resources. In organizations that rely heavily on procedures and paper work requirements for accountability, there are fewer opportunities for exercising professional judgment and little time available to spend with families and children (Munro, 2011). Child welfare systems, for example, have spent more than 40 years of work classifying cases as substantiated or unsubstantiated, but the process has not created meaningful classifications of risk (Drake, 1996; Drake, Jonson-Reid, Way, & Chung, 2003). Mounting information clearly and consistently shows that children in both categories have highly elevated risk of early, nonaccidental death (Putnam-Hornstein, 2011). Also needed are strategies, appropriate policy, and funding changes to extend the support for children with known risks. Promising new approaches look at cases by their service needs rather than by legal classifications (Hughes, Rycus, Saunders-Adams, Hughes, and Hughes, 2013), although the sometimes diminished tracking of information about the children and families, which are less formally served, undermines needed research.

In summary, this grand challenge meets the criteria that are essential if efforts to address it are to be successful. The grand challenge of reducing severe or fatal maltreatment of children can catalyze the public, generate new approaches for social work, make a significant contribution to society, and show progress within a decade. Solving this grand challenge could have broad implications, improving strategies for reducing less serious—but very harmful—forms of child maltreatment. Such improvements could level the playing field for many vulnerable children

who now suffer from stress, cruelty, and diminished capacity. This lifting of the burden on our country's youngest members would be a blessing to all.

ACTION STEPS AND GOALS

Reducing severe and fatal maltreatment of children by 50% in the next decade would create a trajectory of change that could ultimately predict a reduction to zero incidents. Below, we specify several steps required to address the challenge and we identify milestone goals:

1. Increase understanding that severe and fatal child abuse are significant public-health problems.
    a. In a decade, half of state strategic plans for health will include the goal of preventing child maltreatment.
    b. In a decade, at least 20 states will have found a way to integrate child abuse data into their work with NVDRS.
2. Implement birth match programs in order to identify and reach out to very high risk families within days of new births.
    a. In a decade, 20 states will have instituted birth match programs that alert child welfare services if births occur in families with prior failed cases or current open cases.
3. Improve safe haven programs so that they are consistent across states in defining what a safe haven is, cover children for a longer age span (at least up until 1 year of age), and have abundant signage and media outreach to more broadly engage the public in understanding the purpose of safe havens.
    a. Within the next decade, 50% of states will have revised their safe haven program to include coverage for children at least up to age 1. In a decade, five states will have piloted the expansion of safe haven programs up to age 2.
    b. All states will invest in signage, marketing, and social media communications to promote awareness of safe haven opportunities
4. Create integrated or interoperable data systems so states can monitor the transitional risks from birth, to child welfare service involvement, to severe or fatal maltreatment, to all child deaths.
    a. In the next decade, 20 states will have implemented such integrated data systems.
5. Reorient home visiting programs so that they are more comprehensive and more focused on the most at-risk families

   a. Within a decade, all states will have added or retooled home visiting programs that will focus on the families most at risk of severe or fatal maltreatment.

6. Adopt predictive analytic tools to complement other decision aids used at child protection hotlines in the screening of maltreatment allegations and to highlight current cases that may lack the necessary service components to address the risks of severe or fatal maltreatment.

   a. Within a decade, 25% of states will have integrated prior-child-maltreatment, home-visiting, and birth data, making the integrated data available on a weekly basis in order to inform service decisions.

   b. All states will have integrated child-welfare, birth, and death data in order to analyze fatal maltreatment risks.

   c. A consortium of state public child-welfare agencies, the federal government, and nonprofit organizations will make progress on identifying a severity index for one or more types of child maltreatment.

7. Promote the involvement of managers, supervisors, and line staff in regular review and monitoring of child protection work to ensure timely, comprehensive investigations of maltreatment reports, appropriate safety and risk decisions, and provision of appropriate and adequate services.

   a. Within a decade, one half of child welfare organizations will have administrative review processes that identify, on a daily basis, open cases with insufficient service plans or with insufficient personnel to profoundly reduce the risk of severe or fatal maltreatment.

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