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MCHB/DCAFH

April 2008

The Importance of Teamwork:
a State Example and a New Opportunity

April 30, 2008

Moderator:
Stephanie Bryn

CAPT Stephanie Bryn, MPH
Director, Injury and Violence
Prevention



**Bridging Injury and
Neglect:
A Public Health Model**

Angelo P. Giardino, MD, PhD, MPH
Medical Director, Texas Children's Health Plan
Physician Advisor, Center for Childhood Injury Prevention
Texas Children's Hospital
Clinical Associate Professor, Pediatrics
Baylor College of Medicine, Houston, TX



Objectives

- Explore similarities and differences
- Strategize on how to identify potential partners and build relationships
- Explore how injury prevention benefits from collaboration with child protection
- Action planning to foster future community collaboratives

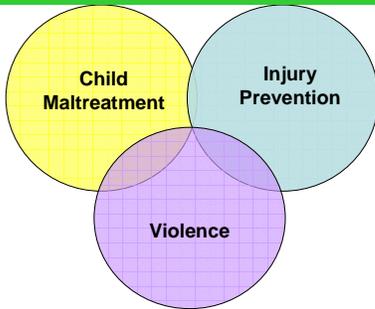


Overview

- Overlapping Missions in Public Health
 - Intersecting circles of activity
 - Multidisciplinary and community-based
- Conceptual Models
- Exploring the connection
 - Work of Lizette Peterson, PhD
 - Work of Tom Christoffel, JD and Susan Scavo Gallagher, MPH
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- Action Planning for Future Collaboration



Intersecting Circles



Child Maltreatment as a Public Health Problem

- Abused and neglected children:
- Suffer a wide variety of physical, emotional and developmental problems
 - hampers their ability to live healthy and productive lives.
 - Have difficulty in school, problems with substance abuse and problems with the law.

A public health issue of vital importance for WHO, and it represents a challenge for the next millennium

Dr Bjorn Thylefors, Director of WHO's Division on Disability, Injury Prevention and Rehabilitation.
<http://www.who.int/inf-pr-1999/en/pr99-20.html>



Child Maltreatment as a Public Health Problem

- Experts from both developed and developing countries,
 - disciplines as diverse as violence and injury prevention, medicine, social science, public health, psychiatry, psychology and law.
- Determined that it is possible to reduce the prevalence of child maltreatment
 - when parents are provided training in parenting skills before and after birth in a supportive environment by nursing personnel and/or community health workers.

Dr Bjorn Thylefors, Director of WHO's Division on Disability, Injury Prevention and Rehabilitation.
<http://www.who.int/inf-pr-1999/en/pr99-20.html>



Child Maltreatment as a Public Health Problem

The experts recommended:

1. The development of worldwide **data collection** on child abuse and estimates of the public health impact and related costs.
2. **Sharing of interventions and best practices** which are successful in the prevention of child abuse and neglect.
3. Continuing **evaluation** and research on child abuse prevention.
4. National programs for prevention, as well as that **provide social support to victims and families.**

Dr Bjorn Thylefors, Director of WHO's Division on Disability, Injury Prevention and Rehabilitation.
<http://www.who.int/inf-pr-1999/en/pr99-20.html>



Injury Prevention as a Public Health Problem

- WHO and UNICEF collaborate on World report on child and adolescent injury prevention
 - Advocacy tool as well as a science-based book on:
 - what we know about child and adolescent injuries and
 - how these injuries might be prevented.
- The report covers:
 - Child injuries in context
 - Road traffic injuries
 - Burns and scalds
 - Drowning and non-fatal drowning
 - Falls
 - Poisoning

http://www.who.int/violence_injury_prevention/child/injury/world_report/en/



Injury Prevention as a Public Health Problem

- More than 100 experts from all over the world are currently collaborating with WHO and UNICEF on this Report which is scheduled for release in 2008. Advisors to the Report are drawn from the following organizations:

- [WHO & UNICEF](#)
- [SafeKids Worldwide](#)
- [The Alliance for Safe Children](#)
- [The Child Accident Prevention Foundation of Southern Africa](#)
- [The European Child Safety Alliance](#)
- [US Centers for Disease Control and Prevention](#)
- [The China Centers for Disease Control and Prevention](#)
- [International Society for Burn Injuries](#)
- [International Life Saving Federation](#)

http://www.who.int/violence_injury_prevention/child/injury/world_report/en/



Violence as a Public Health Problem

- Violence destroys the social fabric of communities and has a disruptive impact on community and intra-familial relationships.

- **Fatalities** from homicide and suicide,
- **Physical consequences**
 - Such as brain injuries, bruises and scalds, chronic pain syndromes, irritable bowel syndrome
- **Psychological consequences**
 - Such as cognitive impairment, depression and anxiety, phobias and panic disorders, psychosomatic disorders
- **Behavioral consequences**
 - Such as alcohol, tobacco and drug use, physical inactivity

- During 2005, the following publications were released by WHO:

- *Violence Prevention Alliance. Building global commitment to violence prevention,*
- *Manual on pre-hospital trauma care systems for victims of trauma,*
- *The solid facts on unintentional injuries and violence in the WHO European Region.*

http://whqlibdoc.who.int/publications/2007/9789241595476_eng.pdf



Shared Dilemma

Lessons learned

- **Plenty of activity, not enough evaluation**
- **Outcome evaluation studies show that prevention works**



