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### Child Welfare Workers' Training, Knowledge, and Practice Concerns Regarding Child Maltreatment Fatalities: An Exploratory, Multi-State Analysis

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## **Child Welfare Workers' Training, Knowledge, and Practice Concerns Regarding Child Maltreatment Fatalities: An Exploratory, Multi-State Analysis**

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*Research has rarely focused on child welfare professionals as agents of prevention for maltreatment fatalities. This study presents results on 426 child welfare workers' training, knowledge, and practice concerns regarding fatalities. Workers' knowledge of risk varied and revealed deficits in knowledge of parent and household risk factors. Receipt of training had a minor impact on knowledge. More than 25% of workers reported that a parent had disclosed potential intent to kill his/her child. Workers worried that a child will die on their caseloads; they reported assessing for risk, but wanting additional training. Implications are discussed for both research and practice communities.*

*KEYWORDS* *fatal child maltreatment, child welfare profession, professional knowledge*

Researchers and practitioners who provide services to children and families have increasingly paid attention to child maltreatment fatalities (CMFs). Our knowledge of risk factors (Chance & Scannapieco, 2002; Graham, Stepura,

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Baumann, & Kern, 2010; McClain, Sacks, Froehlke, & Ewigman, 1993; Stiffman et al., 2002) and our responses to CMFs have drastically improved (Douglas, 2005; Durfee, Parra, & Alexander, 2009; Durfee & Durfee, 1995; Webster et al., 2003), but we still lack important information about at least one key element of prevention—the readiness of child welfare professionals to recognize risk factors associated with CMFs. The current study explores child welfare workers' (CWWs) level of training, knowledge of risk factors, and practice concerns with regard to CMFs among a multi-state sample of professionals.

### CHILD MALTREATMENT FATALITIES

According to official statistics, in 2009, 1,770 children died from maltreatment (U.S. Department of Health & Human Services, 2010), but research confirms that CMFs are undercounted (Ewigman, Kivlahan, & Land, 1993; Herman-Giddens et al., 1999), thus, the true number is likely much higher. CMFs describe a wide range of causes of death that include active (e.g., assault/shaking) and passive behaviors (e.g., neglect/lack of supervision) that result in a child's death. In 2009, 36.7% of the 1,770 identified CMF victims died from a combination of abuse and neglect, 35.8% from neglect, and 23.2% from physical abuse; the cause of death for the rest was due to less prevalent types of maltreatment such as medical, psychological, or sexual abuse (U.S. Department of Health & Human Services, 2010).

Age is the most consistent risk factor for suffering a CMF. Younger children, especially infants, are at an elevated risk for becoming victims (Anderson et al., 1983; Kunz & Bahr, 1996). Perpetrators of CMFs are usually caregivers, and most often mothers (U.S. Department of Health & Human Services, 2010)—presumably because mothers generally do more caregiving than fathers (Manlove & Vernon-Feagans, 2002; Wood & Repetti, 2004). Individuals who kill children through maltreatment are usually younger, (Herman-Giddens et al., 2003; Kunz & Bahr, 1996) and are more likely to have age-inappropriate expectations of their children (Korbin, 1987) or to see their children as “difficult” (Chance & Scannapieco, 2002; Fein, 1979). Victims are more likely to have nonfamily members living in their households (Stiffman et al., 2002) and to be especially mobile (Anderson et al., 1983).

### PROFESSIONAL PRACTICE AND RESPONSES TO CMFS

There have been a number of professional responses to CMFs, such as child fatality review teams, which are multidisciplinary work groups that identify barriers to providing services to children and their families (Douglas & Cunningham, 2008; Durfee, Durfee, & West, 2002; Durfee et al.,

