

Module 20: Preventing Recurrence of Maltreatment

THINGS TO LOOK AT	WHAT WE KNOW ABOUT IT	WHAT TO DO ABOUT IT
<p>CLIENT FACTORS- CHILD CHARACTERISTICS Q: Are any child characteristics associated with maltreatment recurrence or preventing recurrence?</p>		
<p>Demographics (i.e. age, gender, race/ethnicity)</p>	<p>Evidence</p> <p><u>High level of evidence</u> Many studies have found that <u>younger children (under age 6) are more likely to experience recurrent maltreatment</u> when compared to older children.¹</p> <p>The child's <u>gender has not been found to be significantly related to maltreatment recurrence rates.</u>²</p> <p><u>Medium level of evidence</u> In one study, <u>younger girls, aged 0-6</u>, were more likely to experience recurrent maltreatment.³</p> <p><u>Studies of race/ethnicity have had mixed findings.</u> Some studies have found that in general, children of color are less likely to experience maltreatment recurrence.⁴ Other studies have found that White children and African American children have similar rates of recurrence.⁵</p>	<p>Possible Steps to Take</p> <p>Data analyses. Compare recurrence rates (either by using a data reporting system or by reviewing cases) for:</p> <ul style="list-style-type: none"> • Very young children (0-3), young children (5-12), and older children (12-18). <ul style="list-style-type: none"> • ASK: Are higher rates of recurrence for younger children due to a truly higher incidence of maltreatment recurrence or due to the greater willingness of mandated reporters to report young children? • White children and children of color (make a combined variable). Then compare African American, Native American, Asian/Pacific Islander, Hispanic/Latino, and White children, respectively <ul style="list-style-type: none"> • Look for disproportionate rates of recurrence among these populations. • ASK: Do placement rates vary by race/ethnicity (higher placement rates for white children, for example). Could this account for differences in recurrence rates rather than actual differences in the incidence of maltreatment recurrence by race/ethnicity? <p>Target Interventions. Target program improvement and service interventions to the groups of children who are most at risk for true recurrence of maltreatment. This may involve mental health services, home-based services, or family services. (See <i>Family Characteristics</i> for more steps to take.)</p>

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<p>Disability (e.g. physical disability; learning disability; developmental disability)</p>	<p>Evidence Medium level of evidence Some studies suggest that <u>children with disabilities may be more likely to experience re-referral or maltreatment recurrence</u>. For example, in one study, children with <u>learning disabilities</u> were more likely to experience recurrence.⁶ In another study, children with <u>developmental delays</u> were more likely to recur.⁷</p>	<p>Possible Steps to Take</p> <p>Data analysis. Run data analyses comparing rates of maltreatment recurrence for:</p> <ul style="list-style-type: none"> • children with identified disabilities; • children with none; and • children by type of disability <p>Training. Ensure that staff members have adequate training and understand the various types of disabilities children face and the services they and their families need. Some of these include:</p> <ul style="list-style-type: none"> • specialized health care for physical disabilities • educational testing to diagnose and treat learning disabilities • special education advocates to ensure that children receive appropriate, timely IEPs and other educational services • mental health treatment for emotional and behavioral issues • behavioral assistants to help parents reinforce new behaviors • respite services for parents • support groups for children and parents of children with similar disabilities. <p>Consult. Work with disability advocacy groups to understand how to better facilitate permanent, timely placements for these children. These are selected advocacy/support groups and web resources:</p> <ul style="list-style-type: none"> • The Beach Center on Disability: http://www.beachcenter.org/ • Parents Helping Parents: Helping Children with Special Needs: http://www.php.com/ • Family Resource Center on Disabilities: http://www.ameritech.net/users/frcdptiil/index.html • Family Voices: http://www.familyvoices.org/ • Parent Educational Advocacy Training Center: http://www.peatc.org/ • Children with Disabilities: http://www.childrenwithdisabilities.ncjrs.org/ • National Information Center for Children with Disabilities: http://www.nichcy.org/