Scope of the Problem




Scope of the Problem

- In US:
 - **900,000** cases of child maltreatment
 - 60 % Neglect
 - 20 % Physical Abuse
 - Approximately, 1,400 fatalities
 - **27,707,000** injuries
 - 93 % unintentional
 - 156,000 injury deaths
 - 106,700 unintentional
 - Violence related injuries
 - **31,000** suicide deaths
 - **17,600** homicide deaths
 - **1,800,000** non-fatal assaults

Rounded 2001 data



Child Maltreatment Iceberg

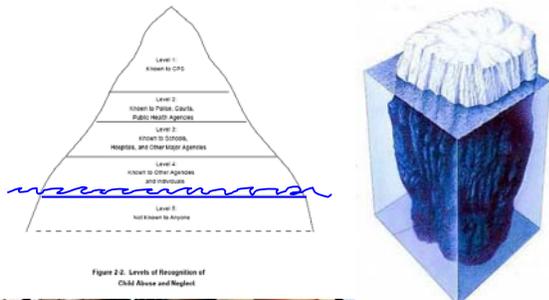
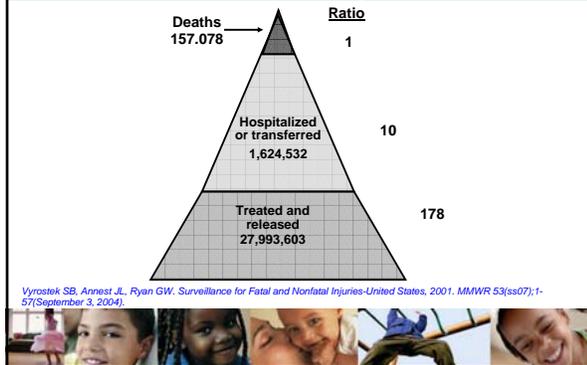


Figure 2.2. Levels of Recognition of Child Abuse and Neglect



Pyramid of All Causes of Injury – United States, 2001

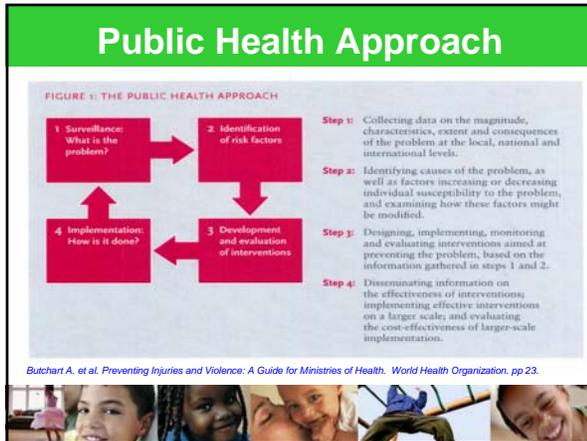


Overview

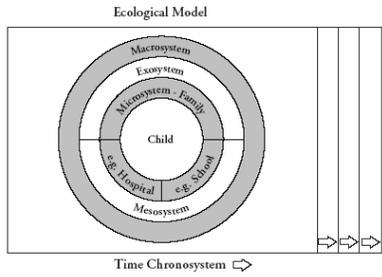
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Public Health Approach



Child Maltreatment

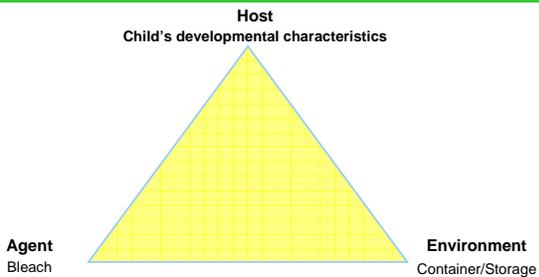


Child Maltreatment

- Parent/Caregiver factors
 - Coping, parenting skills, stress management
- Child factors
 - Behavior
 - Special needs
- Environment
 - Stress, isolation/connection, resources



Unintentional Injury



Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Bartlett Publishers, Inc. 2006. p 53.



The Haddon Matrix

Factors \ Phases	Human Factors	Agent or Vehicle	Physical Environment	Sociocultural Environment
Pre-event				
Event				
Post-event				

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Bartlett Publishers, Inc. 2006. p 32.



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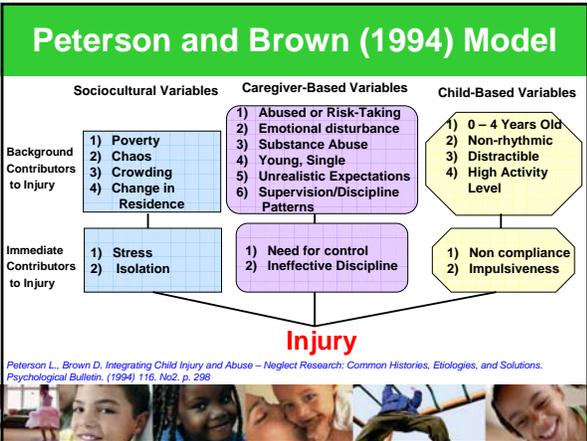