2009; Palusci, Yager, & Covington, 2010; Pollack, 2009). Similarly, the legal professions have focused on better identifying victims and collecting necessary evidence for prosecution (Dallas Police, 1994; Dinsmore, 1994; Douglas, 2005). The medical profession, too, has provided better education concerning risk factors for CMF (Berkowitz, 2008; Russell, Trudeau, & Britner, 2008; Tomashek, Hsia, & Iyasu, 2003). Many communities and states have initiated or require shaken baby syndrome prevention campaigns for new parents (Dias et al., 2005; National Conference of State Legislatures, 2009). Other states have responded by proposing legislation that would stiffen penalties for mandated reporters who fail to report abuse or neglect (Saunders, 2001). States have passed “safe haven” legislation that is intended to prevent fatalities among newborns by encouraging parents to relinquish their children in pre-designated areas, with no consequences to them (Child Welfare Information Gateway, 2010). Finally, the U.S. Congress (2011) and the U.S. Government Accountability Office (2011) have recently recognized the importance of CMFs and have called for high quality data to better understand this phenomenon.

Some research has examined how the child welfare profession responds to CMFs (Ayre, 2001; Douglas, 2009; Gustavsson & MacEachron, 2004; Horwath, 1995; Regehr, Chau, Leslie, & Howe, 2002). Agency-related CMFs have been linked to the development of a culture of blame and mistrust in child protection work (Lachman & Bernard, 2006) and to an increase in policing functions of child welfare professionals (Regehr et al., 2002). No research, however, has focused on child welfare professional preparation to prevent CMFs.

Approximately 30% to 40% of CMF victims or their families were known to child welfare agencies or social services prior to their death (Anderson et al., 1983; Beveridge, 1994). This places child welfare professionals in the unique position to prevent many fatalities among the families with whom they work. No other professionals, with potential exception of medical practitioners, have the opportunity to intervene, and to be a force of prevention in the areas of children’s deaths. Presumably, such work cannot be achieved without adequate training, education, and preparation to recognize and respond to risk. That said, the literature is largely silent on the preparation CWWs receive that would enable them to prevent the worst outcome in child protection work: the death of a child. Thus, this exploratory study assessed:

1. The knowledge of child welfare professionals concerning risk factors for maltreatment;
2. If receipt of training is associated with higher levels of knowledge; and
3. CWWs’ practice concerns regarding CMFs, including worrying about a child dying or threats made by parents.

These analyses were completed on a multi-state sample of 426 CWWs. The literature offers no foundation for advancing hypotheses, outside of the presumption that those who have received training will have more knowledge of maltreatment fatalities.

## METHODS

### Procedure

Data for this study were collected as part of a larger study, *Child Maltreatment Fatalities: Perceptions and Experiences of Child Welfare Professionals* (CMF-POCHIWP), from September 2010–January 2011. CWWs and managers were recruited to participate in an online survey that focused on CWWs' perceptions of and experiences with CMFs. Potential participants were recruited through (1) online advertisements (e.g., Child Welfare League of America), and (2) postings on the Facebook pages of the National Association for Social Work and of chapter affiliates. Most responses, however, came from (3) announcements that were made to the Child Maltreatment Research Listserv (maintained by the National Data Archive on Child Abuse and Neglect, Cornell University), where members in the field forwarded the recruitment statement to workers and supervisors, and (4) through direct appeals that were emailed to the most appropriate and easily identified agency administrator in each state.

Individuals who responded to the solicitation were directed to the online survey, which was created using Survey Monkey. Potential participants were informed of their rights as a participant in the study, including that some of the questions may cause them distress. Individuals were assured that they could skip any questions that they liked and cease participation at any time. On the final page of the survey participants were given resources to national hotlines and websites where they could seek assistance for psychological distress should they need it after taking the survey. The methods for this study were approved by the Institutional Review Board at Bridgewater State University. Responses were received from 493 CWWs, only 452 of which were complete enough to retain for analysis. Among those 452 individuals, 26 were no longer CWWs. Thus, this study reports on the findings concerning 426 current CWWs.