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<p>Child's History of Abuse or Neglect (e.g. type of maltreatment, multiple types of maltreatment, severity of maltreatment)</p>	<p>Evidence</p> <p><u>High level of evidence</u> <u>Children with a history of reported child maltreatment are more likely to recur</u> than those children with no prior CPS involvement.⁸</p> <p>In a multi-state study, <u>children who experienced neglect were 27% more likely to experience recurrence</u> than children who experienced physical abuse.⁹</p> <p>In another multi-state analysis, cases involving <u>multiple maltreatment types</u> were 15% more likely to recur than cases involving one form of maltreatment.¹⁰</p> <p>Several studies have found that <u>subsequent allegations</u> in cases that recur often <u>involve a different type of maltreatment</u>.¹¹</p> <p><u>More severe maltreatment</u> is associated with higher rates of recurrence..¹²</p> <p><u>Medium level of evidence</u></p> <p>In one significant study, <u>neglect cases were 52% more likely to be re-referred</u> than sexual abuse cases. Neglect was 32% more likely to be re-referred than physical abuse.¹³</p> <p>In a study using survival analysis, <u>neglect cases were found to recur more quickly than abuse cases</u>.¹⁴</p>	<p>Possible Steps to Take</p> <p>Data Analysis.</p> <p>The authors of a publication from the National Resources Center on Child Maltreatment, "Child Maltreatment Recurrence: A Leadership Initiative of the National Resource Center on Child Maltreatment (http://www.gocwi.org/PDF/MaltreatmentRecurrence.PDF) suggest asking the following questions to guide your state or agency's data analysis (page 20, Supplement to the Briefing Paper):</p> <p>"Prior reports and prior substantiations. Are children who come to your agency the first time handled differently compared to children who have been reported or substantiated before?"</p> <p>"Multiple maltreatment types and recurrence. What percent of cases with multiple maltreatment types involve neglect?</p> <ul style="list-style-type: none"> Is this element a large reason for the higher rates of recurrent maltreatment in multiple vs. single types of maltreatment cases?" <p>Target Neglect. As neglect is the predominant form of maltreatment, program improvements should target neglect reporting and services. Some studies suggest that agencies should respond as quickly to neglect allegations as they do to physical and sexual abuse allegations. Other researchers suggest that neglect must be differentiated from poverty and that neglect can be prevented by providing parents with concrete needs and services such as transportation, employment, food, housing, medical care, educational assistance. Other researchers suggest that unmet mental health and substance abuse treatment needs of parents are to blame for persistent neglect. Others still suggest stricter rules for removal of children from neglectful homes.</p>

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<p>CLIENT FACTORS- FAMILY CHARACTERISTICS Q: Are any family characteristics associated with maltreatment recurrence or preventing recurrence?</p>		
<p>Parent and Family Characteristics (e.g. family size, family structure, socioeconomic status, presence of substance abuse, presence of domestic violence)</p>	<p>Evidence</p> <p><u>High level of evidence</u> Families with more <u>children</u> are more likely to recur.¹⁵</p> <p>Families in which the <u>primary caregivers are younger</u> at the time of report are more likely to recur.¹⁶</p> <p>Families with a <u>prior history of child maltreatment</u> are more likely to recur or re-refer.¹⁷</p> <p>Families in which there is <u>caregiver substance abuse</u> are more likely to recur.¹⁸</p> <p>Families in which there is <u>domestic violence</u> are more likely to recur.¹⁹</p> <p>Families who <u>lack social support</u> and who experience a <u>high amount of stress</u> are more likely to recur.²⁰</p> <p>Families with <u>lower income levels</u> are more likely to recur.²¹</p> <p><u>Medium level of evidence</u> Studies have found higher rates of recurrence for:</p> <ul style="list-style-type: none"> • Children living with <u>step-parents</u>²² • Children living in <u>single parent families</u>²³ <p>Families with <u>greater ability to use agency resources</u> recur less.²⁴</p> <p>Families <u>rated by caseworkers as posing lower risk</u> recur less.²⁵</p>	<p>Possible Steps to Take</p> <p>Data Analysis. The authors of a publication from the National Resources Center on Child Maltreatment, "Child Maltreatment Recurrence: A Leadership Initiative of the National Resource Center on Child Maltreatment (http://www.gocwi.org/PDF/MaltreatmentRecurrence.PDF) suggest asking the following questions to guide your state or agency's data analysis (page 20, Supplement to the Briefing Paper):</p> <ul style="list-style-type: none"> • "Single Parent/Mom perpetrators: Are single parents and moms who are perpetrators more likely than two parent families to be reported for neglect than other types of maltreatment?" • "Substance Abuse: Are your data regarding the assessment of substance abuse adequate? How many cases are present where substance abuse is an issue? Are these cases more likely to recur?" • "Domestic Violence: Are your data regarding the assessment of domestic violence adequate? How many cases are present where domestic violence is an issue? Are these cases more likely to recur?" <p>Target Substance Abuse, Poverty, Domestic Violence, Teen & Young Parents, Social Support.</p> <ul style="list-style-type: none"> • Work with local mental health providers to provide timely substance abuse treatment. If treatment resources are inadequate, consider having the state enter into a memorandum of understanding (MOU) with substance abuse/mental health providers. Include in the MOU a clause about developing SA programs specifically for women with children. • Provide concrete resources. Ensure that case management services are being provided. Consider developing a housing liaison, as inadequate housing plays a big part in neglect cases. • Provide parenting training for younger parents. Consider working with or developing a Teen Parent Center like this one in Santa Fe, NM: http://www.catholiccharitiesasf.org/santafe/teenparent.htm. • Work with local agencies to target domestic violence. Improve education among mothers as to the signs of an abusive relationship. Read this policy from New York: http://www.opdv.state.ny.us/coordination/model_policy/childw el.html • Work with local faith communities and agencies to help families access more social support and reduce stress.