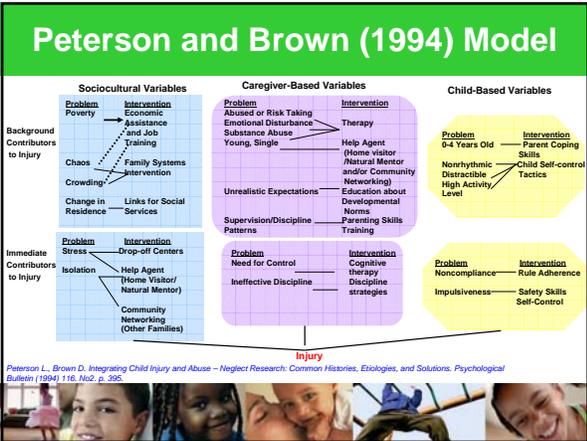
Peterson & Brown (1994)

- Unintentional injury and Child Maltreatment
 - Similar histories, definitions, etiologies, influenced by similar preventive efforts
 - Currently face similar challenges, address a similar multidimensional phenomenon

Peterson L., Brown D. Integrating Child Injury and Abuse – Neglect Research: Common Histories, Etiologies, and Solutions. Psychological Bulletin (1994) 116. No2. pp 293-315







Christoffel & Gallagher (2006)

Intentional and unintentional injury prevention efforts have traditionally operated independently

- Failed to take advantage of commonalities
 - Reinforced by funding streams, disciplinary perspectives and “turf wars”
- Similarities in interventions, community-based programs and surveillance data

Target	Method					
	Legislated/mandated			Educational/skill building		
	Populationwide	Milestone	High risk	Populationwide	Milestone	High risk
Environment	Poison Prevention Packaging Act (Walton, 1982)	Safety requirements for crib manufacturers (Consumer Product Safety Commission, 1979)	Window barriers for low-income apartment dwellers (Spiegel & Lindaman, 1977)	Community bicycle paths (Organization for Economic Co-operation and Development, 1983)	Safe day care, safety inspection for day-care sites (Gallagher, Messenger, & Guyer, 1987)	Community efforts to reduce child exposure to asbestos (Butler & Metowich, 1987)
Parent	Bicycle helmet use laws (Rivara, 1985)	Safety seats for children who weigh less than 18 kg (40 lb) or who are less than 4 years old (Roberts & Turner 1986)	In-home safety screen for neglectful families (Tertinger, Greene, & Lutzker, 1984)	Burn prevention (Mackay & Rothman, 1982)	Physician anticipatory guidance regarding falls (Biss, Mehta, Oitovsky, & Halperin, 1985)	Parent feedback (Gallagher, Hunter, & Guyer, 1985)
Child				Helmet use advertisements (Peterson & Roberts, 1992)	Street-crossing skills as children enter school (Yeaton & Bailey, 1978)	Latchkey home safety training (Peterson, 1984a, 1984b)

Peterson L., Brown D. Integrating Child Injury and Abuse – Neglect Research: Common Histories, Etiologies, and Solutions. Psychological Bulletin (1994) 116. No.2. p. 302.



Points of Natural Intersection-I

- Linkage of different data sets
- Mapping of injuries for high risk areas
- Good parenting interventions
- Youth connections with adult role models
- School-based youth mentorship programs
 - Peer pressure, aggressive behavior, alcohol use and anger management related to road rage and violence

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Bartlette Publishers, Inc. 2006. p.36.



Points of Natural Intersection-II

- Teen pregnancy programs
 - Parenting, dating violence, lack of child passenger safety seats and child neglect
- Teen worker safety programs
 - Enforcement of child labor laws, violence and sexual harassment avoidance/reduction
- Safe streets
 - Pedestrian protection, lighting, parks, playground and violence protection
- Safe Routes to School Initiatives

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Bartlette Publishers, Inc. 2006. p.36.



Points of Natural Intersection-III

- Health communities movement
 - Exercise, walking and physical fitness
- Safe rides home at night
 - Reduce drinking and driving
 - Reduce dating violence
- Home visiting programs for first time moms
- Product designs to make guns less accessible
- Programs aimed at reducing binge drinking



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Multidisciplinary Team (MDT)

“group of professionals that agrees to work in a **coordinated and collaborative** way to address the problem of _____”

(Wilson, 1992)



Injury Prevention Science

- Lack of affordable, ongoing surveillance
- Gaps in epidemiologic data
- Gaps in information regarding the efficacy of interventions
- Lack of access to current research
- Lack of data dissemination in targeted formats useful and meaningful to policymakers

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Bartlett Publishers, Inc. 2006. p. 418.



Myths That Impede Injury Prevention Programs

Myth #1: Injury/child maltreatment/violence interventions don't work; they aren't feasible.

Myth #2: Injury/child maltreatment/violence interventions cost too much; they aren't economically efficient

Myth #3: Individual behavior and uncontrollable, random events lie at the heart of most injuries.

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Bartlett Publishers, Inc. 2006. p. 418.



Benefits of Teamwork

- Improved information sharing
- Joint decision making
- Joint planning
- Collaborative educational opportunities
- Mutual support for team members



What About Conflict on the MDT?

- Conflict is inevitable
- Resolution must occur w/o compromising mission of team nor goal of serving child and family
- **Commonly:** tension around decision making, **interpersonal**, **competition**, **turf**, lack of cooperation



Ells (1998) Approach to Handling Conflict on MDT

- Don't lose sight of team's purpose
- Look forward to opportunity, **NOT** backward to blame
- Respect! (consider, listen, restate)
- Voice opposing view
- State your position clearly and firmly
- Don't keep repeating your position.....

