

## **MCHB/DCAFH**

### **Is it Injury or Neglect?**

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STEPHANIE BRYN: Greetings, everyone. I'm Stephanie Bryn, the director of injury and violence prevention for the health resources and services administration. Our web cast today Is it Injury or neglect? We've put it together to bridge our understanding of child neglect and unintentional injuries. The web cast will describe efforts to better define neglect in the context of accidental injury. And show models of case review that will lead to improved understanding, reporting and prevention strategy. Our speakers today are Doctor Angelo Giardino, Dr. Steven Wirtz, Teri Covington and Stephanie Biegler.

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At the end of the web cast, the interface will close automatically and you will have the opportunity to fill out a web cast evaluation online. Please fill out this evaluation because it will only help us to improve our future web cast and to also improve our technical support. We thank you for joining us today and now let's hear from Dr. Giardino. We'll have a model to show us the knowledge of child abuse and neglect.

ANGELO GIARDINO: Thank you for giving me the opportunity to talk today about how we can bridge injury prevention folks with people in working on neglect. We'll be using a public health model.

What we're going to do today is explore the similarities and differences between the two fields. We'll look at how injury prevention can benefit from collaboration with people working and do some action planning. Now, as far as an overview, we'll talk a little bit about the overlapping into public health and look specifically about the -- at the intersecting between child prevention. We'll look at conceptual models, we'll explore some connections between these fields or among these fields, specifically looking at seminal work by Dr. Peterson and then looking at work from others. We'll talk about team work and then talk finally about some action planning. We have intersecting circles. We see the mild maltreatment and injury prevention and violence. There's a little bit of overlap but not much and my hope, of course, is that over time, we would get those circles more and more overlapping.

So on the next slide; let's look at the public health approach. Looking at some work from the world health organization, we can see that they define abuse and neglected children by suffering a wild variety of physical, emotional and developmental problems. They hamper their ability to live healthy and productive lives and these children have difficulty in school, problems with substance abuse and problems with the law. They define the child maltreatment. The world health organization has a group of experts from other countries that are disciplines that diverse and include people who work in the violence and injury prevention field as well as medicine, social science, public health, psychiatry and psychology and law. All of the experts got together on ways to reduce the problems of child maltreatment and interestingly enough, one of the comments they made is when parents are provided training and parenting skills before and after birth in a supportive environment by nursing personnel and/or community health workers that we can prevent or reduce the problems of child maltreatment. Many of us would say that there are ways of adjusting child neglect and then when I talk with my colleagues who do injury prevention work, they would also talk about parent education. One of the bridges is parent education and giving families the support and the participatory guidance to anticipate the problems the children may face and then overcome them. That's part of the bridge. The experts at the world health organization impaneled, made the following recommendations. They talked about the need to develop a worldwide data collection effort around child abuse. They talked about the sharing of interventions and best practices and really focusing on successful interventions to reduce child neglect. They talked about the need for national programs, around prevention that provide social support to victims and families. Looking now at the world health organization and the united nations efforts around injury prevention, we're going to see some similar content. So my point here is that there are major efforts at trying to get us, those of us in our specific fields, to look at how we can work across the great divide. So on this slide, we talk about a report that the world health

organization and UNICEF are working on, looking at child and adolescent injury prevention. It's like a science textbook around what we know about child and adolescent injuries and how these injuries might be prevented. If you look on the slide, it says that the report covers childhood injuries on burns and scalds, drowning and non-fatal drowning, falls and poisoning. They would be interested in learning what the injury prevention folks are doing in those areas since those are so much of a concern to those of us trying to prevent neglectful parenting. Here is an idea of all of the organizations collaborating on the effort. It's pretty significant and does cross a number of the boundaries that we would see. I wanted to now talk about violence and again, look at how violence gets discussed and you can see there, violence destroys the social fabric of community and has a disruptive impact on community and intra-familial relationships. They talk about chronic pain, irritable bowel syndrome, some of the mental health things like depression and anxiety and phobias and finally the behavioral consequences. Mostly focusing on the substance abuse and now our attention, of course, is on physical activity and then its relationship to obesity. So again, what the world health organization is trying to say here is that violence is also public health problems.

So we turn to the next slide and see what they have a shared dilemma. Maltreatment and neglect folks, we have plenty of activity but not enough evaluation. Evaluation studies looking at outcomes certainly show that prevention works and again, a great deal of this work relations to the family partnership data we know comes from Dr. David Oldsgroup in Colorado but we do know that there are certain evidence basic techniques that have randomized clinical trial data that support them. I would like to turn our attention to the scope of the problem. That's a picture of an iceberg. You can see the tip of the iceberg but there is usually a huge amount of ice under the water. Like most of the problems in the public health, we know the problem may be much larger and of course, to look at that

larger part, we have to do surveillance and investigate it. I have the statistics for us to see how huge this is in the United States. As you can see, we have 900,000 cases of child maltreatment on a childhood basis. 60% are neglect, 20% are physical abuse. There's approximately 1400 fatalities as well. Then in the middle of the slide we see there's 27,707,000 injuries, 93% of those are unintentional and then there's 156,000 injury deaths. Again, 106,000 of those are unintentional. And then violence, 31,000 suicide, 17,600 homicide deaths and 1.8 million non-fatal assaults. The point there is that this is a huge problem. And some of these circles overlap, of course, but we are really dealing with a very, very significant problem that affects many, many people in our communities. We have the child maltreatment iceberg and this comes from the national incidence studies that are done periodically and the model they use is based on this iceberg. We certainly know about the cases reported to C.P.S., the cases that hospitals and law enforcement deal with, those are above the water line and then there are some cases that do not hit our reporting system and regrettably some of those cases are ones that only the child and the perpetrator know about and of course, we're always looking for techniques to get below the water line.

