The American Professional Society on the Abuse of Children
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THE NEW YORK FOUNDLING
Strengthening Practice Through Knowledge

Understanding CHILD MALTREATMENT 2016

US Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau (2018) Child Maltreatment 2016

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About the American Professional Society on the Abuse of Children

Founded in 1987, the American Professional Society on the Abuse of Children (APSAC) is a nonprofit, national organization whose mission is *to improve society's response to the abuse and neglect of its children by promoting effective interdisciplinary approaches to identification, intervention, treatment and prevention of child maltreatment.*
APSAC is strongly committed to:

- Preventing child maltreatment
- Eliminating the recurrence of child maltreatment
- Promoting research and guidelines to inform professional practice
- Connecting professionals from the many disciplines to promote the best response to child maltreatment
- Ensuring that America's public policy concerning child maltreatment is well informed and constructive
- Educating the public about child abuse and neglect

In 2016 APSAC entered a partnership with The New York Foundling.

About the APSAC Center for Child Policy

The mission of the Center for Child Policy, a program of The American Professional Society on the Abuse of Children is to translate the best available research findings into useable resources that promote best practices in all professions involved with child maltreatment. We believe that all professionals working with children and families involved in child maltreatment need access to quality information, based on the best available data, that they can translate into useable solutions to solve their most critical policy and practice issues.

About this Report

This is the 6th edition of this report, originally commissioned by Prevent Child Abuse America. This paper is distributed to help ensure that data published in the Child Maltreatment annual series is interpreted and applied considering aspects of its reliability and validity. The annual release of the Child Maltreatment reports provides an opportunity for advocates to highlight issues within the Child Protective Services systems including wide variations among states in definitions, policy and practice, millions of screened out cases, the relative costs of prevention, the overwhelming presence of child neglect in the system and other timely issues

Acknowledgements

Special thanks to Lauren Biagioli for editorial support, and Kathleen Faller, PhD, Chair of the APSAC publications committee for review and comment.

Understanding Child Maltreatment 2016

Child Maltreatment 2016 is the 27th edition of a report on the status of child maltreatment in the United States published by Administration for Children Youth and Families, Children's Bureau (ACF) of the U.S. Department of Health and Human Services. For the past five years, the national office of Prevent Child Abuse America provided an analysis of this high-profile report to support the chapters and Healthy Families America networks in understanding the contents of the report, applying the findings to their community, and using the findings to support advocacy for prevention services. This edition is being produced by The American Professional Society on the Abuse of Children (APSAC) to increase the reach and impact of this report.

General Observations:

Child Maltreatment 2016 provides an estimate of 676,000[1] victims of child abuse and neglect known to CPS agencies throughout the United States who received an intervention in federal fiscal year 2015: "Three-quarters (75.3%) of victims were neglected, 18.2 percent were physically abused, and 8.5 percent were sexually abused."[2] "In Federal fiscal year 2016, approximately 3.5 million children were the subjects of at least one report; a total of 17.2% of children were classified as victims with dispositions of substantiated and indicated."[3]

Using very similar language to the prior year announcement, the press release accompanying the report offered the following: "Newly released federal data on child abuse and neglect shows an increase from Fiscal Year 2015 to 2016 in three key metrics: referrals to child protective services (CPS) agencies alleging maltreatment (3.6 percent), referrals CPS agencies accepted for investigation or alternative response (4.0 percent) and the number of children who were the subject of an investigation or alternative response (3.3 percent)."[4]

Prior editions of this paper, Understanding Child Maltreatment have consistently noted that data from the NCANDS system are unsuitable for trend analysis given self-reported changes by states and the changes made to annual national totals in subsequent years' reports as states submit late or corrected data.

Estimating Costs:

A 2012 study commissioned by Prevent Child Abuse America estimated that the national cost of child maltreatment exceeds $80 billion annually. Adjusted for inflation using the Consumer Price Index, this figure for 2016 is estimated to be $87.2

[1] CM 2016, Page xii
[2] CM 2016 Page ii
[3] CM 2016 page x
[4] https://www.acf.hhs.gov/media/press/2018/child-abuse-neglect-data-released

billion. A study published by the U.S. Centers for Disease Control and Prevention estimates the lifetime cost of a single case of non-fatal child maltreatment at $210,012 in 2010 dollars.[5] Adjusted for inflation, that cost in 2016 would be $234,618.

This paper contains a table applying these highly credible cost figures to the current CPS child maltreatment data in each state.

Child Maltreatment 2016 is derived from a dataset created by compiling Child Protective Services (CPS) data from all fifty states, Washington DC, and Puerto Rico. The lack of a uniform definition of child maltreatment is a weakness in using this report as an indicator of anything beyond state-level Child Protective Services activity. This is particularly true for child sexual abuse, where the age of or relationship to an alleged perpetrator is a factor in being classified as a CPS case; policies and practices vary among states.

Another limitation is the number of states reporting changes in policy or technology, rendering it unwise to use their state's data to assess trends. In FFY 2016 11 states reported that changes in policy, practice, or technology made their data unsuitable for trend analysis, (CT, IN, KS, MN, MS, NM, OH, OR, PA, PR, SC). An additional 7 states (AL, AK, AZ, DE, LA, MA, OK) reported changes that could possibly have an impact. Please see Attachment 1 for a state-by-state review.

Data in this report can be used as descriptive data for advocacy or public education efforts, but it is recommended that a state's data representative, as identified in the State Commentary section of Child Maltreatment 2016, be contacted before using this data for research or technical analyses.

Policy Considerations:

Even with the limitations, data from Child Maltreatment 2016 has important implications for advocates:

- **The field needs a current National Incidence Study (NIS-5)**

The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), a project which uses multiple sources of data, estimated a decrease in the number of maltreated children between NIS-3 in 1996 and NIS-4 in 2006, with a significant decline in abuse, but not neglect.[6] When considering both the long-term trends

[5] See https://www.cdc.gov/violenceprevention/childmaltreatment/economiccost.html

[6] NIS-3 1996 harm standard estimate 1,553,000; NIS-4 2005 harm standard estimate 1,256,600 The number of children who experienced Harm Standard abuse declined significantly, by 26%, from an estimated 743,200 (*11.1 abused children per 1,000*) in the NIS–3 to 553,300 (*7.5 abused children per 1,000 children*) in the NIS–4. The incidence of Harm Standard neglect showed no statistically reliable changes since the NIS–3, neither overall nor in any of the specific neglect categories (physical, emotional, and educational neglect).

reported in the series of Child Maltreatment reports and the NIS-4, an argument can be made for a decline in abuse, but not neglect over the past two decades. However, without the NIS 5, we lack valid and reliable trend data to properly assess the impact of changes on policy and proactive.

- **Variability in mandatory reporting laws render even the number of reports unreliable for national aggregation and trend analysis**

State to state differences in mandatory reporting laws confound the reliability of the very basis of the data reported by NCANDS. Issues such as the definitions of mandated reporters, public and professional education in each state, and immunity from liability for reporter's impact how children become known to CPS. A digest of state reporting laws can be found at the APSAC Center for Child Policy website.

- **Little is known about how CPS systems handle psychological maltreatment**

Psychological Maltreatment (PM) is defined as a repeated pattern or extreme incident(s) of caretaker behavior that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expenses. Many clinicians believe that PM is a byproduct from every type of maltreatment. There is a need to develop and promote evidence based screening prevention initiatives related to psychological maltreatment; policy analysts must consider whether the CPS system is the best place to deal with psychological maltreatment.

- **Prevention is undervalued**

Child maltreatment costs public systems an estimated $87 billion annually.[7] While preventing abuse before it occurs is clearly the humane alternative, the economic cost argument often resonates with public officials.