Ells, M. (1998). Forming a multidisciplinary team to investigate child abuse: A portable guide to investigating child abuse. Washington, DC: US Department of Justice



Ells (1998) Approach to Handling Conflict on MDT

- Avoid personalizing position
- Offer suggestions not just criticisms
- Resolve on consensus, **NOT** abdication of responsibility
- In the end, refer to written protocol for guidance
 - Set's stage for agreed upon standards of completeness
 - Defines roles and responsibilities
 - Steps that must be accomplished at each stage w/time frames
 - How routine and special circumstances are handled

Ells, M. (1998). Forming a multidisciplinary team to investigate child abuse: A portable guide to investigating child abuse. Washington, DC: US Department of Justice.



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Measurements Indicating Key Implementation Activities are Taking Place - I

Collaboration

- Community, grassroots coalition in place
- Activities planned or ongoing
- Working relationships among various agencies and groups established

Staff Training

- Workshops, professional education, materials available to staff
- Staff with previous experience in injury control, public health education
- Technical assistance provided to local programs

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Barlett Publishers, Inc. 2006. pp. 306-307.



Measurements Indicating Key Implementation Activities are Taking Place - II

Integration

- Existing health department programs with an injury control component
- Injury prevention identified in the State Health Plan
- Protocols exist for information sharing across program areas
- Injury prevention included in the training of other health professionals in health agencies

Use of appropriate strategies

- Formative evaluation carried out in the community
- Materials checked for reading level and cultural appropriateness

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA. Jones and Barlett Publishers, Inc. 2006. pp. 306-307.



Potential Collaborators in Building Support for Injury Prevention Programs

- Elected/appointed officials(and their staffs)
- Physicians organizations (e.g., state medical society or AAP chapter)
- Dental organizations
- Nursing organizations (e.g. Emergency Nurses Care)
- Other health professional organizations
- Business organizations

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA, Jones and Bartlette Publishers, Inc. 2006. p. 313.



Potential Collaborators in Building Support for Injury Prevention Programs

- Labor organizations
- Religious organizations
- Law enforcement departments
- Fire departments
- Hospitals/hospital associations
- Foundations
- Managed care groups and organizations
- Insurance companies

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA, Jones and Bartlette Publishers, Inc. 2006. p. 313.



Potential Collaborators in Building Support for Injury Prevention Programs

- Health professional schools
- Departments of transportation/motor vehicles
- Departments/boards of health
- Mental health departments and agencies
- Senior centers
- Social service departments and agencies
- Substance abuse departments and agencies
- Schools/school boards/education departments

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA, Jones and Bartlette Publishers, Inc. 2006. p. 313.



Potential Collaborators in Building Support for Injury Prevention Programs

- Other government agencies
- Teacher organizations
- Youth groups
- Parent groups
- Volunteer agencies
- Advocacy groups
- SAFE KIDS coalitions
- Metropolitan planning organizations
- Architects

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA, Jones and Bartlett Publishers, Inc. 2006. p. 313.



Potential Collaborators in Building Support for Injury Prevention Programs

- Poison control centers
- Newspaper reporters and editorial boards
- Broadcast journalist
- Universities, colleges, think tanks
- Alcohol servers
- State, county, and local highway engineering offices
- Survivor organizations

Christoffel T., Gallagher SS. Injury and Public Health: Practical Knowledge, Skills and Strategies. Second Edition. Sudbury, MA, Jones and Bartlett Publishers, Inc. 2006. p. 313.



Conclusion



“Children who have a lifetime before them have the most to lose by injury, and yet as a population, they are the most at risk and the most underserved. It is hard to imagine a more compelling research initiative than this.”

Peterson L., Roberts MC. Amer Psychol. 1994. Aug; 47(8). pp. 1040-4.



References

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- http://whqlibdoc.who.int/publications/2007/9789241595476_eng.pdf
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- Vrcostek SB, Arnest JL, Ryan GW. *Surveillance for Fatal and Nonfatal Injuries-United States*. 2001. *MMWR* 53(ss07);1-57(September 3, 2004).
- (Wilson, 1992)
- World Health Organization. *Injury: a leading cause of burden of disease*. Geneva. 2002



Is It Injury or Neglect? Developing Consistent Child Maltreatment Definitions for Child Death Review Teams

Steve Wirtz, PhD

Epidemiology and Prevention for Injury Control (EPIC) Branch
California Department of Public Health

Is it Injury or Neglect?
Bridging our Understanding of Child Fatalities Caused from
Unintentional Injury and/or Neglect.

April 30, 2008

Social Construction of Child Maltreatment

- Child maltreatment (CM) definitions are shaped by the different purposes they serve.
 - Morality (i.e., victims represent a threat to the community)
 - Humanitarian (i.e., child vulnerabilities & rights)
 - ☐ Protect from physical harm
 - ☐ Physical neglect and emotional maltreatment were added later
 - Criminal justice
 - ☐ Punitive – hold responsible parties accountable
 - Medical
 - ☐ Battered child syndrome
 - ☐ Child abuse reporting laws of the 1970s
 - ☐ Initially more therapeutic than legalistic



EPIC

Social Construction of Child Maltreatment

- Shaped by different purposes (continued)
 - Social services (Child Protective Services)
 - ▣ Responding to reporting laws - Child Dependency Statutes
 - ▣ Increasing demand for allocation of resources
 - ▣ Sharing responsibility with other service systems
 - Public health
 - ▣ Providing broad preventive and health services
 - ▣ Conducting surveillance
 - Lay public
 - ▣ Tend to be more strict
 - ▣ But generally in agreement with professionals