If we look at the next slide, there are other incidence models to look at and people that deal with injuries talk about the pyramid and at the top of the pyramid are the deaths. You know, among the most serious injuries, of course, are ones that result in death. Then below the deaths would be the hospitalized patients and then below those would be those that are treated and released and you can see those numbers tie back to the original slide. My point is that in looking at the numbers, I think the child protection folks and the injury prevention folks and the violence prevention folks would kind of have similar approaches to how they would look at the numbers reported, the ones that are known, the ones that are not known.

On the next slide, highlights we want to look at and then the health approach. If you follow that cycle there, you surveil to find the cases and then as you surveil, you identify the cases and then you develop interventions, test them out and implement them and then teach surveilling. This is a classic public health approach, also the rudiments of a quality improvement moments. The injury prevention folks and other professionals would definitely have a lot of comfort using this. The next model ties the child abuse field together. Those of us that work with neglect, that would be the human ecological model. The child is at the center of the system and then be in a family system and the child in the family would interact and impact each other and of course, the child and family are in a neighborhood that has hospitals and schools and other institutions and then those -- that family and those institutions are in a community, that community is in a society, that society is in a nation. So then the final piece of that model is that time marches on. Something that would happen to a child at three months might be different than something -- the same thing that happens when the child is eight years old, for example. So time is a factor that you need to look at. If you think about child maltreatment specifically neglect, the parent and the caregiver factors, there's the way that the parent or the caregiver copes. Their parenting skills, the parenting to which they were exposed to, the way they manage stress and then child factors. Certain behaviors of the child that makes them easier or more difficult to care for. There may be special needs that makes their care more challenging and then finally the environment, the stress, isolation, connectedness, resources, what we know about neglectful families is that they report being more isolated. Now, whether that isolation exists before the neglect or after the neglect is open to question but regardless, there's an experience of isolation. We see that there's a model that the folks who work in unintentional injury use and that's the classic agent, host and environment model and this is the rate on the slide is look at bleach exposure, the agent is

the bleach, the host is the child, the willingness to explore the environment and perhaps get exposed to something dangerous and then the environment itself, the container to which the bleach is stored in, how safely it's stored in that container, either in the reach or out of the reach of the child. Injury prevention has a matrix where you see the prevent, the event and the post event and then a rate across the horizontal moving from left to right are human factors, agent or vehicle, physical environment and then the socio-cultural environment. These models would be very interesting and comfortable discussion points for professionals working in child neglect, child protection and injury prevention and violence prevention. These would all have some relevance but the human ecology model is talked about the professionals and people in injury prevention would talk about the matrix. If we could kind of use these creatively, you would see we would find a lot of common ground.

The next slide is a directional slide. We'll look at the works of Dr. Peterson and Tom Christoffel and Susan Gallagher. Dr. Peterson laid the groundwork in this paper by Peterson and brown about how unintentional injury and child maltreatment could work together and she talked about similar histories and talked about these being influenced by somewhat preventive efforts and I think she laid interesting work. You can kind of see she's taken a lot of work and put it in one place but right down the left vertical are the background contributions to injury and the immediate contributions to injury and then across the horizontal moving from left to right are the socio-cultural variables, caregiver based variables and the child based variables. You can see where maybe some of her work was influenced by both the human ecology model and some of that agent, host, environment and matrix kind of material. In the boxes are some of the very specifics about the various variables. Those variables are a raid with some specific interventions and I think the individuals working in neglect violence child maltreatment would start to see

commonalities in those. You're looking at how some of the socio-cultural variables are affecting how the parent behaves, you're looking at how some of the child variables interact and then there's some interventions that come from that. These diagrams, although they were developed in 1994, are still relevant today in 2008 and I think we can really use those and I would love to see some collaboration with people projecting these on a screen and then thinking about how to work together. Christoffell and Gallagher talked about the need for intentional and unintentional injury efforts to work together. They traditionally operated independently, however, and they say that failed to take advantage of the commonalities. This is reinforced by funding streams, disciplinary perspectives and the turf wars that exist in various institutions and communities. They do focus their whole text on the similarities and community based programs and the surveillance data. I've taken from the brown and Peterson, the Peterson and brown article and have tried to rate for you how robust Dr. Peterson's work is and how useful it is today. Again, what we have here are down the left-hand side, some targets in terms of targeting the environment, the parent or the child and then across the horizontal, at the first level is either a longitudinal method and then subsections where we focus either on the population, milestone that the child or family are reaching or the factor of a high risk. The neglect and the child injury prevention professionals would really be able to wrap their hands around this and talk about this.

The next slide Christoffel and Gallagher talk about the points of natural connection.

There's certainly possible terms linking different data sets, mapping the injuries of high risk areas, the focus on good parenting, the focus on connecting youth and young parents to adult role models, the ability to use school based models.

On the next page, additional points of natural intersection. Teen pregnancy programs, teen worker safety programs, safe streets programs. We talk about the way to keep yourself safe from the street and pick what environment would introduce you to violence.

Next slide, the points of natural intersection. You can see that home visiting programs are listed in the middle of the slide for first time moms and again, that's going to be a big point of connection for neglect and child injury prevention folks to work on. And seize the opportunity to embed the content that each one is to provide in this program. Of course, this connection or bridge between child abuse and neglect and injury prevention and violence really comes in the way -- in the framework of team work. We have the definition of multidisciplinary teams and then some comments about injury prevention science.

There's a lack of affordable, ongoing surveillance, gaps in epidemiologic data, gaps in information regarding the efficacy of interpretations, et cetera. We talk about the myths. The injury and child maltreatments say they don't work, they cost too much, they are not economically efficient and finally, individual behavior and uncontrollable, random events lie at the heart of most injuries. Again a myth. System approaches can fix all of those myths. There's the benefits of team work which all of you are supportive of. Then the realization if you're going to do team work, the conflict is inevitable and resolution must occur without compromising the mission of team more goal of serving child and family and commonly, tension around decision making, personal injuries, competition and turf as we talked about before. Ells talks about conflicts. This is probably stuff you're committed to and connected to and all of you probably work on being.