We can pair the number of child maltreatment victims reported for each state in Child Maltreatment 2016 with the two major national studies on the cost of child maltreatment.

[7] Source: http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf, adjusted for CPI

[8] http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf

A cost analysis commissioned by Prevent Child Abuse America[8] found that the national cost of child abuse and neglect exceeds $80 billion annually. Adjusted to 2016 dollars, this figure is $87.2 billion.
The Centers for Disease Control and Prevention[9] estimates that each case of non-fatal child maltreatment will cost the economy $210,012 over a lifetime. Adjusted to 2016 dollars, this figure is $ 234,618

Attachment 5 provides two methods to estimate the potential cost of child maltreatment in your state. The table allocates the annual estimated public cost of $87.2 billion proportionally by each state's number of victims. The table also shows the results of multiplying the number of victims in your state in 2015 by $235,618. As an advocacy tool, consider comparing those numbers to the funds spent on prevention.

- **Neglect continues to dominate the CPS caseload**

Neglect continues to comprise the largest proportion of CPS caseloads, accounting for almost 74.8% of all victims[10] and 74.6% of child fatalities.[11] Both NCANDS data and the National Incidence Studies (NIS) show a stable rate of child neglect. While abuse has shown decreases in prior years, neglect has not. Advocates and practitioners can focus on policies and programs shown to impact neglect. The Technical Package published by the Centers for Disease Control and Prevention in 2016 is a valuable resource. Highlights from this package related to neglect can be found Attachment 6 to this document.

- **Differential response/alternative response continues to be a part of the CPS system, but valid and reliable outcome studies are still lacking**

CM 2016 does not report a specific number of alternative response cases. Table 3 B[12] indicates that 13.9% of the 4.2 million referrals (duplicated count of children), or 583,800 cases received an alternative response. 13.9 is an average, and obscures the true variability in use of DR; "several states reported that they have an alternative response program that is not reported to NCANDS; several states mention that children who are alleged victims of child sexual abuse are not eligible for an alternative response;" in other states, AR is not available statewide[13] Readers are encouraged to review a special edition of the *APSAC Advisor* summarizing the research indicating the wide variation in states practices and a lack of consistent evidence for promoting this practice. Please see excerpts from this issue of the *Advisor* in Attachment 7.

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[9] http://www.sciencedirect.com/science/article/pii/S0145213411003140
[10] CM 2016, page 44
[11] CM 2016, page 56
[12] CM 2016, Page 18
[13] CM 2014, page 18

- **Mandatory reporting laws vary widely:**

A recent APSAC analysis of mandatory reporting laws indicates wide variations among states. There is also variance in both sanctions for failing to report, protection from liability in reporting and lack of or inconsistent public training. Again, state level variations impact the utility of this data as anything more than an indicator of CPS workload, and not the true incidence of child maltreatment. An analysis of mandatory reporting laws can be found on the website for the APSAC Center for Child Policy.

- **Who is serving the screened-out children and families?**

There continues to be an increase in the number of children and families being screened out of receiving services from CPS systems. Child Maltreatment 2016 provides information for each state on the number of initial calls, called *referrals*. Referrals are either screened out or accepted into the system as *reports*. States then respond to those reports with investigations or services. CM 2016 estimates that for 2016, there were 4.1 million referrals representing an estimated 7.4 million children. 42% of the initial referrals to CPS agencies were screened out and never considered reports. This represents more than two million cases, involving more than three million children, where some question was raised, While the proportion of all referrals screened out remained relatively constant at about 40%, both the estimated number of screened out cases and the rate per 1,000 children is increasing.

- **Assessing our progress**

The lack of uniform definitions or metrics within the CPS system make it difficult to promote a national strategy for prevention or to measure the impact of efforts over time. Unlike requirements for NCANDS data, the federal requirements for reporting crime and health data are generally consistent among states. Advocates for child maltreatment prevention may find that health data, particularly from states implementing the ACES module of the Behavioral Risk Factors Surveillance System (BRFSS), are more useful indicators of child well-being than the NCANDS data set.

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Understanding Child Maltreatment 2016

Introduction

This paper presents findings from a review of the report Child Maltreatment 2016, the 27th annual report on child maltreatment incidences, published by the US Department of Health and Human Services, Administration for Children Youth and Families, Children's Bureau.

Part I: What these numbers mean

- **What is the source of data for Child Maltreatment 2016?**

The information in this report is derived from data voluntarily submitted by each state's Child Protection Services (CPS) system to a federal database known as the National Child Abuse and Neglect Data Set, or NCANDS. NCANDS contains data on all screened-in referrals to CPS agencies receiving a disposition, including, in many states, those receiving an alternative response. These data represent the universe of known child maltreatment cases for Federal Fiscal Year (FFY) 2016. This dataset does not record information about "screened-out" referrals, which are referrals that do not meet a state's legal standard to warrant an investigation.

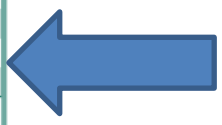
If a state does not submit an NCANDS report, an estimate is generated applying the national average rate per 1,000 children to the state's population. States have the option to submit actual numbers or corrections to their data files in subsequent years. This causes the 'official' number of child victims to change. The tables below offer an example of how the official count for 2014 changed; in CM 2015, the number of victims in 2014 is reported as 676,000. In the current report, the number of victims reported for 2014 has been corrected to 675,000. While a small change, it illustrates the weakness of using NCANDS data for trend analysis.

Exhibit 3–C Child Victimization Rates, 2011–2015

Year	Reporting States	Child Population of Reporting States	Victims from Reporting States	National Victimization Rate per 1,000 Children	Child Population of all 52 States	National Estimate of Victims
2011	51	73,920,615	651,180	8.8	74,783,709	658,000
2012	52	74,546,847	656,372	8.8	74,546,847	656,000
2013	52	74,399,539	656,361	8.8	74,399,539	656,000
2014	52	74,371,086	675,693	9.1	74,371,086	676,000
2015	52	74,382,502	683,487	9.2	74,382,502	683,000

The number of victims is a unique count. The national victimization rate was calculated by dividing the number of victims from reporting states by the child population of reporting states and multiplying by 1,000.

If fewer than 52 states reported data in a given year, the national estimate of victims was calculated by multiplying the national victimization rate by the child population of all 52 states and dividing by 1,000. The result was rounded to the nearest 1,000. If 52 states reported data in a given year, the number of estimated victims was calculated by taking the number of reported victims and rounding it to the nearest 1,000. Because of the rounding rule, the national estimate could have fewer victims than the actual reported number of victims.



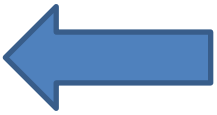
Note: For the data reported in CM 2014, 702,200 victims were counted in 2014. For the data reported in CM 2015, 676,600 victims were reported for 2014.

Exhibit 3–C Child Victimization Rates, 2012–2016

Year	Reporting States	Child Population of Reporting States	Victims from Reporting States	National Victimization Rate per 1,000 Children	Child Population of all 52 States	National Estimate/ Rounded Number of Victims
2012	52	74,542,811	656,372	8.8	74,542,811	656,000
2013	52	74,383,731	656,361	8.8	74,383,731	656,000
2014	52	74,346,098	675,437	9.1	74,346,098	675,000
2015	52	74,349,174	683,261	9.2	74,349,174	683,000
2016	51	73,642,285	671,622	9.1	74,338,157	676,000

The number of victims is a unique count. The national victimization rate was calculated by dividing the number of victims from reporting states by the child population of reporting states and multiplying by 1,000.