### Participants

Table 1 shows that 27.8% of the predominantly female (89.8%) child welfare workers in this sample identified as a racial or ethnic minority, with the largest percent being African Americans/Blacks (17.0). The remainder (75.5%) of the child welfare workers identified as White. The sample of

**TABLE 1** Demographic Characteristics of Study Participants ( $n = 426$ )

| Demographic characteristic                                | Percent/mean (SD) |
|---|-------------------|
| Age—Mean (SD)   | 41.30 (10.71)     |
| Gender—Female (Percent)                                   | 89.8              |
| Race/Ethnicity <sup>a</sup>                               |                   |
| American Indian   | 1.7               |
| Asian   | 3.3               |
| African American/Black                                    | 17.0              |
| Latino/Hispanic   | 6.6               |
| Pacific Islander  | 0.7               |
| White   | 75.5              |
| Education (degree)  |                   |
| Associate's   | 0.9               |
| Bachelor's  | 48.6              |
| Master's  | 50.5              |
| Specialization area                                       |                   |
| Social work   | 57.4              |
| Human services  | 4.5               |
| Other social science field                                | 31.8              |
| Other   | 6.4               |
| State of employment                                       |                   |
| North (CT, ME, NY, PA)                                    | 10.8              |
| Midwest (IL, MI, ND, OH, WI)                              | 15.7              |
| South (AL, DC, GA, LA, MD, NC, OK, TX, VA, WV)            | 43.7              |
| West (AK, CA, CO, OR, WA, WY)                             | 29.8              |
| Experienced child maltreatment fatality (CMF) on caseload | 27.2              |

<sup>a</sup>Numbers do not tally to 100%. Participants were instructed to select all that apply.

CWWs was mid-career with a mean age of 41.3; the sample was also well educated, with 48.6% reporting that they had a bachelor's degree and 50.5% had a master's degree. The majority of the sample had a degree in social work (57.4%) or human services (4.5%), followed by a degree in another social science discipline (31.8%) or a degree in another field (6.4%). The CWWs came from 25 different states, with large percentages of workers coming from California, North Carolina, Wisconsin, Louisiana, and New York. More than 25% of the sample (27.2%) had experienced a CMF on a caseload.

### Instrument

The survey asked participants about their understanding of risk factors for CMF, opinions about CMFs, training and practice concerns regarding CMFs, their experiences with having a child die on their caseload, and demographic characteristics. The survey also included an assessment of their practice behaviors and a measure of their trauma symptomatology, which are not relevant to the present article. The survey questions pertaining to knowledge and opinions were developed from a review of the literature about CMFs (Douglas, 2005; Graham et al., 2010; U.S. Department of Health &

Human Services, 2011), much of which was presented in literature review for this study. Specifically, the instrument was designed to ask about five different types of risk factors and knowledge concerning CMFs: (1) child risk factors, (2) parental risk factors, (3) parent-child relationship risk factors, (4) household/environment risk factors, and (5) maltreatment classification for children's deaths and perpetrator relationship to victim. The survey was pretested on a small sample of caseworkers and supervisors in Massachusetts and Texas before full implementation. At the start of the survey, participants were introduced to the topic of the study and given the definition that is used by the National Child Abuse and Neglect Data System:

For clarification, a child maltreatment fatality (CMF) is: "a child dying from abuse or neglect, because either (a) the injury from the abuse or neglect was the cause of death, or (b) the abuse and/or neglect was a contributing factor to the cause of death."

Further, before addressing the questions relevant to this article, workers were given the following set of instructions:

Child maltreatment fatalities, (CMFs), or when children die from maltreatment have been receiving increasing levels of attention in the past few decades. There is still much to be learned, however, and we want to know what your experiences have taught you about CMFs. Some of the questions address which children might be more or less at risk. Other questions address who might be responsible when a child dies and is known to protective services. Please don't worry about answering these questions "correctly." We want to know your most honest thoughts, perceptions, and opinions on this important topic.