Next slide, additional work on conflict resolution and again, what ellis would say on this slide is that having written protocols at the beginning of the project would probably serve you well in terms of avoiding conflict or at least not perhaps avoiding conflict but in terms

of resolving conflict, you would have a document that you agreed to before, before the conflict emerged so that you could use that as a governing document to navigate through. Then finally, we'll talk about action planning. Measurements indicating key implementation activities are taking place. That's one. Gallagher and Chrisoffel talk about collaboration. If there's collaboration happening, this is what you would kind of expect to see. You would expect to see community grassroots coalition in place, expect to see activities planned or on going, expect to see work in relationships. In terms of staff training, you would expect to see joint workshops and professional educations that are shared. You would certainly expect to see some staff that has some previous experience and who would bring that experience to these meetings and then you would also want to see the technical assistances available. You would like to see integration, health department programs that have neglect and injury prevention as a focus. You would certainly like to see protocols that were being shared. In terms of use of appropriate strategies, you certainly would want to see projects that have community collaboration and evaluation and feedback being present. And you certainly would want things to be called sensitive and if there's patient education material that the reading level would be part of that.

Next slide are several slides where we'll talk about the kinds of people that get involved and I'm sure you're working with the people but elected officials, business organizations. We see fire departments and then we see health professional schools, mental health departments, social services, substance abuse and then the next slide, potential collaborators and this is a laundry list of organizations.

Finally some other groups like poison control centers, survivor organizations and then finally, conclusion, this is from Peterson and she says 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. And I think to that, I would just add that this is what is compelling, the fact that children are being injured, they're being injured because of avoidable injuries, neglectful parenting, community violence. There is a bridge and the talk so far has been laying the ground work for that. There's similar conceptual models, there's shared data sources and there are commitments in each field to team work and what you do for your efforts to learn more about child maltreatment, injury prevention and violence and I hope that the words of Dr. Peterson written a decade and a half ago are still compelling today. Thank you for your attention.

STEPHANIE BRYN: Thanks very much, doctor. That was thoughtful, compelling and I think real incentives for partnerships. We now want to turn to Dr. Steven Wirtz in Sacramento, California. Steve?

STEVEN WIRTZ: Thank you, Stephanie. That was an impressive overview of the similarities and injury and neglect approaches. I'm going to focus on a much smaller piece of this, perhaps the first step around data and surveillance but it's going to be centered around several of the points just made, around team work and practical solutions.

So with the next slide, I want to start my discussion with a little bit of background about the social construction of the context of child maltreatment. In terms of data collection and surveillance, there are important reasons to have a clear sense of the definitions for child maltreatment. I'm going to focus on that and come back to the broader preventions at the end. With a very brief history, looking at history around the definitions of child maltreatment, I just wanted to point out that the definitions that we have are shaped by different purposes they serve, by the different agencies and people and times and so on

and it's just of interest to understand in my review of the history, the first concern around victims of child maltreatment was around morality, not around the children but the bad influence the children who were neglected or abused would have on the rest of society. A very interesting different view than we might take. It was only later we got more of a humanitarian view of child vulnerabilities and their rights and protecting them from physical harm and later, physical neglect and emotional maltreatment were added. We obviously know the criminal justice perspective has -- one part of it, punitive, withhold people responsible and accountable component and we know in the 1960's and 1970's the medical profession began to focus on the battered child syndrome and quickly from that focused attention on the child abuse reporting laws. That sort of led to the construction of a social response and the social services, child protective services came into being to really respond to the reporting laws and we had the child dependency statutes that we have today which obviously increased the demand for the allocations of resources. There was some tendency to change the definition to include less cases so that you could allocate your resources. But in addition to that, there was the recognition and the growing partnership to share the responsibility with other service agencies and other service systems. And I think there we are going into this partnership we're talking about now with overlap between unintentional injuries and violence injuries and child maltreatment and public health provides a broad, preventive and health services framework to look at this as well and one of the central pieces that I'm going to focus on today is really the conducting of surveillance to keep track of whether we're having trends of increasing or decreasing. It's interesting to note in terms of social construction that the lay public has actually often a more strict sense of what neglect and abuse might be but in general, there's a lot of agreement with professionals. The few studies done in this area ask about scenarios, whether these would be considered neglect or abuse, the lay public

actually is in agreement in a large way with the professionals. If anything they have a more strict view.

The next slide suggests what I want to highlight from that brief history is that the definitions that we have around child maltreatment are really reflecting social judgment. They reflect the negotiated settlement between society's various cultures and scientific knowledge base we have at the time. So there are communities, minimal standards of care that are articulated through a social, political process and through comparisons and so on. And the knowledge part of this is obviously expressed by professional experts and the literature that would indicate what is harmful to children and what risks children face from various things and how widespread those risks are. So to take an example of the dynamic historical or social context of what might be considered neglect, for example, is the use of child safety car seats in the United States. We know now from the literature that they prevent, you know, perhaps as much as 2/3 of injuries and 90% of deaths if used appropriately. There are laws in place, people are aware of the laws that generally people act on those laws. So therefore, there are norms in place now that say that the use of child car safety seats are expected and suggests that potentially it would be neglect regardless of the motivation or even the consequences. Most of the time even if you drive your child without a car seat, you're not necessarily going to be in an accident and there may not be injuries so the point there, though, is that we have a social norm and people would generally agree that if there was -- if you put a child in -- a 3-month-old child in the back seat of a car without any kind of restraint that that would both be risky and unacceptable.