If fewer than 52 states reported data in a given year, the national estimate/rounded number of victims was calculated by multiplying the national victimization rate by the child population of all 52 states and dividing by 1,000. The result was rounded to the nearest 1,000. If 52 states reported data in a given year, the number of rounded victims was calculated by taking the number of reported victims and rounding it to the nearest 1,000. Because of the rounding rule, the national estimate/rounded number could have fewer victims than the actual reported number of victims.



Note that the 'final' number reported for 2014 in CM 2015 was 676,000;
in CM 2016 that number is adjusted to 675,000

- **Is this report really a measure of CPS activity rather than child maltreatment?**

Yes. The data used to develop Child Maltreatment 2016 come from each state's CPS data system. For multiple reasons, there are many cases of child maltreatment that never come to the attention of CPS. Variances in definitions of child maltreatment, and variances in mandatory reporting requirements among states further compromises the reliability of these figures behind a measure of CPS activity.

State definitions are based on standards set by federal legislation, which provides a foundation for states' definitions by identifying a baseline set of acts or behaviors that

define child abuse and neglect. The Child Abuse Prevention and Treatment Act (CAPTA), (42 U.S.C. §5101), as amended by the CAPTA Reauthorization Act of 2010, retained the existing definition of child abuse and neglect as, at a minimum: "*Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or an act or failure to act, which presents an imminent risk of serious harm". Additionally,* most states recognize four major types of maltreatment: neglect, physical abuse, psychological maltreatment, and sexual abuse.[14] But beyond the commonly recognized forms of maltreatment and the standards and baseline foundations set by federal law, variation among states' definitions of child abuse and neglect renders it impossible to consider NCANDS all inclusive, and a case that may be counted by one state's definition could be eliminated by another.

In FFY 2016, 11 states reported that changes in policy, practice, or technology made their data unsuitable for trend analysis, (CT, IN, KS, MN, MS, NM, OH, OR, PA, PR, SC). An additional 7 states (AL, AK, AZ, DE, LA, MA, OK) reported changes that could possibly have an impact. Reasons cited ranged from "All report, child, and victim counts are significantly higher due to an increased focus on completion" (Oregon) to "In July 2016, Kansas's level of evidence changed from clear and convincing to preponderance"

Attachment 1 lists the states that indicate either a definite or possible issue with using their NCANDS data for trend analysis. If your state indicates an issue, consider contacting the NCANDS data expert for your state. Their contact information can be found on page 112 of Child Maltreatment 2016.

The National Incidence Study (NIS) of child maltreatment is conducted periodically and provides estimates of child maltreatment in this country using two standards: the *Harm Standard*, and the *Endangerment Standard*. "Under the *Harm Standard,* children must have experienced some harm or injury from maltreatment. The Harm Standard definitions specify, for each category of maltreatment, the severity of harm or injury needed for the child to be counted. Under the *Endangerment Standard*, children in any category of maltreatment are counted as long as they are regarded as endangered by the abuse or neglect."[15] The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), a project which uses multiple sources of data concluded "…that CPS investigated the maltreatment of only 32% of children who experienced Harm Standard maltreatment and of 43% of those whose maltreatment fit the Endangerment Standard."[16]

The relative value of a national incidence study is magnified when considering the strengths and weaknesses of the NCANDS data set. The Keeping Children and Families

[14] CM 2016 Page viii
[15] https://www.nis4.org/DefAbuse.asp
[16] NIS-4 page 16 accessed at http://www.acf.hhs.gov/programs/opre/research/project/national-incidence-study-of-child-abuse-and-neglect-nis-4-2004-2009

Safe Act of 2003 (P.L. 108-36) mandated the NIS-4, which collected data in 2005 and 2006, and was published in 2010. NIS-3 was published in 1996, and NIS-2 in 1986. There is no indication that data collection for NIS-5 is underway. This is a troubling fact for advocates and researchers who rely on the NIS as "the nation's needs assessment on child abuse and neglect."[17]

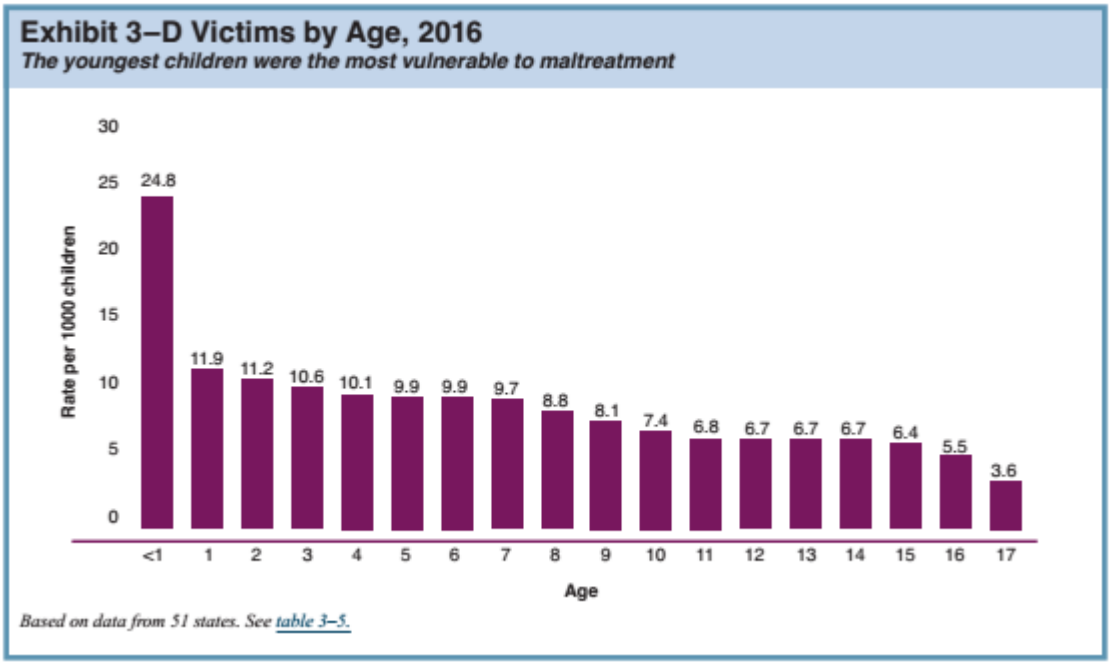
- **Are non-white children still overrepresented in the CPS System nationally? In individual states?**

Yes. American-Indian or Alaska Native children had the highest rate of victimization at 14.2 per 1,000 children in the population of the same race or ethnicity; African American children had the second highest rate at 13.9 per 1,000 children of the same race or ethnicity. [18] Hispanic and White children had lower rates of victimization at 8.0 and 8.1 per 1,000 children in the population of the same race or ethnicity." For details on your state, see Table 3.7 on page 42 of Child Maltreatment 2016.[19]

