PUBLIC COMMENT

Government Oversight Committee
Maine's Child Protection System:
A Study of How the System Functioned in Two Cases of Child Death by Abuse in the Home

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My name is Emily Douglas. I'm a full professor and head of the Department of Social Science & Policy Studies at Worcester Polytechnic Institute in Massachusetts. I grew up in Maine and lived here for 35 years before leaving for employment outside the state. I am a national expert on children who die from abuse or neglect. I have published more academic papers on this one dark topic, than anyone else in the country and my last book focused on the policy, program, and professional responses to child fatalities. I have testified before the Congressionally-created National Commission to End Child Abuse and Neglect Fatalities and last year I was a Congressional fellow, working in Washington for the U.S. Senate Finance Committee on child welfare policy. But, I got started studying children and their welfare right here in Augusta, Maine, when as a graduate student, I worked for the Maine Child Death & Serious Injury Review Panel. It's where I first learned how compromised families can be, how well-intentioned service providers can miss opportunities to take protective action, and how children can fall through the cracks. For me, my interest and expertise in this topic started here in Augusta and I have been studying this tragedy now for close to two decades. Today I want to briefly comment on the report issued by the Office of Program Evaluation & Government Accountability concerning the deaths of Kendall Chick and Marissa Kennedy.

Official statistics from the U.S. Department of Health & Human Services tell us that annually 1,500 - 2,000 children die from maltreatment every year. [1, 2] We know that these statistics are undercounted and that it is likely many more. A death related to abuse or neglect is more than a tragedy. It is incomprehensible and can leave us feeling enraged and hopeless. Nevertheless, Maine usually performs relatively well in this area, with one to three children dying each year. [3] And, even though it is cases of physical abuse that bring us all together today, across the nation, more children die from physical neglect than physical abuse. [3] Abuse is more lethal, but less common, thus fewer children die this way. [4] What else do we know about children who die from abuse or neglect? We know that there are categories of risk – in the areas of child risk factors (e.g., age), parent/caregiver risk factors (e.g., unemployment, mental health concerns, low knowledge of child development), the parent-child relationship (e.g., parents who see their children as difficult), and household risk factors (e.g., being especially mobile, having non-family members residing in the home). [3-7]

I have worked with child welfare professionals in trainings, as a CASA guardian *ad litem*, taught countless current and future child welfare workers, and still today conduct reviews on cases where children in Massachusetts live in foster care. I am a friend of the child welfare workforce. But, my research shows that we do not adequately prepare them for their jobs. In two studies that I conducted, with over 1,000 child welfare workers participating from across the country, I found that there are serious deficits in their knowledge of risk factors for maltreatment fatalities. [8, 9] I asked workers about their knowledge of the type of risk factors that I just mentioned. Specifically, I asked about nine or ten risk factors and in four or five instances only 50% or more were able to accurately identify a risk. That's right, for half of the question, half of the participants got the answers wrong. To make matters worse, about 70% of the participants reported that they had received training

about risk factors, but it rarely made a difference in their level of knowledge. At the same time, the vast, vast majority, above 90%, said that they worry that a child on their caseloads will die, that they look for what they think are risk factors for death when they work with children and families, and that they want more training. Can you imagine working in such a high-stakes profession and not having the best knowledge and research tools to adequately do your jobs? Child welfare workers can. Just ask them what it's like.

I've made this the central focus of my statement here today, because I noted in the report by OPEGA that there was no specific mention or discussion about workforce training, knowledge, or skillset for recognizing risk factors for maltreatment death. There are several references to supervision of workers, which is excellent. It's not enough to train a workforce. They need regular and ongoing supervision. [10] Training may be perceived as a dichotomous entity – trained or not trained. But, in truth, knowledge retention is achieved when it is incorporated in daily work skills and referenced in supervision on a regular basis.