So next slide, I want to point out how this view plays out and I think there's two sort of standards that can be looked at here that are applied. First, there is what we call the standard of care model which sort of focuses on a child's death standard. Sexual abuse is

regardless of the intent or the outcome. Namely it's considered not in the best interest of the child and it violates a widely accepted community standard which is a minimum standard of care how you treat children. That's independent whether it causes harm, whether it was intended for good reason. That's one model. Standard of care model focusing on child focus approach. The other model is the standard of consequences model. And here we use physical abuse as an injury. Corporal punishment is an acceptable behavior in the U.S. whether as we as professionals would agree with that or not, the social norm is that it's acceptable. Physical abuse is judged based on being too harmful. It's an assessment of the risk being too high. It's not an absolute standard that hitting a child is bad and given the social norm but rather it has to reach a certain level of being too harmful. Those are the two models that can be approached when we look at neglect, for example. And in neglect, I think we're really trying to balance the risk assessment, namely the degree of harm, and the social acceptability, meaning does this meet the minimum standard of care.

Next slide we see this basic approach translates into a legal framework for identifying child maltreatment and I'm just going to quickly highlight what lies behind that legal standard. That standard will reflect a conflicting social and political values and the perfect example of that is on one side you have the state power to use coercive interventions and expand societal resources. Texas with the 400 police children, that state power is used to intervene to protect the best interest of the child. On the other side is the values of parental rights to family privacy. In the United States it's for family or marketplace to dominate and for the state to stay out of the private business. Sometimes that's called the family bubble kind of notion that you're protected within the bubble to do what you want. And so legally, we tend to get a principle or a standard of minimum intrusion where you have to have demonstrable injury or harm or at least endangerment where the potential

for immediate and predictable injury or harm is present. You can see that's translated into our current laws. Each state has its own legal definition based on the minimum standards set by the federal government and I've laid out where some of the standards are set out.

Next slide I want to frame where that puts us. It puts us, child maltreatment sits on a continuum and I'll do a continuum of abuse here. We have assaults or homicides that are inflicted but with no intent or negligence, like a motor vehicle crash all the way to criminal assault or homicide, tensional, knowingly, recklessly or with criminal negligence. The point is where to draw the line on that continuum. It's much harder when you look at the continuum of neglect. You run from unintentional injury all the way to criminal neglect and intentional negligence. These are complex issues. There's no simple way to do it and what we have today, what I'm going to focus on is really this limited piece of this which is where the consequences are clear. We talked about child death. And we have actually proposed solution available to sort of address that. I need to move through these quickly and you can look at them when you have a chance. Tracking maltreatment death has certain challenges and each agency and profession has various definitions of its own based on its legal mandate and so on, guidelines and so on. Therefore, there are serious limitations with any of the data systems trying to track child maltreatment, either abuse or neglect, and especially the neglect in later cases. This results in different reporting rates of child abuse and neglect and non-comparability of finding.

Next slide I wanted to highlight that if you break down the profession, you can look at the different standards of certainty they use in coming to a formal definition of whether something is abuse or neglect. And I want to just move to the next slide to show you what that translates to in terms of data collection. Each line represents a different agency and different process for defining how many cases of child abuse or neglect there are. This is

referring to child abuse and neglect in California and just basically highlights that each agency using their own legal definitions and mandates comes up with fundamentally different numbers. We think there's an opportunity to refine and resolve in large ways this problem with the numbers. And that is focused around the child death review teams that nearly every state has. And this will work in particular if the teams can use a standard classification system for public health surveillance of child abuse and neglect deaths and if they can collect systematic data on this and reconcile that data from various sources. In California we use a reconciliation audit to produce the most accurate statewide data and use that for surveillance planning and prevention purposes. Next slide, so in California we have a project that's underway. I just want to mention that obviously the centers for disease control and prevention is in on this. And we had a great time working on that that I mentioned there.

The next slide says briefly what we did to develop this classification system. We had a team that developed prototype tools, in California they think there's at least 1,000 members of teams and at least 100 of them participated in this process.

To the next slide, I'll give you a brief overview of the classification system and put it in context. In that slide there's four steps that we talked about in this classification system. The first one is around defining whether this is a child abuse and/or neglect case and the second one is whether it has a caregiver involved in it or not. I won't go into the distinction there right now but the third one is obviously whether it's a preventable death, regardless of whether it's child a because or neglect and finally, whole process we have the kind of developed effective recommendations. Next how we define the cases, we broke this down into the classification system having components of having an agent who in this case needs to be a parent or care giver who takes an action, an act of commission or omission

and omission is the neglect one, that either is directly or indirectly related to the injury to a child under the age of 17 that leads to death.

Fairly straight forward, leading to the next slide, definition, the state forward definition that suggests that the death of a child under the age of 18 directly or indirectly caused by a caregiver acts of commission or omission that are judged by a team weighing risk of harm and level of social acceptability. We need to identify four conditions that have to be met.

The causal link, the caregiver agent, the child and the age of the child has to be appropriate and the judgment around the behavior has to be such that it's considered child abuse and neglect.

If we could go past the next slide what assessment categories those are and go directly to the first of the conditions, I'll just highlight what we do in the training is present the definition, given the first condition is causal link, present a general definition, go through case scenarios and have discussion about whether this -- whether there is, in fact, a direct or indirect cause. Second condition, we explore the notion of caregiver agent and here we look at a broader definition and sometimes is used around parental caregiver and we include both people who are implicitly or explicitly assigned a caregiver role or who have less circumstance in return but may well have established a caregiver role in the past.

Third condition, seems like a simple one of the child's age zero to 17 but we spent a lot of time what it means to be a live birth and we look at babies and substance exposure and go through scenarios to define how we decide whether it's a live birth or not and obviously there's similarities of prevention, whether it's a live birth or not, but for accounting purposes we need to be clear on that.

Next slide highlights the most preventable within. We need to weigh the risk of harm and the level of social acceptability of the behavior at hand and the risk assessment is really a question of the likelihood of harm and the likelihood of the severity of harm, we give examples of that. The social assessment touches on societal norms overall like we talked about before on the child safety seats but also if there's any cultural, religious or other mitigating factors that might need to be considered that doesn't rule out neglect and caregiver good faith effort as well.