- **Is age of the child a reliable risk factor for CPS involvement?**

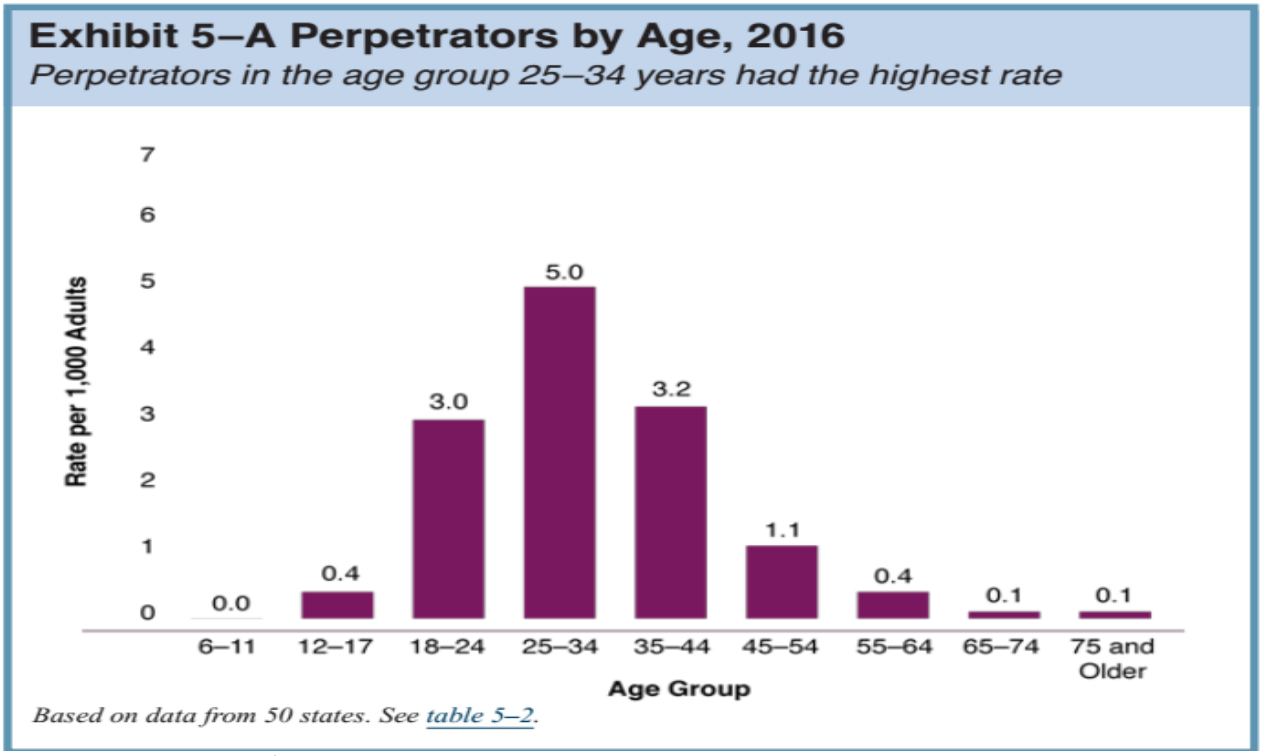
Yes. Children under one year of age have the highest rate of maltreatment reported to CPS, at 24.8 per one thousand children in the population. Generally, the risk of a child being classified as a victim by CPS decreases with age. [25] Results from the NIS-4 and other studies show that older children are also maltreated and may be less likely to be referred to or accepted for CPS services. However, the lack of demographics on cases that are reported but never become referrals prohibits a conclusion that some selection bias may be occurring. While many states are employing tools to remove the subjectivity from screening, none are foolproof. [26] Analysis of the demographics of cases that are 'referred' but not 'reported' could provide useful insights into community needs.

[17] https://www.acf.hhs.gov/opre/resource/fourth-national-incidence-study-of-child-abuse-and-neglect-nis-4-report-to
[18] CM 2016 Page ix
[19] CM 2016 page 42



- **How about age of parents?**

Parents between age 25 and 34 years had the highest rate of perpetuating abuse that became known to CPS systems. These findings are contrary to popular belief that young adults or teenage parents are the largest demographic group of child abuse and neglect perpetrators.



Source CM 2016 page 65

- **What is the impact of "alternative response" (AR) or "differential response" (DR) on the numbers cited in this report and the CPS system?**

Variations in the use and definitions of alternative and differential response add to the potential unsuitability of using the NCANDS figures for generalization and trend analysis. While efforts at standardization were made in 2015, readers are once again cautioned to refer to State Commentary to see how this may affect trends in your state. Further, while NCANDS data report recidivism on certain issues, like multiple reports, it does not capture any data that addresses the effectiveness of DR/AR.
An increasingly vocal contingent of researchers are expressing concern about variations in AR/DR For an interesting discussion of this issue, consider the work of Dr. Elizabeth Bartholet, which can be downloaded from this site[20] and commentary on that work, which can be read here.[21] APSAC devoted a special issue of their *APSAC Advisor* publication to differential response. Excerpts of this issue can be found in Attachment 7.

- **A special focus on victims with alcohol and drug abuse risk factors**

During the 2010 CAPTA reauthorization, certain amendments were expanded to specifically include detection and intervention in Fetal Alcohol Spectrum Disorder. States were asked to require health care providers to notify CPS of infants affected by substance exposure, provide referrals to services, develop a safe care plan for affected infants, and report the total number of children who came to the attention of CPS because of substance exposure.[22] Given this expansion, it makes sense that the highest concentration of children with the "alcohol abuse" risk factor alcohol are less than one month old; the same is true for children with caretaker substance abuse as a risk factor. *This is an indication that early screenings are effective, and further emphasizes the need for screening and outreach that identifies older children where the substance abuse risk factor develops later in their childhood.*

"In 2016, the Comprehensive Addiction and Recovery Act (CARA) was enacted which, among other provisions, amended CAPTA to remove the term "illegal" as applied to substance abuse affecting infants and to specifically require that plans of safe care address the needs of both infants and their families or caretakers."[23] CARA also calls for additional requirements for data collection and monitoring, which will be reflected in the 2018 data submission.

In CM 2016, "three years of data for victims with the alcohol abuse caregiver risk factor were analyzed." This is a change from prior analyses which examined a single year of victim and nonvictim data. From 2014 to 2016, there was an overall increase in the

[20] http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2477089##
[21] https://chronicleofsocialchange.org/analysis/harvards-elizabeth-bartholet-takes-on-differential-response/8731)
[22] CM 2016, Page 22
[23] CM 2016, Page 22

number of victims reported with the alcohol abuse caregiver risk factor, which is due to better reporting"[24] The same methodological change, and conclusion, is reported for the caregiver drug abuse as a risk factor. The total number of victims with caretaker drug abuse as a risk factor increased 1.4 times from 2012–2016; the total number of victims with caretaker alcohol abuse increased 1.2 times from 2012–2016.[25] The larger rate on increase for the substance abuse risk factor may be an indicator of the opioid crisis, better screenings and better reporting.

The APSAC Center for Child Policy has convened an expert working group on Opioid Abuse and Child Maltreatment to synthesize research findings and offer policy recommendations.

- **Is there new information on fatalities in this report?**

No. The National Commission to Eliminate Child Abuse and Neglect Fatalities[26] conducted high profile hearings and other activities in 2014 and 2015, and several states began efforts to shore up their reporting and counting of child fatalities. The national estimate of maltreatment-related fatalities for 2015 as published in CM 2015 was 1,670, an increase from 1,590 in 2014. In CM 2016, the 2015 number has been adjusted to 1,680. The 2016 figure, 1,750 is the highest reported in 5 years, and is generally considered an artifact of the continued improvements in reporting.

Exhibit 4–A Child Fatality Rates per 100,000 Children, 2011–2015

Year	Reporting States	Child Population of Reporting States	Child Fatalities from Reporting States	National Fatality Rate Per 100,000 Children	Child Population of all 52 States	National Estimate of Child Fatalities
2011	52	74,783,709	1,575	2.11	74,783,709	1,580
2012	51	74,281,517	1,619	2.18	74,546,847	1,630
2013	51	74,137,598	1,551	2.09	74,399,539	1,550
2014	51	74,111,988	1,583	2.14	74,371,086	1,590
2015	49	70,448,467	1,585	2.25	74,382,502	1,670

Data are from the Child File and Agency File or the SDC. National fatality rates per 100,000 children were calculated by dividing the number of child fatalities by the population of reporting states and multiplying by 100,000.