EPIC

Social Construction of Child Maltreatment

- CM definitions represent social judgments
 - Negotiated settlement between a society's diverse cultures and scientific knowledge
 - ▣ Community minimal standard of care articulated through socio-political processes (and cross-cultural comparisons)
 - ▣ Knowledge as expressed by professional experts
- Dynamic historical and social context
 - Use of child safety car seats in the U.S. (prevent 2/3 of injuries & 90% of deaths, laws, awareness, & norms)
 - Neglect regardless of motivation or consequence (e.g., most unprotected children are not injured)

EPIC

Different Standards for Child Maltreatment

- Standard of care model
 - Adult sexual contact with a child is sexual abuse regardless of intent or outcome (child-focused)
 - Violates a widely accepted community standard - minimum standard of care
- Standard of consequences model
 - Corporal punishment is "acceptable" in the U.S.
 - Physical abuse is judged based on being "too harmful" – an assessment of risk
- Standard for neglect
 - Balance of risk assessment (degree of harm) and social acceptability (minimum standard of care)

EPIC

Legal Framework for Child Maltreatment

- Legal and statutory concepts of CM reflect conflicting social and political values
 - State power to use coercive interventions and expend societal resources
 - ▣ Protect the “best interests” of the child
 - Parental rights to family privacy and autonomy
 - ▣ U.S. preference for familial or marketplace provision (“family bubble”)
 - Principle or standard of “minimum intrusion”
 - ▣ Demonstrable injury or harm
 - ▣ Endangerment – potential for immediate and predictable injury or harm

EPIC

Federal Child Maltreatment Definitions

- Each state has its own legal definitions of child abuse and neglect based on minimum standards set by Federal law.
- Federal Public Law 108-36, 2003 - Child Abuse Prevention and Treatment Act
- Federal data sources & standards
 - National Child Abuse and Neglect Data System (<http://www.acf.hhs.gov/programs/cb/pubs/cm06>)
 - National Incidence Study-4 (NIS-4) (<https://www.nis4.org/DefAbuse.asp>)
 - Child Maltreatment Surveillance: Uniform Definitions for Public Health (http://www.cdc.gov/ncipc/dvp/CM_Surveillance.pdf)

EPIC

Continuum of Child Maltreatment

- Continuum of abuse
 - From non-criminal assault or homicide – inflicted but with no intent or negligence (e.g., MVC not at fault)
 - To criminal assault or homicide - intentionally, knowingly, recklessly, or with criminal negligence
- Continuum of neglect
 - From unintentional injury or death – momentary or reasonable lapse of attention without negligence
 - To poor or inadequate parenting
 - To failure to provide, protect, or supervise
 - To criminal neglect - intentional negligence
- Complex issue with no easy answers
- Limited focus on the most extreme outcomes
 - Consequences are clear (death)
 - Potential solution available

EPIC

Tracking Child Maltreatment Deaths: Opportunities

- Critical role for Child Death Review Teams (CDRTs) if they can:
 - Use a standard classification system for public health surveillance of child abuse and neglect deaths
 - Collect systematic data on causes and circumstance of child deaths
 - Reconcile data from multiple sources (e.g., California FCANS Reconciliation Audit) to produce most accurate statewide estimate
 - Disseminate and use data for surveillance, interventions, planning, and prevention of CM and all childhood injuries and preventable deaths.

EPIC

Child Maltreatment Classification Project

- Centers for Disease Control and Prevention grants (through RTI International) to California, Oregon and Michigan
- Statewide process underway in California to create a consistent CAN classification system and guidelines for its use by CDRTs
- California Child Maltreatment Surveillance Team:
 - Sibylle Lob, MD, MPH
 - Dale Rose, PhD
 - Christine Brennan, MA
 - Patrick Fox, PhD, MSW

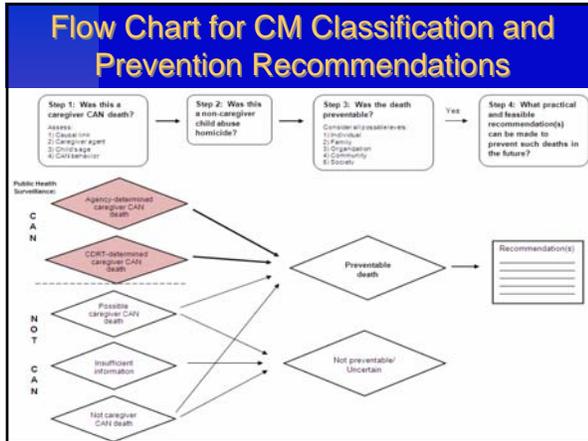
University of California, San Francisco

EPIC

California Child Maltreatment Surveillance Classification Project

- Process to create a consistent CM classification system and guidelines for its use by CDRTs:
 - Project team developed prototype tools
 - Field tested tools - Central California, Greater Bay Area, & Coastal Tri-counties Regional CDRT meetings
 - Expert Advisory Panel review – Sacramento, September 26th
 - Endorsement by State Council – October 22nd
 - Further refinement and testing based on reviews
 - Application on a sub-set of 2005 cases
 - Formal study using volunteer CDRT to test inter-rater reliability