So skipping to the next slide, that translates to how we classify the cases. We're testing this right now and we don't need to go through each category of cases. The bottom line is that the team makes a determination of whether those four conditions were met and if they were met, the case can be called the caregiver, child maltreatment death and we believe that the process is going to help lead the team to be more consistent in their counting and in their process of classifying. All of this is not to minimize the role of prevention here.

The next slide talks about whether it could be a child abuse issue, not perpetrated by a caregiver.

I'll skip that one to the next slide and just tell you again that this system is not focused on child treatment and neglect but the third step is regardless of whether it's a child abuse or neglect case, does it fit the definition here we have of preventability? We have a wide definition so that we include a lot of things and with the next and final slide, the point of having the wide classification of preventability and child maltreatment is that we are developing effective recommendations, we will focus on which of the ones that were preventable and which ones are likely to be able to -- for us to take actions on. So the bottom line here is that the child death teams are a valuable tool in helping us identify the

range of neglect that's available and to help define which kinds of cases fall under neglect and which ones fall onto some other broader health direction type of approach. With that, I will be done.

TERI COVINGTON: Thank you, Steve. I'm Teri Covington and I appreciate Steve's definitional issues and what I'm going to do is show how we use some of those issues in some of the backgrounds that lead to systems in two states, Michigan and Nevada. For those of you, I know many of you on the web cast are familiar with child death review. One of the things that has happened over the last 15 years and it's focused from only an investigative focus which helps us to understand child abuse and neglect to include a prevention focus which we're using our understanding of child abuse and neglect and unintentional injuries and it can be a powerful tool to prevent other deaths in children. This is where child death is around the country today. Most states are using a public health model. The states in blue are reviewing not only their child and abuse deaths but unintentional injury deaths as well. States in yellow are still focused on reviewing maltreatment deaths and the states that are in red are really transitioning from reviewing maltreatment deaths to include a broader perspective and actually, California should have been blue for a while. As it says on the slide, most of the reviews now are mandate or enabled by law in our state.

Next slide shows our first example which is Michigan. In Michigan prior to having child death review, it was in -- up to 1997, the state of Michigan decided that they were no longer going to report the number of child maltreatment deaths to the national child abuse and neglect data system because they didn't feel they were getting an accurate number. Our vital stats typically show we had 14, 15, 16 maltreatment deaths a year but the state really felt that number was highly underestimated. Child death review in Michigan started

in 1997 and in 1998, the state felt comfortable enough that the local child death review teams had identified 40 maltreatment deaths and they began reporting that data to the federal child abuse and neglect reporting system. Our next slide shows that we were funded to the C.D.C. along with California and Rhode Island to try to get a better sense of what was going on with child maltreatment and try to do a better job of counting those deaths. We were funded for three years and what we did in our state was we expanded our child maltreatment case definition so that it became more than just the criminal and the C.P.S. civil definition. We expanded it into a broader public health definition, much along the lines of what Steve just presented. Then we created a system where we combine four data systems, using death certificates, local review, C.P.S. case reports of all child deaths that happened to children in the C.P.S. system and/or receiving social services in the state and law enforcement records. The other thing we did is we also took the state vital registry of all injury deaths of children over the three-year period and we linked those electronically to families, parents and children, that were on the state registry of substantiated child abuse and that's when we ended up finding a lot more child neglect deaths than we did by just linking our four data sources. What we did next is as we obtained case information on the deaths, where there was a link between an injury death with a prior substantiation or when one of the four data sources suggested that the death might have been due to abuse and neglect and we did a case by case review at the state level using a very comprehensive, multidisciplinary team.

Next slide shows what happened to our numbers. And we went from 40 to 48 in 1998 and 1999 and in the year 2000, once we had linked the injury deaths to the C.P.S. registry, our number went into 76 and in 19 -- in 2001 it went up to 107 deaths that we felt were the result of abuse and neglect. The majority of those were neglect. There were only 26 physical abuse deaths. That does not mean that we went and initiated criminal

proceedings against the families or that we even, in many cases, initiated substantiations. It's just that the review team felt that there was significant numbers of usually lack of supervision but other situations as well that we felt contributed to the death of those children. So one of the things we did with that information is we wanted to use it to try to make system changes in our state child welfare system. And we identified seven major areas where we were looking at systems changes. The first was better identification of and reporting to C.P.S. of suspected child abuse and child deaths, better investigation by law enforcement of suspected deaths, better investigations by our medical examiner and coroners, better case intake and investigation by C.P.S. of the deaths and as you'll notice, because our numbers increase so much, many, many of those deaths had never come to the attention of C.P.S. in terms of being probable and neglect or abuse. We wanted to look how well C.P.S. substantiated child abuse and then the kinds of services that were provided by C.P.S. and that importantly included prevention services to our families. And then finally, the actions that were taken by the criminal and civil divisions.

OKAY. Next slide, please. I just wanted to give you some examples of what happened over a six-year period. We also had three following years of funding from the C.D.C. for a second round of the project and between 1999 and 2001, in the reviews of those deaths, we looked at 186 total deaths or we looked -- and we had 186 findings in those deaths. And we also had, the following three years, we had 170 findings. Over the course of the six years, between the first three-year period and the second three-year period, we presented those findings to the state department of social services and to the other agencies at the table with very well crafted recommendations for systems improvement that we felt needed to be made and what we found after those recommendations were presented to the state and the state very aggressively read those recommendations and made their own decisions in terms of what actions they planned to take, we found a 35%

decrease in the actual findings related to systems problems and a 9% drop in the deaths that were specifically related to those findings over time. We also had a couple of specific examples of where some major systems issues were made and it was really because we were trying to get a better -- along with what the Dr. Was saying, trying to understand the link between neglect and unintentional injuries. And when we looked at these cases, one of the findings we came up with was that there were 230 cases of sudden and unexplained infant death in which there was a worker being called upon to investigate an infant death as a result of poor sleeping conditions. Now, that doesn't mean that C.P.S. went and substantiated these. They were just part of an investigative team and a lot of those families were living in pretty high risk, high stress situations.