If fewer than 52 states reported data, the national estimate of child fatalities was calculated by multiplying the national fatality rate by the child population of all 52 states and dividing by 100,000. The estimate was rounded to the nearest 10. If 52 states reported data, the national estimate of child fatalities was calculated by taking the number of reported child fatalities and rounding to the nearest 10. Because of the rounding rule, the national estimate could have more or fewer fatalities than the actual reported number of fatalities.

[24] CM 2016, Page 21
[25] CM 2016, Page 23
[26] https://eliminatechildabusefatalities.sites.usa.gov/

Exhibit 4–A Child Fatality Rates per 100,000 Children, 2012–2016

Year	Reporting States	Child Population of Reporting States	Child Fatalities from Reporting States	National Fatality Rate Per 100,000 Children	Child Population of all 52 States	National Estimate of Child Fatalities
2012	51	74,277,427	1,621	2.18	74,542,811	1,630
2013	51	74,121,591	1,551	2.09	74,383,731	1,550
2014	51	74,086,682	1,588	2.14	74,346,098	1,590
2015	49	70,416,380	1,589	2.26	74,349,174	1,680
2016	49	72,009,469	1,700	2.36	74,338,157	1,750

Data are from the Child File and Agency File. National fatality rates per 100,000 children were calculated by dividing the number of child fatalities by the population of reporting states and multiplying by 100,000.

If fewer than 52 states reported data, the national estimate of child fatalities was calculated by multiplying the national fatality rate by the child population of all 52 states and dividing by 100,000. The estimate was rounded to the nearest 10. If 52 states reported data, the national estimate of child fatalities was calculated by taking the number of reported child fatalities and rounding to the nearest 10. Because of the rounding rule, the national estimate could have more or fewer fatalities than the actual reported number of fatalities.

Seventy percent of the fatalities were in children under three years of age. Risk "mostly decreases with age"[27], and boys had a higher fatality rate than girls.[28] While this descriptive data may be useful, as in prior year reports the authors offer several reasons why the numbers are unsuitable for trend analysis, including the length of time it may take to determine cause of death (a death may occur in one year but be reported in NCANDS as a fatality in the next) and the fact that the occurrence of fatalities is so low that "the national rate and national estimate are sensitive to which states report data and changes on the child population estimates produced by the US Census Bureau".[29]

Part 2: Implications for Prevention, Policy and Advocacy

While this data has questionable use as a true measure of incidence and prevalence of child maltreatment, it is a credible source of data to be used for policy and advocacy messaging.

- **The field needs a current National Incidence Study (NIS-5)**

The Fourth National Incidence Study of Child Abuse and Neglect (NIS-4), a project which uses multiple sources of data, estimated a decrease in the number of maltreated children between NIS-3 in 1996 and NIS-4 in 2006, with a significant decline in abuse, but not neglect.[30] When considering both the long-term trends reported in the series of

[27] CM 2016, Page 54
[28] CM 2016, Page 54
[29] CM 2015, Page 52
[30] NIS-3 1996 harm standard estimate 1,553,000; NIS-4 2005 harm standard estimate 1,256,600 The number of children who experienced Harm Standard abuse declined significantly, by 26%, from an estimated 743,200 (*11.1 abused children per 1,000*) in the

Child Maltreatment reports and the NIS-4, an argument can be made for a decline in abuse, but not neglect over the past two decades.
However, without the NIS-5, we lack valid and reliable trend data to properly assess the impact of changes on policy and proactive.

- **Variability in mandatory reporting laws render even the number of reports unreliable for national aggregation and trend analysis**

State to state differences in mandatory reporting laws confound the reliability of the very basis of the data reported by NCANDS. Issues such as the definitions of mandated reporters, public and professional education in each state, and immunity from liability for reporter's impact how children become known to CPS. A digest of state reporting laws can be found at the APSAC Center for Child Policy website.

- **Little is known about how CPS systems handle Psychological Maltreatment**

Psychological Maltreatment (PM) is defined as a repeated pattern or extreme incident(s) of caretaker behavior that thwart the child's basic psychological needs (e.g., safety, socialization, emotional and social support, cognitive stimulation, respect) and convey a child is worthless, defective, damaged goods, unloved, unwanted, endangered, primarily useful in meeting another's needs, and/or expenses. Many clinicians believe that PM is a byproduct from every type of maltreatment. Given that, the 37,072 cases reported in CM 2016, down from 42,549 cases reported in CM 2015, could be considered a gross undercount. This decrease is troubling to advocates. There is a need to develop and promote evidence-based screening prevention initiatives related to psychological maltreatment; policy analysts must consider whether the CPS system is the best place to deal with psychological maltreatment. This work is a logical adjunct to work preventing adverse childhood experiences (ACE's), which is being addressed in many states through departments of health and/or education.

Psychological Maltreatment (PM) Reported in Child Maltreatment 2016[40]

PM alone	15,504
PM and neglect	12,858
PM and physical abuse	5,109
PM and sexual abuse	425
PM physical and neglect	3,176
TOTAL Psychological Maltreatment	***37,072***

NIS–3 to 553,300 (*7.5 abused children per 1,000 children*) in the NIS–4. The incidence of Harm Standard neglect showed no statistically reliable changes since the NIS–3, neither overall nor in any of the specific neglect categories (physical, emotional, and educational neglect).

- **Prevention is undervalued**

The Annie E. Casey Foundation's 2014 report, *Home Visiting: The Potential for Cost Savings from Home Visiting Due to Reductions in Child Maltreatment*, concludes that "18 agencies that implemented HFA, NFP, PAT, or SafeCare enrolled a family for 45 weeks and spent $6,554, including state infrastructure costs, on services per family[31]. Further, the authors cite findings from the HomVEE review[32] showing that some home visiting models, including all four included in their study, reduce child maltreatment. The ACE studies and other research also document the reduction in adult earned income and productivity for adults who were victimized as children[33]

We can pair the number of child maltreatment victims reported for each state in Child Maltreatment 2016 with the two major national studies on the cost of child maltreatment.
A cost analysis commissioned by Prevent Child Abuse America[34] found that the national cost of child abuse and neglect
exceeds $80 billion annually. Adjusted to 2016 dollars, this figure is $87.2 billion.
The Centers for Disease Control and Prevention[35] estimates that each case of non-fatal child maltreatment will cost the economy $210,012 over a lifetime. Adjusted to 2016 dollars, this figure is $ 234,618

Attachment 5 provides two methods to estimate the potential cost of child maltreatment in your state. The table allocates the annual estimated public cost of $87.2 billion proportionally by each state's number of victims. The table also shows the results of multiplying the number of victims in your state in 2015 by $235,618. As an advocacy tool, consider comparing those numbers to the funds spent on prevention.

The Adverse Childhood Experiences (ACE) studies are widely accepted as having demonstrated the potential for lifetime harm caused by adverse childhood experiences, including child maltreatment. Details can be found at www.AceStudy.org.

- **Neglect continues to dominate the CPS caseload**

Neglect continues to comprise the largest proportion of CPS caseloads, accounting for almost 74.8% of all victims[36] and 74.6% of child fatalities.[37] Both NCANDS data and the National Incidence Studies (NIS) show a stable rate of child neglect. While abuse has shown decreases in prior years, neglect has not. Advocates and practitioners can focus on policies and programs shown to impact neglect. The Technical Package published by

[31] http://www.casey.org/media/evidence-based-home-visiting.pdf page 5
[32] http://homvee.acf.hhs.gov/
[33] See for example, Long-Term Consequences of Child Abuse and Neglect on Adult Economic Well-Being Janet Currie Cathy Spatz Widom Child Maltreatment Vol. 15 Issue 2 2010
[34] http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf
[35] http://www.sciencedirect.com/science/article/pii/S0145213411003140
[36] CM 2016, Page 44
[37] CM 2016, Page 56

the Centers for Disease Control and Prevention in 2016 is a valuable resource. Highlights from this package related to neglect can be found Attachment 6 to this document.