EPIC



Step 1 - Classification of Caregiver CM Deaths

Framework for Creating a Consistent CM Definition for CDRTs

Components of CM Operational Definition

Agent	→ Action	→ Causal Linkage	→ Recipient	→ Types of Consequence	Impacts
Parent(s) Caregiver(s)	Commission Omission	Direct causal chain Contribution	Child 0-17	Actual harm	Death

Operational Definition of Caregiver CM Death

- The death of a child under the age of 18 directly or indirectly caused by a caregiver's act(s) of commission or omission that are judged by a CDRT as CAN, weighing risk of harm and level of social acceptability.
- That means ALL four conditions need to be met
 - Causal link
 - Caregiver agent
 - Child's age/live birth
 - CAN behavior

Assessment of Conditions

- Possible outcomes for each condition:
 - Yes/Probable
 - ▣ A preponderance of evidence exists; judgment is sufficiently clear
 - Possible/Suggestive
 - ▣ Available evidence is limited but reasonably suggestive; or *judgment* of these conditions (especially CM behavior) is not sufficiently clear
 - Insufficient Information
 - No
 - ▣ Evidence exists and judgment is made that a condition was not met




Conditions

- Condition 1 - Causal link
 - a specific act (or acts) of commission or omission that caused (i.e., *directly*) and/or substantially contributed to (i.e., *indirectly* caused) the death of the child
 - ▣ Direct cause = necessary and sufficient
 - ▣ Indirect cause = necessary but not sufficient




Conditions

- Condition 2 - Caregiver agent is a person who EITHER:
 - **at the time of the maltreatment** is in a primary custodial role or has been explicitly or implicitly assigned a temporary custodial role; OR
 - was **at some point in the past** in a primary or explicitly/implicitly assigned temporary custodial role and, based on reasonable assessment of the quality of the relationship with the child at that time, is still considered to be in that role.




Conditions

- Condition 3 – Child’s age
 - Child had been born alive and was between 0 and 17 years of age at the time of death




Conditions

- Condition 4 – Child maltreatment behavior
 - Judgment based on weighing risk of harm and level of social acceptability
 - ▣ Risk assessment
 - ▣ Social assessment
 - Societal norms
 - Cultural, religious, and other exceptions and mitigating factors
 - Caregiver good faith effort




Categories for Classification of Caregiver CM Deaths

- For each child death reviewed, the CDRT assesses:
 - whether ALL four conditions are met; and
 - whether an investigative agency has made or is intending to make a formal determination that a caregiver CM death occurred
- Depending on the outcome, deaths are classified into one of five categories:
 - Agency determination (i.e., Coroner/Medical Examiner, Law Enforcement, District Attorney, CPS) of caregiver CM death
 - CDRT determination
 - ▣ Caregiver CM death
 - ▣ Possible caregiver CM death
 - ▣ Insufficient information
 - ▣ Not caregiver CM death

Step 2 – Non-Caregiver Child Abuse Homicide

- Act or acts determined to be causally linked to the child's death
- The perpetrator is an adult (i.e., 18 years old and older)
- The perpetrator is not a caregiver as determined by the team using Condition 2 above (e.g., stranger)
- The victim is between 0 (live birth) and 17 years of age;
- Youth peer violence is excluded (e.g., gang-related violence, drive-by shootings, dating or spousal violence)



EPIC

Step 3 - Classification of Preventability

- A death is preventable if, in retrospect, its likelihood of occurrence could have been substantially reduced through a known mechanism, action, behavior or intervention (e.g., using a seatbelt or helmet)



EPIC

Step 4 – Developing Effective Recommendations

- After determination that a death (or group of deaths) was preventable (CM or not), use the Guidelines for Writing Effective Recommendations to identify and **prioritize** potential prevention opportunities, taking into account
 - magnitude of the problem
 - existence of effective interventions
 - capacity for and feasibility of taking action (available resources, political climate, etc.)
- **Practical and feasible** recommendations are made and follow up progress is tracked



EPIC

Teri Covington, MPH

**Director, National Center for
Child Death Review**

Michigan Public Health Institute

Child Death Review can find neglect deaths- and because it has evolved from only an Investigative Focus

To include a Prevention Focus, can work to prevent deaths





Legend:

- Review all types of deaths
- Review mostly child abuse deaths
- Transitioning to all types of deaths
- No review team(s)

- ✓ CDR is now mandated or enabled by law in 39 states.
- ✓ 48 states review deaths through age 17.
- ✓ 37 states now have local review teams.
- ✓ Half review deaths to all causes.

Example: Michigan

Officially Reported Child Maltreatment Deaths

	1994	1995	1996	1997	1998	1999
Michigan Vital Stats	14	16	13	13	14	16
NCANDS Data	0	0	0	0	40	48

Local Child death review

CDC maltreatment surveillance project

- Expanded CM case definition.
- Identification of all potential CM deaths statewide, using four data sources: death certificates, child death review reports, CPS reports, law enforcement records.
- Linking of all injury deaths to state CPS registry.
- Intensive case finding and collection of additional information.
- Case by case review.

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 Reported Cases					40	48	76	107
NCANDS Data	0	0	0	0	40	48	52	53

State Panel Linked all injury deaths to CPS registry

Making Systems Changes

1. Identification of and the reporting to CPS, of suspected child abuse and child deaths.
2. Investigation by law enforcement of suspected abuse and of child deaths.
3. Investigations of child deaths by the Coroner's Office.
4. Case intake and investigation by CPS of suspected child abuse and of child deaths.
5. CPS substantiation of child abuse.
6. Provision of Services by CPS.
7. Actions taken by the civil and criminal divisions of the District Attorney's Office and the Courts.