Next slide shows what the department of social services did with that information. They ended up creating a very wonderful video on safe sleep that they distributed and has now made available within all of the state social service agencies. They worked with C.P.S. and social service prevention workers to do anticipatory guidance when they felt families didn't have safe places for babies to sleep and worked on putting a crib distribution in place through the social service agencies. Now, this was an interesting process because in Michigan, social services took the lead quite a bit sooner than the state public health agency but when you talk about team work and crossing over and working together as Dr. Giardino did, one of the things that happened was the state department of social services worked with the Michigan department of community health to launch a safe sleep campaign in Michigan. Another example is what happened in Las Vegas. They were legislatively mandated by the state to look at deaths that they felt had slipped through the crack in the social service agencies in Clark county, Nevada and they did this process in Clark county, Nevada. They did it in Reno, northern Nevada and then they also did it for all of rural deaths and I'm only going to give you the Las Vegas example. So in looking

closely at their deaths of children in the state, there were 79 deaths that the state felt might have been due to abuse or neglect in which only six had been coded on death certificates as maltreatment and only nine substantiated as maltreatment by C.P.S. so they asked us to do a comprehensive team review of all of those 79 deaths, using, again, a multidisciplinary team. This is a pretty noisy slide but if you look at it closely, you'll see a lot of deaths that were being looked at were not what you think of classically of physical child abuse. There were poisoning deaths, there were drownings, children that were left in cars on hot days, there were some medical conditions, children who died of medical conditions, there were some SIDS deaths so it really crossed the broad range of accidental deaths much like Dr. Giardino presented to us.

Next slide, one of the things that the review found was that most of the 79 deaths did not come to the attention of social services because law enforcement and others who were doing the investigation felt that even though they were accidental deaths, the parents did not intend harm, there had been no criminal intent, the death was accidental or undetermined through the medical examiner's determination or the coroner's or that the parents had suffered enough. As a result of that, child protective services was not aware of and in most cases did not investigate the vast majority of the deaths. That included 19 deaths that had prior substantiations to significant neglect with the family.

Our next slide shows -- I'm going to give you case examples to give you a sense of the kind of cases. 14 of the 79 cases had intrauterine intoxication and these were typically babies born a little early. During the autopsy there was acute cocaine and methamphetamine intoxication. Most were those were identified as accidental. A lot of the families had a long history of substance abuse with the mother, very few information on the father and most of those children who died had surviving siblings. With one or two

exceptions, none of the cases had been reported to C.P.S., therefore, none were investigated and if investigated, none of the cases had been substantiated for neglect. Another example, medical cases. This is -- we had a toddler with a long medical history. He died of natural causes. In looking at the cases, it turned out there were many missed medical appointments, failure to follow medical guidance, some prior C.P.S. history of neglect. Those cases were usually investigated but not substantiated. There was a case of a 5-year-old who died of septicemia after being very sick for a week but the parents didn't seek medical care. We looked at cases where the child died of diabetes. In one case the child did not take the Insulin for a three-day period but the case wasn't substantiated because the child should have been old enough to take the Insulin themselves and that wasn't substantiated.

Next slide is a typical drowning case. This is a 1-year-old left alone with a 4-year-old while the parent went to sleep but they had a swimming pool in the back. They latched the door but the 4-year-old was able to open it and the 1-year-old drowned in a pool. Another child died in a trailer park pond. This looked like a typical accidental drowning until during the review it was discovered there were numerous prior calls to C.P.S. by neighbors who reported consistently they were afraid this child was going to drown because they were always unsupervised in the trailer park. Another case was children that are left in vehicles. The first one a child was left in the car on a hot day for a couple of hours. We see this across the country. The parents get distracted and in this case they answered the phone and forgot the child was still in the car. Another case was a 5-year-old child who got into an old car in the backyard with no interior door handles and he died due to heat -- overheating. The mother had been asleep for eight hours recovering from meth. at the time and never discovered the child was missing and then a 3-year-old playing with friends while the parents were at an athletic event today. The child went back to the car

but the parents lost sight of the child for 30 minutes and he was overheated. Those look like typical accidents until you start pulling away the layers and you realize there was some neglect issues that maybe needed to be looked at more rigorously. Some examples of asphyxia and undetermined cases. There are raging debates about these cases. Most are ruled natural, sudden and explained or ruled accidental. There was a 2-year-old sleeping with the parents and it was ruled accidental laying over by the parents. There were prior cases of removal of other children and the parents were intoxicated. A set of infant twins suffocated in a at the present time because the family was homeless, sleeping in a very stuffy, hot tent in a friend's backyard. Another example of cases that we looked at, this was a case with children left in a van while the father went inside visiting with friends. The kids got into some matches in the van and there was a tank of gasoline in the back seat which they -- which ended up exploding and killing the kids. Another accident of three teens killed in a crash by a 14-year-old unsupervised -- unlicensed driver. The grandmother who had extensive C.P.S. history for neglect with her kids had knowingly allowed these teens to go on the trip with unlicensed driver she knew was too young to drive. This last case was a 1-year-old ejected from the back seat. It looked like an accidental death but the dad was intoxicated. Even though he didn't cause the crash, he didn't fasten the child into the car seat. I'm just trying to give you examples of the cases so you sort of see how there's neglect issues involved and when you really dig and pull at some of these cases, you do find issues, not necessarily where you're going to go make criminal charges but where you can implement some interventions and you can implement some prevention strategies in the long run and make some systems changes. Some of the systems issues we found were one, in many cases we found that C.P.S. reports were not made by investigators to C.P.S., even though the investigators knew that the caretakers' actions contributed to the children's death because there were no surviving siblings and that was a pretty typical finding we found looking at the cases. One of the things Nevada

quickly did after this report came out was that they worked on getting a new state law passed that required notification to C.P.S., a child death when it looks like neglect or abuse, even if there are no surviving siblings. They made a systems change rapidly. Another example. One of the things found routinely in looking at the cases is one of the reasons that C.P.S. and public health and law enforcement rarely followed the cases as fatal neglect was because they really worked together in doing their investigations and they never talked to each other. It was pretty much the standard across the board on those deaths. The change that was readily made in Las Vegas that they now have a new multidisciplinary investigations team that created protocols and is meeting regularly and now conducts joint investigations on all of their sudden and unexpected child deaths and accidental deaths in Clark county.