- **Differential response/alternative response continue to be a part of the CPS system, but valid and reliable outcome studies are still lacking**

CM 2016 does not report a specific number of alternative response cases. Table 3 B[38] indicates that 13.9% of the 4.2 million referrals (duplicated count of children), or 583,800 cases received an alternative response. 13.9 is an average, and obscures the true variability in use of DR; "several states reported that they have an alternative response program that is not reported to NCANDS; several states mention that children who are alleged victims of child sexual abuse are not eligible for an alternative response;" in other states, AR is not available statewide[39] Readers are encouraged to review a special edition of the *APSAC Advisor* summarizing the research indicating the wide variation in states practices and a lack of consistent evidence for promoting this practice. Please see excerpts from this issue of the *Advisor* in Attachment 7.

- **Who is serving the screened-out children and families?**

There continues to be an increase in the number of children and families being screened out of receiving services from CPS systems. Child Maltreatment 2016 provides information for each state on the number of initial calls, called *referrals*. Referrals are either screened out or accepted into the system as *reports***.** States then respond to those reports with investigations or services. CM 2016 estimates that for 2016, there were 4.1 million referrals representing an estimated 7.4 million children. 42% of the initial referrals to CPS agencies were screened out and never considered reports. This represents more than two million cases, involving more than three million children, where some question was raised, While the proportion of all referrals screened out remained relatively constant at about 40**%,** both the estimated number of screened out cases and the rate per 1,000 children is increasing.

This point supports the need for community-based family support services targeted to families not served by the public CPS system. Who is serving the 40% of people who called and were not eligible for services from their states CPS system? Even if half the calls were for general information, that leaves more than a million families in distress.

[38] CM 2016, Page 18
[39] CM 2014, Page 18

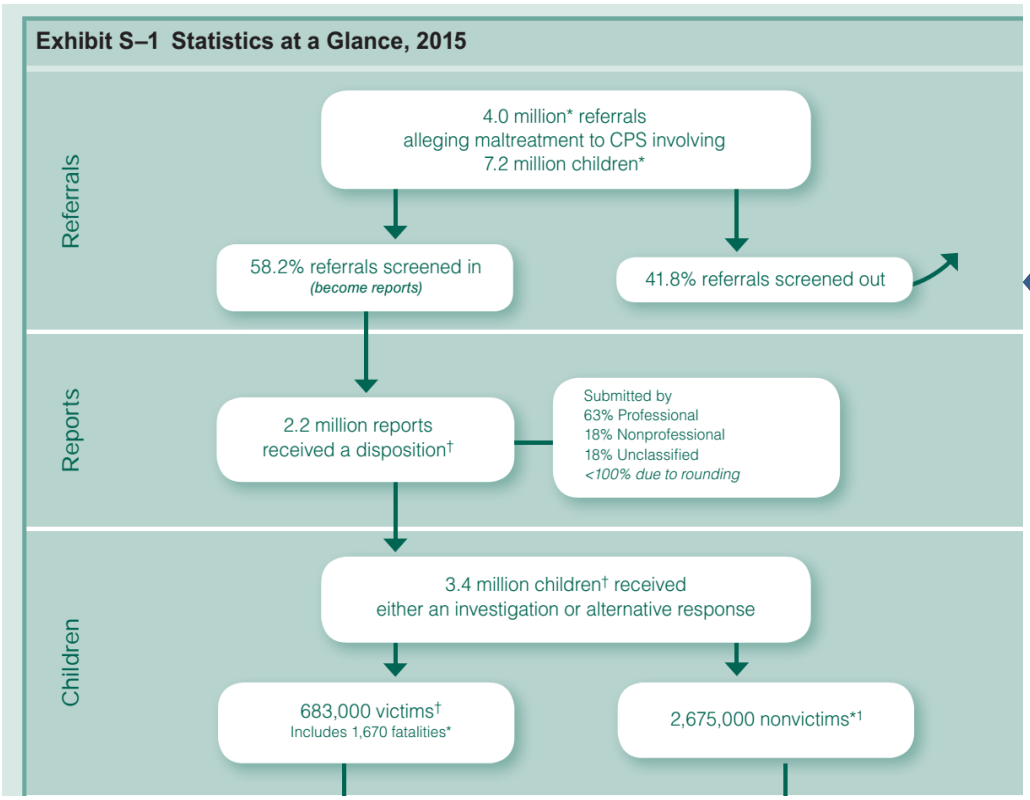


Exhibit S–1 Statistics at a Glance, 2015
Referrals
4.0 million* referrals
alleging maltreatment to CPS involving
7.2 million children*
58.2% referrals screened in
(become reports)
41.8% referrals screened out
Reports
2.2 million reports
received a disposition†
Submitted by
63% Professional
18% Nonprofessional
18% Unclassified
<100% due to rounding
Children
3.4 million children† received
either an investigation or alternative response
683,000 victims†
Includes 1,670 fatalities*
2,675,000 nonvictims*1

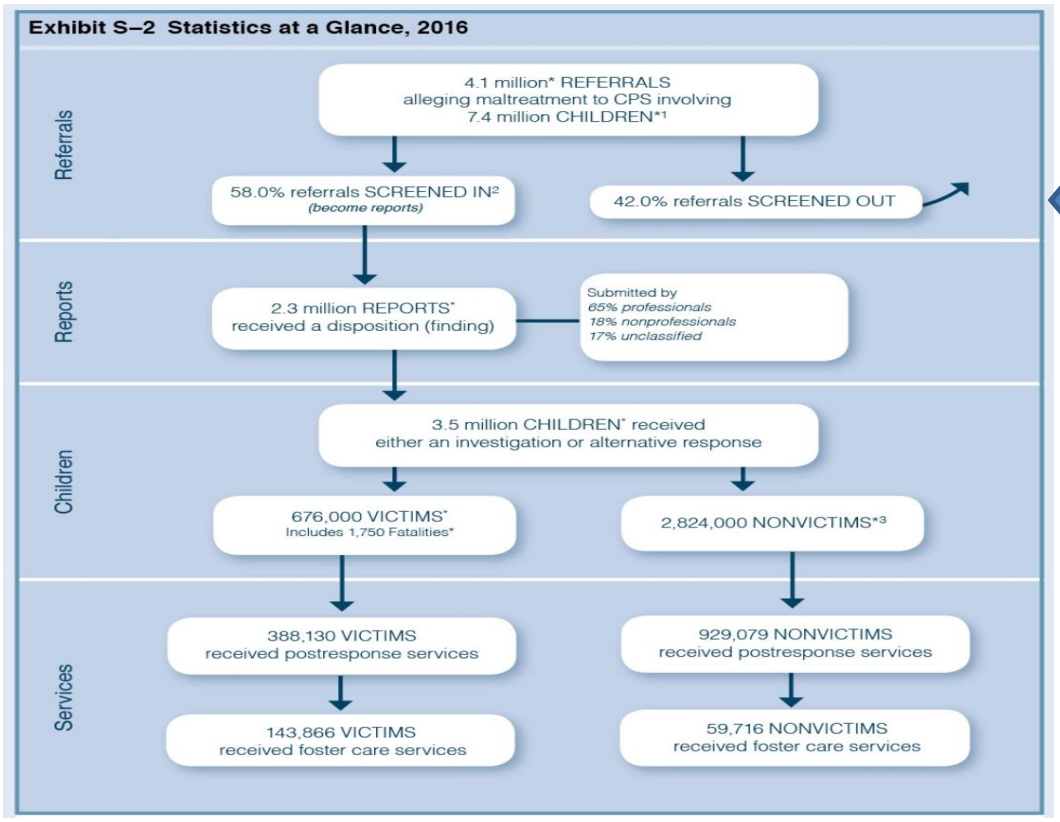


Exhibit S–2 Statistics at a Glance, 2016
Referrals
4.1 million* REFERRALS
alleging maltreatment to CPS involving
7.4 million CHILDREN*1
58.0% referrals SCREENED IN2
(become reports)
42.0% referrals SCREENED OUT
Reports
2.3 million REPORTS*
received a disposition (finding)
Submitted by
65% professionals
18% nonprofessionals
17% unclassified
Children
3.5 million CHILDREN* received
either an investigation or alternative response
676,000 VICTIMS*
Includes 1,750 Fatalities*
2,824,000 NONVICTIMS*3
Services
388,130 VICTIMS
received postresponse services
929,079 NONVICTIMS
received postresponse services
143,866 VICTIMS
received foster care services
59,716 NONVICTIMS
received foster care services