In Michigan Major Policy Changes Made Following Reviews

186 deaths from 1999-2001 186 findings

172 deaths from 2002-2004 170 deaths

35% decrease in findings and a 9% drop in deaths-

These have been matched to improvements made by the state to specific recommendations made by the review panels for systems improvements.

State Actions: Social Service Contacts prior to death

•230 cases of sudden and unexplained infant deaths had a social service contact within 6 months of the child dying.

•On average twice a week a CPS worker is called upon to investigate an infant death as a result of poor sleeping conditions.



- Local offices distribute print and video information on safe sleep
- Prevention workers do anticipatory guidance and service referrals.
- Crib distribution programs put into place.
- State DHS launched a safe sleep campaign

- ### Example: 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.

Types of Deaths

Type of Death	Manner				Total
	Natural	Accidental	Homicide	Undetermined	
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

- Based on law enforcement and others' statements that:
 - the parents did not "intend harm",
 - that there was no criminal intent,
 - that death was accidental or undetermined,
 - or that parents had suffered enough,

CPS did not know of or investigate the vast majority of deaths. This included 19 deaths with prior substantiations for significant neglect.

Interuterine Intoxication

14 cases: 32-36 week gestation, usually acute cocaine and methamphetamine intoxication, ruled accidental, long history of substance abuse on mother, little information available on father, surviving other children either in home or "with relatives", or "in another state."

Some not reported to CPS. Most not investigated by CPS. If investigated-not substantiated.

Medical Cases

- Toddler with long medical history, dies of natural causes. Many missed medical appointments, sub-standard care by parents, some prior CPS history for neglect. Case is investigated but not substantiated.
- 5 year old died of septicemia after being very sick for a week with no medical care.
- 12 year old dies of diabetic ketoacidosis. Did not take insulin over 3 day period. Case not substantiated because "child old enough to take insulin by self."

Drowning

- Pool drowning of one year old, left alone with 4 year old while parent is sleeping. Child opens back door and falls into pool.
- Toddler drowns in trailer park pond. Numerous prior calls to CPS from neighbors afraid child will drown while unsupervised.

Left in Vehicle

- Toddler left in car on a hot day for 2 hours, parent was putting away groceries, answered phone, then forgot about child.
- 5 year old got into old car with no interior door handles. Mom asleep for 8 hours recovering from a Meth bender.
- 3 year old playing with friends, while with parents at an athletic event. Child went back into car unnoticed for 30 minutes.

Asphyxia and Undetermined



- 2 month old infant dies while sleeping. Ruled accidental, overlay by parent. Prior history of CPS and removal of other children for neglect. Both parents intoxicated.
- Infant twins suffocated in a tent, hot summer night-homeless family camping in a friend's back yard.

Fire/Motor Vehicle

- 6 and 8 year-olds left in van while father visiting friends-playing with matches caused gasoline tank in back seat to explode.
- 3 teenagers killed in crash by the 14 year-old unlicensed driver. Grandmother with extensive CPS history for neglect knowingly allowed teens to go on the trip.
- One year old ejected from back seat, not fastened into car seat-dad was intoxicated although did not cause crash.

- Finding: A report was not made to CPS by many investigators when caretakers' actions contributed to the children's deaths, because there were no surviving siblings.
- Change: new state law requiring notification even when there are no siblings.

- Finding: Police, coroners, medical examiners and CPS rarely worked together in investigating fatal child abuse.
- Change: A new multi-disciplinary investigation team created protocols, is meeting regularly and conducts joint investigations of all sudden and unexpected child deaths.

- Finding: There is an inconsistency in the determination of cause and manner determinations across pathologists, when the circumstances in the case are very similar.
- Change: Pathologists now hold daily case conferences on all child deaths; a new medical examiner position was created; and the Chief Coroner appointed a chief medical examiner.

- Finding: 64 of the children who died had surviving siblings, but CPS interviewed only two sets of the 64 siblings following the deaths.
- CPS did not investigate 11 infant deaths that had maternal substance abuse and perinatal drug exposure.
- Almost all deaths with safety assessments in the case record were incomplete, incorrect or dated long after the event. This includes failure to note known parents' substance abuse prior CPS and abusive histories, siblings' status, and parents' actions related to deaths.
- Change: 144 new CPS worker positions were funded for Clark County. A special unit is expanded specifically to investigate child deaths, 24/7.



- The death certificate does not identify fatal neglect.
- The Child Death Review process was the best method for identifying CM neglect.
- The in-depth review of a child's death is necessary to determine if CM contributed to the fatality.
- The reviews can lead to major state and local systems changes and prevention initiatives.

Limitations

- Case review is time consuming and costly.
- Intentionality is not described, and range from murder to negligence is wide.
- Natural deaths are still an “unknown territory”
- Consider other data sources, e.g. crash reports, fire reports, to determine negligence.