All states suffer the tragedy, outrage, and embarrassment of a child maltreatment death. One doesn't have to look too far to see that many other states are grappling with these same events and that truly, no state escapes. Or, no state has escaped so far. The pressure to do something immediate, to produce results, and to show the public that the outrage is shared at all levels of government is crushing, for all. Sometimes this results in substantive changes, such as new assessment techniques or collaborations between different agencies or professional groups. Other times it results in surface-level changes, like the change of an agency name. But, it always results in tremendous pressure on the child welfare workforce. [11, 12] They question their decisions, skill set, and motives – desperate not to appear in the next round of headlines. If a child dies in foster care, suddenly more children will remain with their birth parents. And, if a child dies at the hands of their parents, suddenly more children will be removed and placed in foster care. [13] The scramble to do the right thing is panic-inducing. I'm not suggesting that these informal practice changes can be completely avoided. But, what I am saying is that workers across the nation have deficits in their knowledge of risk factors and an overwhelming percent of workers want training. My guess is that the same thing is true of workers here in Maine. So, I recommend that as part of the investigation into the deaths of Kendall and Marissa, that the entities who are empowered to do so, determine the level of training that workers have received around fatal child maltreatment and their knowledge in this domain. And, ultimately, yes, that the State of Maine gives workers what they want around training. Help them develop a "child maltreatment fatality lens." Be a national leader. Give workers research-based training in risk factors for child maltreatment fatalities and then incorporate that into their daily child welfare practice skills.

Thank you for giving me the opportunity to speak today.

References Cited

1. Herman-Giddens, M.E., et al., *Underascertainment of child abuse mortality in the United States.* JAMA, 1999. **282**(5): p. 463-467.
2. Ewigman, B., C. Kivlahan, and G. Land, *The Missouri fatality study: Underreporting of maltreatment fatalities among children younger than five years of age, 1983 through 1986.* Pediatrics, 1993. **91**(2): p. 330.
3. U.S. Department of Health & Human Services, *Child maltreatment 2015: Reports from the States to the National Child Abuse and Neglect Data Systems - National statistics on child abuse and neglect*. 2017,

Administration for Children & Families, U.S. Department of Health & Human Services: Washington, D.C.
4. Douglas, E.M., *Child maltreatment fatalities in the United States: Four decades of policy, program, and professional responses*. 2016, New York: Springer.
5. Korbin, J.E., *Incarcerated mothers' perceptions and interpretations of their fatally maltreated children.* Child Abuse & Neglect, 1987. **11**: p. 397-407.
6. Chance, T.C. and M. Scannapieco, *Ecological correlates of child maltreatment: Similarities and differences between child fatality and nonfatality cases.* Child and Adolescent Social Work Journal, 2002. **19**(2): p. 139-161.
7. Fein, L.G., *Can child fatalities, end product child abuse, be prevented?* Children and Youth Services Review, 1979. **1**: p. 31-53.
8. Douglas, E.M., *Child welfare workers' training, knowledge, and practice concerns regarding child maltreatment fatalities: An exploratory, multi-state analysis.* Journal of Public Child Welfare, 2012. **6**(5): p. 659-677.
9. Douglas, E.M. and M.K. Gushwa, *Child welfare workers' knowledge of risk factors for child maltreatment fatalities: A second multi-state assessment.* Human Service Organizations: Management, Leadership & Governance, In Review.
10. Frey, L., et al., *The pivotal role of child welfare supervisors in implementing an agency's practice model.* Children & Youth Services Review, 2012. **34**(7): p. 1273-1282.
11. Regehr, C. *Public inquiries into deaths in care: Effects on emergency responders*. The Australasian Journal of Disaster and Trauma Studies, 2003. **2003-1**.
12. Regehr, C., et al., *Inquiries into deaths of children in care: the impact on child welfare workers and their organization.* Children and Youth Services Review, 2002. **24**(12): p. 885-902.
13. Gelles, R.J., *The book of David: How preserving families can cost children's lives*. 1996, New York: Basic Books.