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<p>SERVICE FACTORS Q: Is the quantity, quality, or type of services provided associated with maltreatment recurrence or preventing recurrence?</p>		
<p>Type and Duration of Services (e.g. post-investigative services, family support services)</p>	<p>Evidence High level of evidence The provision of <u>post-investigative services</u> is associated with higher rates of maltreatment recurrence.²⁶</p> <p>Higher rates of recurrence among families receiving services may be due to a <u>“surveillance effect”</u> in which families receiving services are more monitored.²⁷</p> <p><u>Service plan compliance</u> is associated with <u>lower</u> rates of recurrence.²⁸ In one study, families that attended <u>services identified in their case plans</u> were 32% less likely to recur.²⁹</p> <p><u>Risk assessment protocols and planning tools</u> reduce rates of recurrence.³⁰ In one study, safety assessment protocols reduced recurrence rates by 28.6%.³¹</p> <p>Medium level of evidence</p> <p>The <u>number of services received by a family</u> may reduce recurrence rates.³² In one study, counties providing more services to families had lower recurrence rates. Also, counties that provided more services to families with substantiated physical neglect reports had lower recurrence rates.³³</p> <p>One study found that <u>repeat maltreatment is most likely to occur in the first 180 days</u> after case opening and to decline thereafter.³⁴</p>	<p>Possible Steps to Take</p> <p>Data Analysis. The authors of a publication from the National Resources Center on Child Maltreatment, “Child Maltreatment Recurrence: A Leadership Initiative of the National Resource Center on Child Maltreatment (http://www.gocwi.org/PDF/MaltreatmentRecurrence.PDF) suggest asking the following questions to guide your state or agency’s data analysis (page 20, Supplement to the Briefing Paper):</p> <ul style="list-style-type: none"> • “Case status and recurrence: Is there a correlation between likelihood of revictimization within the first six months and the status of the case (i.e. open vs. closed)? Are families with open cases that experience recurrent maltreatment demonstrating different recurrence rates because they are more closely scrutinized while receiving services, because they inherently have more problems and actually maltreat more, or both?” • Foster care and recurrence: Does your agency have higher rates of recurrence among children placed in foster care? If so, “are the higher rates of recurrence associated with foster care placement due to recurrence prior to, during placement, or after placement? What proportion of foster care recurrences are associated with the use of short-term placements?” • “Service Effectiveness: What is different about the types of families receiving services? Do families that are open for services have different recurrence rates after receiving services compared to families that leave services more quickly? What specific types of services are associated with lower rates of recurrence?” • “Service Targeting: Are interventions designed to address specific children or family issues effective in reducing recurrence? If effective, will the reduction be sufficient to meet your program improvement goals?”