Other next slide shows another systems change that was made. In many of the cases across the board, especially on neglect cases, it was obvious there was inconsistently in the determination of cause and manner by the pathologist, even though they were all working in the same office. When the circumstances in the case were very similar. The change that they made by looking at the cases was that they now hold daily case conferences on all child deaths, they created a new position for another medical examiner because they realized they were understaffed and the chief coroner appointed a chief medical examiner to make determinations on the cases. Another example, these were actually three findings and it's pretty wordy but basically what the findings related to was that C.P.S. often times did not rigorously investigate or respond to these kinds of neglect even when they knew about them. For example, 64 of the children who died had surviving siblings but they interviewed only two sets of siblings following the deaths. When there was known maternal substance abuse, C.P.S. did not investigate 11 of the deaths and in almost all of deaths that had C.P.S. safety assess many, they were incomplete. Especially

on the neglect related deaths. So one of the changes that Clark County readily made was that they obtained new funding and they were able to hire 144 new case worker positions in Clark county and they expanded a special unit specifically to investigate their child deaths on call 24/7.

OKAY. Next. I'm almost done. I just want to -- the experience in Michigan and in Nevada really found one, that the death certificate is not the place to identify fatal neglect. Rarely, rarely, rarely will you find a death certificate that actually lists neglect as the cause of death. In both states and actually, in the California, Rhode Island experience that was funded by the C.D.C., we found that the child death review process was typically the best method for identifying child maltreatment and neglect. We found the in-depth review of the child's death is really necessary to find out if maltreatment contributed to the fatality and when recommendations are made that are solid and delivered to the right agencies, they can lead to major initiatives.

Next slide. The limitations, case reviews can be time consuming and costly N. States that are doing them now, most of them are doing them at the state level as the review panels meet as volunteers. This is not really a criminal process. The cases you can look at range all the way, maybe, from murder to negligence on the part of the caregiver where really it was a -- you know, what some people like to say is it was an accident or there by the grace of God. The range is very broad. In our process in Michigan and Nevada, we looked at very few natural deaths and it's still an unknown territory and I think it would be interesting in both states to go back and link natural deaths to C.P.S. registries and see what we find. Then the other limitation is that beyond just looking at traditional sources, it's important that you look at our data sources as well. Crash reports and fire reports, for

example. Investigators that are actually on the scene doing much more intensive investigations in some of the traditional sources.

Okay. Next slide. I think that's my next slide and I'm going to move us on to Stephanie Biegler now who is in Sacramento and these going to give us an example of how looking at neglect deaths, they were able to do some wonderful prevention programming in Sacramento. Thank you, Stephanie. Thank you for being interested in this subject matter.

STEPHANIE BIEGLER: I have had for the last eight years or so, in addition to managing the work of the child abuse prevention council in Sacramento, supervising the work of Sacramento County Child Death Review Team. The Sacramento child abuse prevention council has that responsibility through funding with the Children's Trust Fund. So what I will present as Teri said are two examples of how we took this data and implemented one program and in the process of implementing a second.

On the next slide, we want to let you know about the Sacramento County. We were created in 1989 and have been selecting data since 1990. We have an ongoing relationship with the Board of Supervisors; we present our annual reports to them. We have funding through the Sacramento County children's coalition. Our population, our child population is about 375,000. We have about tragically, 180 child deaths per year which is about a death rate of 71.7 per every 1,000 children. About 1/3 of our deaths are typically injury related. Of those, about -- which would be about 50. And of those, about 25 or actually child maltreatment deaths and anywhere from about four or five of those are child abuse and neglect homicides per year.

On the next slide, you will see the California statute that actually established interagency child death review teams in each of California's 58 counties. We have the amendment for that statute which actually calls for the release of findings, recommendations, conclusions and statistical data effective in the 2008 year of the 58 counties. Our Sacramento county child review death team, just like other states in the nation, is a multidisciplinary team that obviously includes sheriffs and police, it includes both the medical and the investigative arm of the coroner's office. We have in Sacramento County all four hospital systems on the child death review team. We also have child welfare representatives, fire responders, the public health department, the district attorney and the county's probation department.

Our mission as the next slide indicates is that we want to ensure that all child abuse fatalities are identified but our team, since the onset, has reviewed the death of every child through 17 years of age. We obviously investigate our death through a multi-agency review, we have a very comprehensive data base and part of our report, just like the child death reports of other counties and states, develop pretty comprehensive recommendations for the prevention of deaths related to abuse. About five years ago, with some funding, we wanted to expand our child death review team data to not just look at neglect and abuse deaths but also to expand it to look at injury deaths. And hopefully in the slides that I will be showing to you, you'll able M" f c c { J t i o n of what Dr. Giardino was talking about as well as Steve Wirtz when we talked about child maltreatment and unintentional injury deaths.

This is what we did as outlined in the next slide. To explore the problem a little bit further, we went ahead and combined all of our maltreatment and injury, unintentional injury deaths and we wanted to know who the children were by age, gender and race. We wanted to know how they died, we wanted to know where they died and then take a look

at what assets the community had and actually talk to the individuals in those communities. We wanted to talk to the residents of the communities as well as the service providers in the communities. We obviously took a look at the distribution of all of the neglect and injury related deaths, we did an in-depth analysis of the neighborhood and really sought community and professional input. After determining these steps, the child death review team said what are the almost we need to do? We obviously recognize that there are very complex conditions with underlying each of these deaths. We know as a body that we can make recommendations to policy leaders and have been doing so for eight years. And that our best approach to this was to go ahead and to convene a child death review team sponsored collaborative that would be representative of agencies beyond the child death review team table, that we would go ahead and address our priority areas and weed in more information than what is usually collected at the child death review team.