- **Assessing our progress**

The lack of uniform definitions or metrics within the CPS system make it difficult to promote a national strategy for prevention or to measure the impact of efforts over time. Prevent Child Abuse America continues to focus on the need for valid measures which are reliable over time. Unlike requirements for NCANDS data, the federal requirements for reporting crime and health data are generally consistent among states. Advocates for child maltreatment prevention may find that health data, particularly from states implementing the ACES module of the Behavioral Risk Factors Surveillance System (BRFSS), are more useful indicators of child well-being than the NCANDS data set.

Conclusion

Advocates can use this data to highlight:

- The increasing number of 'referrals' that never became 'reports' – the number of which now represents more than 3 million children, and is steadily increasing over prior years;
- The devastating toll that neglect, still the most common form of maltreatment and one that is not declining, takes on a child's long-term development;
- The financial cost of child maltreatment compared to the cost of prevention;
- The importance of a strong network of community resources to support children and families, and;
- The importance of the NIS-5 as a critical and valid indicator of child maltreatment incidence and prevalence.

The release of this report annually provides is an opportunity for advocates to remind the public of what everyone can do to prevent child maltreatment and promote healthy families. Further, it can be used as a call to action for policy makers and researchers to promote uniform assessments and evidence-based interventions. Differential response, and psychological maltreatment are two areas in need of additional study.

Attachment 1:
Summary of state commentary related to using NCANDS data for trends

State	Issue or change possibly effecting trend	CM 2016 age #	Issue as described in commentary
AL	Maybe	120	Variances in data compared to previous years may occur as we have continued work to strengthen our data collection processes in the system.
AK	Maybe	123	In general, data for 2013 and after may not be comparable to data reported in prior years and over-the-year changes should be interpreted with caution. Over-the-year comparisons are also impacted by the entry during 2012 of a backlog of completed assessment (investigation) data
AZ	Maybe	125	Although the number of reports as recorded by NCANDS increased, the actual number of reports received in federal fscal year (FFY) 2016 as counted by Arizona remained nearly the same as the previous year
CT	YES	135	Connecticut is not yet reporting data from reports handled through our alternate response. Therefore, the decline in the total volume of reports documented in NCANDS is not indicative of the actual trend in reporting for Connecticut at this time
DE	Maybe	140	Management cites that the increasing number of referrals received have resulted from the public's awareness of child maltreatment and professionals mandatory reporting
IND	Yes	152	Based on findings from the Commission to Eliminate Child Abuse and Neglect Fatalities, beginning July 1, 2016, the Indiana Department of Child Services does not screen out reports that allege abuse or neglect against a child that is under the age of 3.
KS	YES	155	In July 2016, Kansas's level of evidence changed from clear and convincing to preponderance. In addition to the finding category of substantiated, the finding category of affirmed was added in July 2016
LA	Maybe	159	It is believed that the additional training and quality assurance case review resulted in an increase in the number of screened-out reports of 10.52 percent over FFY 2015.

			.
		160	The decrease in number of victims is proportionate to the reduced number of investigations,
MASS	Maybe	166	In March 2016, the Massachusetts Department of Children and Families (DCF) implemented major changes to policies and practices focused on ensuring the safety of children in the Commonwealth's child welfare system. The new Protective Intake Policy substantially updates and clarifies protocols for DCF's screening and investigation of reports of abuse or neglect
MN	YES	171	During FFY 2016, the number of reports rose again. This is likely in part a result of heightened scrutiny of CPS over the past two years.
Miss	YES	174	In July 2016, the Division of Family and Children's Services was transitioned to a free-standing agency no longer under the purview of the Mississippi Department of Human Services (MDHS). The number of investigations has increased due to consistency in the screening process and availability of MCI.
NM	yes	193	The number of substantiated victims decreased in FFY 2016 from the previous year. In FFYs 2014–2015, New Mexico experienced large backlogs of pending investigations and addressed this by assigning experienced staff in central office and less-populous counties to assist in a "blitz" to close cases
OH	yes	204	There was a 2.0 percent overall increase of the total number of screened in reports in FFY 2016 from FFY 2015….FFY 2016 is the first reporting period Ohio has had DR implemented statewide.
OK	Maybe	209	Child welfare policy has been updated to include a specialized protocol for child abuse and neglect reports involving child victims of human trafficking
OR	YES	212	All report, child, and victim counts are significantly higher due to an increased focus on completion of assessments in FFY 2016.
PA	YES	214	The federal fiscal year (FFY) 2016 NCANDS Child File is the first fle to collect all 12 months of data under the new statute.

		215	This increase is largely due to legislative changes enacted in late 2014 which expanded the definition of child abuse and perpetrator, streamlined and clarified mandatory child abuse reporting processes, increased penalties for failure to report suspected child abuse, and protected persons who report child abuse.
PR	YES	217	The implementation of the integrated case management mechanized system (SIMCa) has had a significant impact on the production of the NCANDS Child File.
SC	YES	220	Referrals and screened-in referrals continued to substantially increase in federal fiscal year (FFY) 2016 as South Carolina operationalizes regionalized intake centers in a multi-year project.

Attachment 2:
Links for referenced and related documents

Child Maltreatment 2016
https://www.acf.hhs.gov/cb/resource/child-maltreatment-2016

Child Maltreatment 2015
https://www.acf.hhs.gov/sites/default/files/cb/cm2015.pdf

Child Maltreatment 2014
http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2014

Child Maltreatment 2013
http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2013

Child Maltreatment 2012
http://www.acf.hhs.gov/programs/cb/resource/child-maltreatment-2012

Prevent Child Abuse America: Estimated Annual Cost of Child Abuse and Neglect
http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf

The US Centers for Disease Control and Prevention: The economic burden of child maltreatment in the United States and implications for prevention
http://www.sciencedirect.com/science/article/pii/S0145213411003140

The US Centers for Disease Control and Prevention, Technical Package on Preventing Child Abuse and Neglect
https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf

National Incidence Study – (NIS-3)
http://library.childwelfare.gov/cwig/ws/library/docs/gateway/Record?w=+NATIVE%28%27IPDET+PH+IS+%27%27nis-3%27%27%27%29&upp=0&rpp=-10&order=+NATIVE%28%27year%2Fdescend%27%29&r=1&m=6&

National Incidence Study – (NIS-4)
http://www.acf.hhs.gov/programs/opre/abuse_neglect/natl_incid/reports/natl_incid/nis4_report_congress_full_pdf_jan2010.pdf