This article describes the results for 25 questions from the CMF-POCHIWP study. Eight questions asked about worker demographic characteristics and whether they had experienced a CMF on their caseload, including: age, gender, race/ethnicity, education level, educational specialization, and the state in which they currently work. The survey included questions about worker knowledge or risk, their opinions about CMFs, and their practice experiences/concerns with regard to CMFs. All of these questions asked CWWs to rate the extent to which they agreed with each statement on a scale of 1–4, where 1 = Strongly Disagree, 2 = Disagree, 3 = Agree, and 4 = Strongly Agree. Most questions, nine, concerned workers' knowledge of the parent, child, parent-child relationship, and household risk factors for CMF. For example, "Families that move a lot are more likely to suffer a CMF," and "Parents who kill their children often have inappropriate age expectations of their children." Specifically, four questions targeted parental risk factors; one targeted child factors, two targeted household factors, and a final two targeted the parent-child relationship. Further, six questions were posed as

accurate statements; three were posed as false statements so that workers could not simply agree with each statement. Three questions addressed workers' opinions, such as, "Children who are killed by their caregivers aren't really any different from other children in the child welfare system. It's a freak occurrence that could happen to any of our children." An additional three questions focused on practice concerns, such as "I worry that a child on my caseload will die," and "When I work with a family, I look for signs that might cause a child to die." Finally, one question focused on receipt of training: "I have received training on CMFs," which was the basis of comparison for level of knowledge. Finally, one open-ended question was posed to the workers at the end of the survey: "What can the child welfare profession do to better prevent future child maltreatment fatalities?"

## Data Analysis

### QUANTITATIVE ANALYSIS

To aid in the ease of interpretation, the responses to questions were dichotomized: where Strongly Agree/Agree with statement = 1 and Strongly Disagree/Disagree = 0. This permitted one to determine the percent of CWWs who correctly identified each risk factor. A  $2 \times 2$  chi-square analysis, with significance testing, was also completed to compare responses between workers who had received training and those who had not.

### QUALITATIVE ANALYSIS

Responses to the open-ended question were coded by a graduate research assistant, under the supervision of the author, using emergent content analysis (Stemler, 2001). We initially developed codes using the first 50 open-ended responses. All of the responses were then categorized using those codes, revising them and/or establishing new ones to more accurately capture the essence of the responses. Any responses that were unclear were discussed until agreement was reached. Codes that had similar content were consolidated into larger response categories, for example, "conducting comprehensive assessment" and "engaging with families more" were collapsed into "practice behaviors."

## RESULTS

Table 2 displays CWWs' responses to questions pertaining to their knowledge, opinions, and concerns regarding CMFs. The far left column shows the full question that was asked; the second column indicates whether this question was accurate, opinion, or experiential; the third column shows what percent agreed with the statement (even if it was false); columns four and



**TABLE 2** Child Welfare Workers' Knowledge of Risk Factors for and Practice Concerns Regarding Child Maltreatment Fatalities (CMFs)

| Question <sup>a</sup>   | Statement accurate, experiential, or opinion | Received training on CMF   |                                   |  | $\chi^2$ |
|---|--|----------------------------|-----------------------------------|--|----------|
|   |  | % of all workers who agree | % who received training who agree | % who did not receive training who agree |          |
| Knowledge of Risk Factors   |  |                            |                                   |  |          |
| Mothers are the ones who are most likely to kill their children   | Accurate                                     | 20.0                       | 21.9                              | 13.5                                     | 3.63*    |
| Most parents who kill their children do not have mental health problems, diagnosed or otherwise   | False  | 19.4                       | 22.2                              | 10.6                                     | 7.14**   |
| Most children are usually killed by physical abuse (as opposed to neglect or another type of maltreatment)  | False  | 58.4                       | 59.7                              | 55.4                                     | .65      |
| Children are most likely to be killed by a non-family member (such as mother's boyfriend)   | False  | 62.3                       | 63.2                              | 60.2                                     | .33      |
| Younger children are more at-risk for CMFs than older children  | Accurate                                     | 93.6                       | 94.1                              | 92.0                                     | .56      |
| Parents who kill their children often have inappropriate age expectations of their children   | Accurate                                     | 86.0                       | 87.0                              | 83.2                                     | .99      |
| Parents who kill their children probably saw their child as "difficult" or ill behaved in general   | Accurate                                     | 71.3                       | 72.1                              | 69.0                                     | .37      |
| Children are more at risk for a fatality when they have non-family members living in their homes with them  | Accurate                                     | 61.4                       | 63.0                              | 58.2                                     | .78      |
| Families that move a lot are more likely to suffer a CMF  | Accurate                                     | 47.0                       | 44.8                              | 55.0                                     | 3.37*    |
| Opinions about CMFs   |  |                            |                                   |  |          |
| I am not sure that I know what the risk factors are for a CMF   | Opinion                                      | 14.4                       | 7.6                               | 32.7                                     | 41.98*** |
| I would like additional training about the risk factors for CMFs <sup>a</sup>   | Opinion                                      | 90.1                       | —                                 | —  | —        |
| Children who are killed by their caregivers aren't really any different from other children in the child welfare system. It's a freak occurrence that could happen to any of our children | Opinion                                      | 39.4                       | 40.7                              | 36.3                                     | .66      |
| Practice Experiences and Concerns Regarding CMFs  |  |                            |                                   |  |          |
| I worry that a child on my caseload will die  | Experiential                                 | 71.7                       | 70.7                              | 75.0                                     | .76      |
| When I work with a family, I look for signs that might cause a child to die   | Experiential                                 | 92.5                       | 94.0                              | 88.3                                     | 3.76*    |
| A parent on my caseload once told me that s/he might kill her/his child(ren) <sup>b</sup>   | Experiential                                 | 28.2                       | —                                 | —  | —        |