The next slide begins the first of seven action steps that the child death review team established. So the first was to identify and define the problem using child death review team data. We developed a process for community collaboration and input. We developed recommendations and a plan of action, Sacramento county then developed a representative collaborative to address children that would be at risk of injury and child maltreatment related deaths. Step five was we developed a community profile to focus and prioritize efforts to reduce child neglect fatalities and injury related fatalities. We then developed a comprehensive literature review, including best practices and even through this process, we knew what we would do or hoped that we would do was to increase the education and awareness among and within the communities about the danger and consequences of neglect.

The next slide shows we had a pretty collaborative name to this group and we called it the collaborative to reduce child neglect fatalities. We implemented a new assessment process and we reviewed child death data, we researched best practices and we sought community input. Our outcome for our first five commission fundings was that we would develop a community profile that would focus and prioritize efforts that we would increase the education and awareness among agencies and communities and that we would develop a comprehensive strategic plan.

Next slide is just an example of what we felt was the most critical component of all of the seven steps and it was really going out to the community, talking to residents, talking to parents, grandparents as well as the people providing the services in the community and we did it through a neighborhood of focus groups, filled out a questionnaire that we distributed to the professionals that provided services in our communities and we also did some stake holder interviews. We asked three simple questions. Did you know these type of deaths were happening in your community? What is your suggestions for why those were happening? What do you think we should do to prevent these deaths from happening again?

And the next slide actually shows the community and the professional findings. It was actually very surprising to the collaborative that we had consensus from both the neighborhood, the community, the professionals and the stake holders on the cause of those deaths as well as on what should be done. You can see in the slides that they felt that the causes of the deaths were substance abuse, poverty and domestic violence and that really ties very nicely into what Teri were saying when they looked at the Michigan and the Nevada data on, you know, child maltreatment deaths. We asked those experts what they thought could be done and they said, education and awareness campaign,

community support and improving service access and delivery at the local level. And this is a finding that we thought to be thoughtful would be that consensus was more than 90%. 90% of the stake shoulders and parents felt that the parent education and community awareness campaign were a top priority. Some of the comments actually came from the focus groups. We thought those were pretty heartfelt. Teach mothers better coping and interaction skills, that we should incorporate child neglect education and we should do billboards and advertisements and that we should continue to have open discussions about child maltreatment deaths at the community level. This was our main outcome of our strategic plan which was an education and awareness campaign where we would convey consistent messages to change behaviors and attitudes and it was absolutely targeted to the highest neglect related and injury related communities in the 12 years of child death data. What we did then is that we implemented, went to a planning grant so we created this strategic plan from our planning grant dollars and we applied for and received funding to implement the program. We implemented the program and ran it for three years in Sacramento county. The three-year program concluded in June of 2007 and we can tell you that during that time frame, we decreased nearly half sleep infant deaths, including SIDS, in those communities that we targeted and our Sacramento county shaken baby rates dropped by 31%, or injury rates developed by 31% compared to 12% dropped at the state level during that same time frame. So what we then did next is that we went ahead and decided that we should expand the review to the child death review team and we are now looking at a child death model as well as using injury data in Sacramento County. And our goal is to reduce drowning and sleep related deaths and injuries in children zero to five in Sacramento County. What we did with this is our premise is based off the spectrum of prevention. We want to strengthen the knowledge and skills as parents and caregivers at the community level. We want to conduct public education and awareness campaign, we want to be sure that we train community service providers. We are hoping

that we foster coalition and networks and we believe that we are doing so because the funding for this program is actually coming from California kids place and it is a joint effort between the child abuse prevention council of Sacramento that will bring child death review team data to the table and greater Sacramento safe kids which obviously focuses on injuries prevention. We want to mobilize our neighborhoods and communities that we did in the prior model, we are hoping to change organizational practices and that we will influence legislation along the way.

The next slide is our model of who should be at the table. The child abuse prevention council of Sacramento and greater Sacramento safe kids. We will have representatives from hospitals, community based organizations, the residents of our targeted communities, local police and fire departments as well as home visitation programs which ties into the work that Dr. Giardino just showed us.

Next slide shows what our action steps will be. We will analyze drowning and infant sleep related deaths, we'll review research and evidence based practices, determine community needs and assets, we will be conducting community and stake holder groups.

What we hope to have out of this as the next slide shows us, we'll develop and finalize a strategic plan. We'll go ahead and pilot the strategic plan, test and evaluate the pilot and then we're going to go ahead and test any increase in parent and service provider knowledge and then we are going to go ahead and finalize our program model and hope that we can actually take that program model to scale. We want to thank you for your interest in this work and say that we certainly wish you the very best as you develop strategies in your own community that will hopefully reduce child maltreatment and injury

related death and injury. And with this, I will go ahead and turn it back over to Teri and Stephanie.

STEPHANIE BRYN: Thanks very much. I hope you enjoyed this web cast. I know I did. And what we want to mention is it's archived, it will be archived within about 10 days and you will be able to see and share with others this web cast information and start that collaborating and start that collaboration, working on this huge problem that we face. And I want to turn to Teri for the last word.

TERI COVINGTON: Yes. We received several questions from attendees and we're going to try to post the answers to those questions on the archives given the late hour of date in the eastern part of the country. The other thing is if you would like more information on the presenters or on their information or their slides, the best way for you to get that is to contact us at the following email. Info @ child death review.org and that's all one word, child death review. Info @ child death review.org and we'll get more information to you if you send us your request. Thank you again, all, for participating and have a good day. Thank you.