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<p>ORGANIZATIONAL FACTORS Q: How is the organization (agency or unit) impacting the achievement of this outcome?</p>		
<p>Policies and Procedures (e.g. state, agency policies and procedures)</p>	<p>Evidence High level of evidence</p> <p>Several studies have found that the <u>risk of recurrence is greatest soon after the first report is made</u> (initiating incident).³⁵</p> <p>The <u>risk of recurrence declines over time</u> as the subject is followed.³⁶</p> <p>The majority of cases that <u>recur only recur once</u>.³⁷ Furthermore, most substantiated recurrence happens <u>within the first year of the first report</u>.³⁸</p>	<p>Possible Steps to Take</p> <p>Data Analysis. The authors of a publication from the National Resources Center on Child Maltreatment, "Child Maltreatment Recurrence: A Leadership Initiative of the National Resource Center on Child Maltreatment (http://www.gocwi.org/PDF/MaltreatmentRecurrence.PDF) suggest asking the following questions to guide your state or agency's data analysis (page 21, Supplement to the Briefing Paper):</p> <ul style="list-style-type: none"> • "Timing of reports and recurrence: Are multiple reports about the same incident or situation possibly being counted as recurrence? What percent of additional reports received within 30 days are about the same incident or situation? Are these additional reports the result of investigative findings? Are they from the same or different reporter as the first report?" • "In counting recurrent maltreatment, does it make a difference when the report is received in relation to the last report (i.e. within 30 days of the original report, not counted, after 30 days, counted)? What other factors might affect how you handle new reports on open cases? Do such policies reflect prioritization of the safety of the children? • "What about new reports on cases closed with a finding of no maltreatment (unsubstantiated)? Are new reports on those cases handled differently? Does it depend on when the report is received? Does it depend on how many prior reports have been received on the family?" • "Report source and recurrence: Is the fact that cases reported by law enforcement experience lower likelihood of recurrence due to a deterrent effect or incarceration or to the presence of criminal proceedings?" <p>Implement Risk or Safety Assessment Protocols. Measure rates of recurrence before, during, and after implementation. For more information on risk assessment, see:</p> <ul style="list-style-type: none"> • http://www.nccd-crc.org/crcindex.htm (Structured Decision Making) • http://www.childwelfare.com/Risk%20Assessment.htm • http://www.cecw-cepb.ca/Pubs/PubsRisk.html http://www.michigan.gov/fia/0,1607,7-124-5452_7119_7194-15399--,00.html • For cautions on using risk assessment: http://www.gocwi.org/pdf/com2003march.pdf <p>Develop an alternative response system. Alternative response programs divert certain cases to programs emphasizing assessment and services provided accordingly. (see http://www.gocwi.org/PDF/MaltreatmentRecurrence.PDF)</p>

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SELECTED WEB RESOURCES

National Resource Council publication on Child Maltreatment Recurrence:
<http://www.gocwi.org/PDF/MaltreatmentRecurrence.PDF>

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¹ Fluke, et al., 1999; Fryer & Miyoshi, 1994; Hamilton & Brown, 1999; Marshall & English, 1999; U.S. DHHS, 2002.

² Fluke, et al., 1999; Hamilton et al., 1999; U.S. DHHS, 2002.

³ Fryer & Miyoshi, 1994.

⁴ Fluke, et al., 1999. Johnson & L'Esperance, 1984; U.S. DHHS, 2002.

⁵ Inkelas & Halfron, 1997; Levy, et al., 1995.

⁶ Palusci, 2002.

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- ⁷ Marshall & English, 1999.
- ⁸ Hamilton & Browne, 1999; U.S. DHHS, 2002.
- ⁹ U.S. DHHS, 2002.
- ¹⁰ U.S. DHHS, 2002.
- ¹¹ English & Marshall, 1998; Way, et al., 2001.
- ¹² Ferleger et al., 1988; Marks & McDonald, 1989.
- ¹³ Marshall & English, 1999.
- ¹⁴ DePanfilis & Zuravin, 1999a.
- ¹⁵ Baird, 1988; Johnson & L'Esperance, 1984.
- ¹⁶ Baird, 1988; Wagner, 1994.
- ¹⁷ English et al., 1999; Murphy et al., 1992.
- ¹⁸ Baird, 1988; Palusci, 2000.
- ¹⁹ DePanfilis & Zuravin, 1999b.
- ²⁰ Baird, 1988; DePanfilis & Zuravin, 1999b.
- ²¹ Baird, 1988; English & Marshall, 1998; Levy et al., 1995; Way, et al., 2001.
- ²² Hamilton & Browne, 1999.
- ²³ Levy et al., 1995.
- ²⁴ Jonson & L'Esperance, 1984; Marks & McDonald, 1989.
- ²⁵ Baird, 1988; Johnson, 1995.
- ²⁶ DePanfilis & Zuravin, 1999a; Fluke et al., 1999.
- ²⁷ Johnson, 2000; MacMillan et al., 2002.
- ²⁸ Ferleger et al., 1988; DePanfilis & Zuravin, 2002.
- ²⁹ DePanfilis & Zuravin, 2002.
- ³⁰ Fluke, 1991; Fluke et al., 2001
- ³¹ Fluke et al., 2001.
- ³² Johnson, 2000; Inkeles & Halfron, 1997.
- ³³ Johnson, 2000.
- ³⁴ Zuravin & DePanfilis, 1996.
- ³⁵ Fluke, et al., 1999; Fryer & Miyoshi, 1994; Johnson, 1994; Zuravin & DePanfilis, 1996.
- ³⁶ Fluke, et al., 1999; Fryer & Miyoshi, 1994; Johnson, 1994; Zuravin & DePanfilis, 1996.
- ³⁷ DePanfilis & Zuravin, 1999; Fluke et al., 1999; Hamilton & Browne, 1999.
- ³⁸ Fluke, et al., 1999; Fryer & Miyoshi, 1994; Johnson, 1994; Zuravin & DePanfilis, 1996.