<sup>a</sup>Questions are presented here as they were in the questionnaire.

<sup>b</sup>There was no reason to believe that responses to this question would vary by receipt of training. Significance testing was not conducted.

\* $p \leq .10$ ; \*\* $p \leq .01$ ; \*\*\* $p \leq .001$ .

five compare results between those with and without training; the final right column displays whether those differences were statistically significant as indicated by chi-square analysis. Almost three-quarters, 72.8%, of the sample reported receiving training about risk factors for CMFs. This variable was used to compare results between respondents.

### Knowledge of Risk Factors and Influence of Training

CWWs knowledge concerning risk factors for CMFs, varies considerably. Workers were most knowledgeable about risk factors concerning children's age, parental mental health, and the parent-child relationship (having age-inappropriate expectations of their children). There were large gaps in some areas of knowledge, such as the perpetrators of CMFs and their relationships to the victims, most prevalent cause of death, and environmental/household risk factors.

The final column of Table 2, where the chi-square analyses are presented, indicates that the receipt of training had minimal effect of level of knowledge. The only knowledge area which rose to statistical significance ( $p \leq .05$ ) was associated with a *less accurate knowledge*. CWWs who had received training were more than twice as likely to erroneously agree that parental mental illness is not a risk factor for CMFs. The receipt of training produced a trend toward significance in recognizing that mothers are more likely responsible for their children's deaths, and that families who move are more likely to suffer a CMF. Despite this finding, only 14.4% of CWWs agreed that they might not know risk factors for CMFs; those who had received training on CMFs were significantly less likely to agree with this statement.

### Opinions and Practice Concerns

Approximately 40% of the sample believed that a CMF is a freak occurrence that can happen to any children in the child welfare system. Approximately 72% of the sample reported worrying that a child on her/his caseload will die and 92.5%, reported assessing for potential risk of fatality when working with families. There was a trend toward significance that those who had received training were more likely to assess for risk factors. More than a quarter (28.2%) reported that a parent once disclosed the potential intent to kill her or his children. The vast majority of the sample, 90.1%, reported wanting more training about the risk factors for CMFs.

### Areas for Prevention

Workers were also asked to volunteer their own opinions about what the child welfare profession could do to prevent CMFs. The content analyses resulted in eight categories of prevention:

1. Child welfare workforce—smaller caseloads, need for more competent workers ( $n = 78$ , 18.31%): *Keep workers from carrying high case loads so that they have the time to give each case the consideration it deserves; and We need to be able to get rid of problem workers so that the good workers do not have to be hand selected to carry the most difficult cases and the highest numbers. It is impossible to get rid of problem workers. They are protected.*
2. Increase training for workers—training about risk factors ( $n = 66$ , 15.49%): *More training for sure. Our agency holds Roundtables for difficult cases. This is very helpful. It makes you feel like you are not alone; and More trainings on risk factors and community education of risk factors.*
3. Public education—education about healthy relationships, child welfare work ( $n = 61$ , 14.55%): *Inform the media and the public about the importance of the needs to protect children and that all community agencies need to better work together without shame and or blame; and More education on how to parent and interact rather than focus on discipline.*
4. Practice behaviors—conducting comprehensive assessment, engaging family more ( $n = 35$ , 8.22%): *Stress the need for face to face contact with all household members; and Do a full social work assessment at each home call. Do not assume that you know the family and therefore know the current risk level. Also, take all referrals and/or new info seriously. Do not make up your mind about the outcome prior to investigating.*
5. Resources/Services for families—expanded services for vulnerable families ( $n = 33$ , 7.75%): *Provide more intervention services for parents. Education of parents to learn healthier ways to relieve stress, choose a healthier partner, and what defines a healthy relationship and an unhealthy, abusive relationship. More parenting classes that teach developmental levels of children and what risks there are at certain ages; and We need preventative services that involves [sic] community and community partners [sic] especially mental health problems.*
6. More supervision and support for workers—more guidance on how to handle high risk cases ( $n = 26$ , 6.10%): *Teach team decision making models so there is shared responsibility when return home of children is in question; and There is a constant feeling of not being supported by administration, never being able to catch up, etc. If we are dealing with this stress, we can't be as alert to potential problems. We also develop an [sic] "don't care" attitude, which could contribute to a child's death. It's not that we don't care if a child dies or is maltreated (we do!) but we can't do everything well!*
7. Child welfare policy—changes in agency, county, or state child welfare policy ( $n = 24$ , 5.40%): *Confidentiality laws surrounding child welfare and the inability to share case information with other resources such as public health, mental health, domestic violence professionals and pro-*

*bation/parole. This creates a lag in the intervention process and creates holes in the ability to accurately assess a family's situation; and Looking at gaps between county and state agencies and looking at gaps between county agencies. Look at how partners work together and communicate the needs of the family.*

8. Research to better identify risk factors ( $n = 6, 1.41\%$ ): *Continue research and share knowledge of risk factors or "red flags" that alert to risk of CMFs; and Data that supports [sic] risk factors associated with Child Fatalities. Data that supports [sic] preventative measures that reduce incident of child maltreatment.*

## DISCUSSION

The purpose of this study was to assess CWWs' readiness to act as agents of prevention concerning CMFs. Specifically, it examined the knowledge, opinions, and practice concerns of CWWs with regard to CMFs, and explored whether the receipt of training influenced knowledge of risk factors and practice concerns. Workers' knowledge of risk factors for CMFs varied considerably, and the receipt of training had a minor impact of level of knowledge. Most CWWs worried that a child will die on their caseloads; they actively assessed for risk, but also reported wanting additional training.

### Training

Approximately 75% of the sample reported having received training on CMFs. However, 14% of the sample reported feeling insecure in their level of knowledge concerning risk factors for fatality. Workers who had received training were more likely to have confidence in their knowledge. The literature has addressed child welfare training in general (Antle et al., 2009; Franke, Bagdasaryan, & Furman, 2009; Keys, 2009) but has not covered training for maltreatment fatalities, so it is difficult to know if this finding is representative of all workers. It is also not clear if this training was provided during pre-service training or through special workshops or conferences. The vast majority of workers (90%) reported wanting more training about risk factors for fatalities.

### Knowledge of Risk Factors

There was a wide range in knowledge of risk factors for CMFs. Workers were most knowledgeable about children's age as a risk factor and also that parents of fatality victims often have age-inappropriate expectations of their children. Workers had considerably less knowledge concerning parental and perpetrator risk factors. Depending on the phrasing of the question