Stephanie Biegler, BS

Director, Child Abuse Prevention
Council of Sacramento

State Child Death Review Team

Sacramento County



Getting to know the Sacramento County CDRT



- Created in 1989
- Collecting data and reporting annually since 1990
- Maintains an ongoing relationship with the Sacramento County Board of Supervisors
- Funded through the Sacramento County Children's Trust Fund

CDRT Statute

California Penal Code

11174.32. (a) Each county may establish an interagency child death review team to assist local agencies in identifying and reviewing suspicious child deaths and facilitating communication among persons who perform autopsies and the various persons and agencies involved in child abuse or neglect cases.

CDRT Statute

California Senate Bill 1668

Amended Penal Code to provide:

11174.32.(e) 1) No less than once each year, each child death review team shall make available to the public findings, conclusions and recommendations of the team, including aggregate statistical data on the incidences and causes of child deaths.

Composition of CDRT

Comprehensive and Consistent Membership

- Law Enforcement
- Coroner
- Hospitals
- Child Welfare
- Fire Departments
- Early Responders
- District Attorney
- Maternal Health

CDRT Mission Statement

- Ensure that all child abuse fatalities are identified
- Enhance the investigation of all child deaths through multi-agency review
- Develop a statistical description of all child deaths as an overall indicator of the status of children
- Develop recommendations for the prevention and response to child deaths based on the reviews and statistical information

What is Neglect? What is Injury?

Neglect Deaths

Negligent failure of parent or caretaker to provide for adequate basic needs.

- Parent/caretaker not present
- Parent/caretaker present but not capable of supervising
- Failure to use safety measures (seat belts, flotation devices, etc)
- Unsafe infant sleeping situations

Injury Deaths

Death that is a direct result of an injury-related incident.

Exploring the Problem in Sacramento County

- 1. Review the distribution of neglect and injury related child deaths**
 - Demographics – Cause & Manner - Geography
- 2. In depth analysis of neighborhoods**
 - CDRT Data - Census/ Demographic Data- Community Assets
- 3. Community and professional input**
 - Focus Groups – Questionnaires - Interviews

What can we do?

- **CDRT recognizes underlying conditions are complex**
 - Broad-based expertise
 - Stakeholders (service providers and policymakers)
 - Neighborhood Representatives
- **CDRT makes recommendations to policy leaders**
 - Develop a countywide plan to reduce number of neglect-related and injury-related deaths
- **Convene a CDRT sponsored collaborative**
 - Representative collaborative of agencies and neighborhood representatives
 - Utilize existing infrastructure
 - Addressed priority area

What can we do?

- **Identify and define a problem using CDRT data**
- **Develop a process for community collaboration and input**
- **Develop recommendations and a plan of action**
- **Develop a representative collaborative to address children at risk of neglect and injury-related deaths**

What can we do?

- **Develop a community profile to focus and prioritize efforts to reduce child neglect fatalities**
- **Develop a comprehensive literature review including best practices**
- **Increase education/awareness among within the communities about the danger and consequences of neglect**

Collaborative to Reduce Child Neglect Fatalities Model - CRCNF

- **Purpose**
 - Implement a new assessment process
 - Review of child death data, research best practices and seek community input
- **Outcomes**
 - Develop a community profile to focus and prioritize efforts
 - Increase education and awareness among agencies and communities
 - Develop comprehensive strategic plan

CRCNF Model Community and Professional Input

Did you know this was happening?
Why is it happening?
How can it be prevented?

- Neighborhood Focus Groups
- Professional Questionnaires
- Stakeholder Interviews

CRCNF Model
Community & Professional Findings

Consensus on Causes

- Substance Abuse
- Poverty
- Domestic Violence

Consensus on What Can Be Done

- Education/Awareness
- Community Support
- Improve Services Access and Delivery

CRCNF Model
Community and Professional Findings

- Over 90% of stakeholders and parents felt parent education and community awareness were the #1 priority
 - Teaching mothers better coping and interaction skills
 - Incorporating child neglect education at community and public assistance programs
 - Increasing the number of billboards and advertisements
 - Increasing the number of open discussions with community members

CRCNF Outcome
Education and Awareness Campaign

Conveying consistent messages to change behavior and attitudes, saturating areas with the highest neglect-related and injury-related deaths

- Mass media campaign directed toward the general public.
- Community level education process directed by and for those neighborhoods most impacted by neglect related and injury related deaths.

Safe Beginnings Model

“Reduce drowning and sleep-related deaths and injuries in children 0-5 years of age”

Safe Beginnings Model

Developed a 7 approach model based on the “Spectrum of Prevention”

- Strengthen individual knowledge and skills
- Promote community education
- Educate community service providers
- Foster coalitions and networks
- Mobilize neighborhoods and communities
- Change organizational practices
- Influence policy and legislation

Safe Beginnings Model

Child Abuse Prevention Council of Sacramento & Greater Sacramento Safe Kids

- Hospitals
- Community-based organizations
- Residents of targeted communities
- Local Police and Fire Departments
- Home visitation programs

Safe Beginnings Model

- Analyze drowning and infant sleep-related death and injury data
- Review the research and evidence-based best practices
- Determine community needs & assets
- Conduct community and stakeholder focus groups

Safe Beginnings Model

- Develop & finalize a strategic plan
- Pilot the strategic plan
- Test and evaluate the pilot
- Test parent and service provider knowledge
- Finalize program model to take program to scale

You are welcome to contact me

[Stephanie Biegler](#)

sbiegler@thecapcenter.org

(916) 244-1975



Questions and Answers

Thank you for attending this event.

Please complete the evaluation
directly following the webcast.

Archives of the event are located at,
<http://www.mchcom.com>