only approximately 20% to 33% of the sample accurately identified the most common perpetrator of CMFs (mothers), and less than 50% of the sample accurately identified the method by which children most commonly die (neglect). The results of this analysis indicate that workers appeared to believe that children are most commonly killed by non-family members and a small majority believed that they mostly die as a result of physical abuse. Research on CMFs is still developing, but two of the most consistent findings of research on child welfare-related fatalities are that mothers are most often the perpetrators of maltreatment fatalities and that the most common cause of death is neglect. As noted in the introduction to this article, in 2009 parents were the perpetrators of CMFs in 76% of cases; mothers were responsible for the deaths, either solely or in combination with another person in 60% of cases; fathers were responsible in 39% of cases (U.S. Department of Health & Human Services, 2010). Further, neglect was a cause of death, either solely, or in combination with other causes, in 67% of CMFs. It is possible that the phrasing of the survey questions influenced the answers that CWWs provided. The survey used the word *kill*, such as “Mothers are the ones who are most likely to kill their children.” It is possible that workers interpreted the word *kill* to mean action, as opposed to inaction. If the question had been phrased, “Mothers are most often responsible for the deaths of their children,” it is possible that respondents may have answered differently.

Knowledge concerning the risks of the parent-child relationship was more accurate. At least 71% of the sample accurately identified parent-child characteristics that would be considered risks. CWWs had less knowledge of household risk factors. Between 33% to 50% of the sample was inaccurate in their assessment of household risk factors.

Research from other professional fields shows that there is often limited knowledge about risk factors for a variety of other causes of fatalities. For example, only 20% of nighttime childcare centers follow the recommendations of the Centers for Disease Control and Prevention concerning placing babies “back-to-sleep” (Moon, Weese-Mayer, & Silvestri, 2003). Similarly, a study of health providers found that almost two-thirds of the sample reported not knowing the causes of or strategies for preventing still births (Ojofeitimi et al., 2009). Health care providers’ knowledge concerning the lethality of certain types of cancers is sometimes lacking (Rim et al., 2009), as is physicians’ understanding of risk associated with youth taking antidepressants (Cordero, Rudd, Bryan, & Corso, 2008), and providers’ knowledge of youth suicide (Baber & Bean, 2009). Thus, to the extent that this study is representative of CWWs in general, they are not alone in their misunderstanding concerning risks for fatality, but their lack of knowledge is a reason to provide more education.

Training did not have an important influence on the level of knowledge that workers had concerning CMFs. There were several trends toward significance, but the only statistically significant difference concerned knowledge

of mental health problems as a risk factor of fatalities. Workers who had received training were *less likely* to accurately identify this as a risk. Further research is needed to either replicate this finding or to better understand the meaning behind this result. The child welfare profession, in general, is increasing research on training and this is another area which deserves increased attention (Collins, Amodeo, & Clay, 2008; Curry, McCarragher, & Dellmann-Jenkins, 2005; Franke et al., 2009).

### Opinions About CMFs

The survey also asked if workers thought that children who died were “the same” as children who did not die, and that CMF is a freak event that could happen to any child involved in the child welfare system. Approximately 40% of workers agreed with this statement and receipt of training did not have an impact on this belief. This question was included as an opinion; there is no research that indicates the extent to which children who die are “the same” or “different.” That said, some research reports children who are killed are seen as being more difficult than children who do not die (Chance & Scannapieco, 2002; Graham et al., 2010). This might be an indicator that children who die are indeed “different,” at least, according to their parents. This particular finding may have important implications for practice, however. Workers who believe that a CMF is a freak occurrence may be less likely to see themselves as agents of prevention, less likely to assess for risk and to take action when it is warranted. Further, the literature does support a relationship between attitudes/beliefs and practice behaviors (Arad-Davidzon & Benbenishty, 2008; Smith, 2008). Thus, better understanding workers’ attitudes concerning CMFs and their practice behaviors is an area for future research.

### Practice Concerns

Almost three-quarters of workers in this sample worried that a child on their caseload will die and the vast majority reported assessing for risk of fatality when they work with families. These findings did not vary based on the receipt of training by the worker.

A substantial proportion of workers, 28%, had a parent disclose a potential intent to kill his or her child. This study is the first time that this practice event has been measured, thus it is impossible to know if this finding is consistent with other research. The finding is, however, alarming and speaks to many of the high-risk and complex family situations that child welfare professionals encounter. Future researcher may want to explore how workers respond in such situations: did they consult with a supervisor, conduct another risk assessment, make a safety contract with the parent, remove the children, etc.

## Limitations

This study is not without limitations. First, it is based on a convenience sample of CWWs and is not representative of all workers nationwide or workers in their respective states. The sample is, however, similar to a national sample of CWWs (Barth et al., 2008). The sample for the present study has a lower proportion of male participants, is less racial/ethnically diverse, and is better educated than compared to a national sample of workers. Second, the workers who were recruited by agency directors or the workers themselves could have a special interest in CMFs, which may influence the findings of this study. Third, this survey addressed some of the risk factors for fatalities, but not all. Fourth, there was a low response rate on the open-ended questions pertaining to suggested areas for prevention. This may reflect workers' limited time to devote to research inquiries or because it was one of the final questions on the survey. Fifth, this study, assessed for the influence of training on workers' knowledge. The survey did not inquire about the extent of training, how long ago it took place, the duration, or method of training. Finally, as previously noted, the wording of some of the survey questions could have influenced the way workers interpreted the questions. For example, using the word *kill* instead of the phrase *responsible for death* may have implied action versus inaction, as might be suggested in neglect cases.

## CONCLUSION AND RECOMMENDATIONS

This study is the first to assess the knowledge, training, opinions, and practice concerns of CWWs concerning CMFs. The results of this multi-state study indicate that the majority of workers received training, but the vast majority of the sample would like additional training on risk factors for fatalities. Based on the findings of this study, knowledge concerning risk factors for maltreatment fatalities should be improved. The largest deficits were in areas of parent risks, household risks, and the manner by which children die. Workers were more accurate in their knowledge concerning the parent-child relationship and the age of the child as a risk factor. The receipt of training was not related to workers' level of knowledge or practice concerns. The following recommendations are offered to both researchers and practitioners.

### For Members of the Research Community

CMFs have been studied decades and yet knowledge concerning risk for CMFs and the efficacy of prevention efforts is in its infancy. For example, there is still a need to learn if there are differences in risk factors among children who are known and unknown to protective services so that other

providers can assess for potential fatality. Further, research on workers' knowledge, opinions, and practice concerns should be replicated and expanded so that we can better understand how these factors may, or may not be related to CMFs. Research which examines the effectiveness of training models and if which trainings may result in a higher level of knowledge would also be an excellent addition to the field. Finally, the field might consider how workers respond when faced with high levels of risk for fatality or when a parent discloses the potential to harm her or his children. Better understanding these practice behaviors may help to keep more children safe.

### For Members of the Practice Community

The results of this study indicate that there may be serious deficits in CWWs' knowledge of risk factors for CMF. These deficits are not the fault of individual workers or supervisors, but rather reflect a larger systems problem. It is possible that the knowledge of some workers' may be driven in large measure by what is featured in the media, as opposed to evidence that is produced by research. Approximately 90% of workers in this study wanted additional training on risk factors for CMFs. Practicing without adequate knowledge places children at risk and also places CWWs in difficult professional situations, where they may be unprepared for the work that they encounter, and unable to be effective agents of prevention.

### For Both the Research and Practice Communities

This exploratory study provides the first glimpse into CWWs' understanding of risk factors and of their practice experiences concerning CMFs. Knowledge of risk factors is, of course, only a first step in preventing CMFs. In addition to knowledge, the assessment tools that are used by CWWs may also need to be examined to ensure that they adequately capture risk for CMFs. The field would want to ensure that they serve to bridge any gaps in knowledge by providing direction and guidance for all workers, or for when our background, education, and training has been limited. Further, both the practice and research communities will benefit from better knowledge about the effectiveness of trainings within the profession. The field has incomplete information concerning how workers respond when they are faced with risk for fatality and why they pursue any particular course of action. These areas of child welfare practice may be as important, if not more important than our understanding of worker knowledge, and they deserve attention by researchers and practitioners alike. Recent attention to CMFs by both the U.S. Congress (2011) and the U.S. Government Accountability Office (2011) make this an excellent time to focus on maltreatment fatalities through increased resources and to better integrate our knowledge with training for developing and current child welfare professionals.



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