Attachment 3:
Number of child victims by state, by gender of child

Females are at a higher risk

Table 3–8 Victims by Sex, 2015

State	Boy Victims	Girl Victims	Unknown Victims	Total Victims	Boy Rate per 1,000 Children	Girl Rate per 1,000 Children
Alabama	3,854	4,607	5	8,466	6.9	8.5
Alaska	1,397	1,496	5	2,898	14.6	16.6
Arizona	6,069	5,860	26	11,955	7.3	7.4
Arkansas	4,132	5,070	2	9,204	11.4	14.7
California	35,261	36,700	39	72,000	7.6	8.2
Colorado	4,819	5,281	-	10,100	7.5	8.6
Connecticut	3,378	3,551	41	6,970	8.7	9.5
Delaware	761	777	-	1,538	7.3	7.7
District of Columbia	692	655	1	1,348	11.6	11.2
Florida	21,410	21,841	524	43,775	10.2	10.9
Georgia	13,528	13,377	47	26,952	10.6	10.9
Hawaii	719	779	8	1,506	4.5	5.2
Idaho	851	772	-	1,623	3.8	3.6
Illinois	14,698	15,193	102	29,993	9.7	10.5
Indiana	12,817	13,575	5	26,397	15.9	17.6
Iowa	3,931	3,934	12	7,877	10.5	11.0
Kansas	836	1,156	-	1,992	2.3	3.3
Kentucky	9,331	9,360	206	18,897	18.0	19.0
Louisiana	6,155	6,376	100	12,631	10.8	11.7
Maine	1,657	1,711	4	3,372	12.6	13.7
Maryland	3,062	3,720	8	6,790	4.5	5.6
Massachusetts	15,299	14,913	877	31,089	21.6	22.0
Michigan	17,476	17,242	11	34,729	15.5	16.0
Minnesota	2,398	2,722	-	5,120	3.7	4.3
Mississippi	4,141	4,584	5	8,730	11.2	12.9
Missouri	2,552	3,147	-	5,699	3.6	4.6
Montana	910	957	1	1,868	7.9	8.6
Nebraska	1,700	1,783	-	3,483	7.1	7.8
Nevada	2,522	2,430	1	4,953	7.4	7.4
New Hampshire	367	378	-	745	2.7	2.9
New Jersey	4,751	4,919	19	9,689	4.7	5.0
New Mexico	4,350	4,308	43	8,701	17.2	17.7
New York	33,393	33,024	259	66,676	15.5	16.0
North Carolina	3,738	4,119	-	7,857	3.2	3.7
North Dakota	900	849	11	1,760	10.1	10.0
Ohio	10,475	12,502	29	23,006	7.8	9.7
Oklahoma	7,078	7,371	-	14,449	14.4	15.7
Oregon	5,026	5,398	4	10,428	11.4	12.8
Pennsylvania	1,488	2,356	11	3,855	1.1	1.8
Puerto Rico	3,424	3,476	50	6,950	9.0	9.7
Rhode Island	1,618	1,561	4	3,183	15.0	15.1
South Carolina	7,333	7,286	237	14,856	13.2	13.6
South Dakota	544	527	2	1,073	5.0	5.1
Tennessee	5,020	6,300	42	11,362	6.6	8.6
Texas	30,928	32,723	130	63,781	8.4	9.3
Utah	4,376	5,184	9	9,569	9.3	11.7
Vermont	377	544	-	921	6.1	9.4
Virginia	2,979	3,128	5	6,112	3.1	3.4
Washington	2,901	2,978	15	5,894	3.5	3.8
West Virginia	2,401	2,442	14	4,857	12.4	13.2
Wisconsin	2,150	2,668	22	4,840	3.2	4.2
Wyoming	491	477	-	968	6.9	7.0
National	**332,464**	**348,087**	**2,936**	**683,487**	**8.8**	**9.6**

Attachment 4:
Screened in and screened out referrals 2016, by state

Table 2–1 Screened-in and Screened-out Referrals, 2016

State	Screened-in Referrals (Reports)	Screened-out Referrals	Total Referrals	Screened-in Referrals (Reports) Percent	Screened-out Referrals Percent	Total Referrals Rate per 1,000 Children
Alabama	26,036	492	26,528	98.1	1.9	24.2
Alaska	8,385	7,737	16,122	52.0	48.0	86.1
Arizona	54,530	21,451	75,981	71.8	28.2	46.6
Arkansas	34,586	19,989	54,575	63.4	36.6	77.4
California	236,469	156,285	392,754	60.2	39.8	43.2
Colorado	33,306	56,539	89,845	37.1	62.9	71.2
Connecticut	17,935	22,252	40,187	44.6	55.4	53.3
Delaware	6,971	12,728	19,699	35.4	64.6	96.4
District of Columbia	6,356	8,300	14,656	43.4	56.6	121.2
Florida	166,465	58,708	225,173	73.9	26.1	54.3
Georgia	87,652	27,659	115,311	76.0	24.0	45.9
Hawaii	2,082	3,204	5,286	39.4	60.6	17.2
Idaho	8,416	12,789	21,205	39.7	60.3	48.5
Illinois	78,963	-	78,963	-	-	-
Indiana	112,563	57,952	170,515	66.0	34.0	108.2
Iowa	24,923	24,143	49,066	50.8	49.2	67.1
Kansas	23,760	14,234	37,994	62.5	37.5	53.1
Kentucky	51,879	51,111	102,990	50.4	49.6	101.9
Louisiana	23,796	22,810	46,606	51.1	48.9	41.8
Maine	8,392	7,618	16,010	52.4	47.6	62.9
Maryland	21,152	28,767	49,919	42.4	57.6	37.0
Massachusetts	48,126	34,725	82,851	58.1	41.9	60.1
Michigan	91,830	58,230	150,060	61.2	38.8	68.5
Minnesota	31,060	55,268	86,328	36.0	64.0	67.0
Mississippi	26,651	4,562	31,213	85.4	14.6	43.3
Missouri	69,293	19,838	89,131	77.7	22.3	64.3
Montana	9,555	7,756	17,311	55.2	44.8	76.1
Nebraska	11,806	20,799	32,605	36.2	63.8	68.9
Nevada	15,592	18,006	33,598	46.4	53.6	49.6
New Hampshire	11,361	5,461	16,822	67.5	32.5	64.6
New Jersey	56,014	-	56,014	-	-	-
New Mexico	18,510	18,453	36,963	50.1	49.9	75.3
New York	159,401	-	159,401	-	-	-
North Carolina	67,953	-	67,953	-	-	-
North Dakota	3,986	-	3,986	-	-	-
Ohio	80,762	96,606	177,368	45.5	54.5	67.9
Oklahoma	34,625	46,246	80,871	42.8	57.2	84.1
Oregon	40,818	38,471	79,289	51.5	48.5	91.3
Pennsylvania	43,264	-	43,264	-	-	-
Puerto Rico	-	-	-	-	-	-
Rhode Island	5,891	7,762	13,653	43.1	56.9	65.5
South Carolina	34,681	9,515	44,196	78.5	21.5	40.3
South Dakota	2,504	13,521	16,025	15.6	84.4	75.1
Tennessee	75,018	47,733	122,751	61.1	38.9	81.7
Texas	186,024	51,509	237,533	78.3	21.7	32.6
Utah	20,250	17,987	38,237	53.0	47.0	41.5
Vermont	4,194	15,276	19,470	21.5	78.5	164.3
Virginia	33,661	41,759	75,420	44.6	55.4	40.3
Washington	35,327	58,302	93,629	37.7	62.3	57.5
West Virginia	24,096	16,095	40,191	60.0	40.0	107.2
Wisconsin	26,991	51,407	78,398	34.4	65.6	60.9
Wyoming	2,916	3,998	6,914	42.2	57.8	49.8
National	**2,306,777**	**1,374,053**	**3,680,830**	-	-	-
Reporting States	**51**	**45**	**51**	-	-	-
National for states reporting both screened-in and screened-out referrals	**1,897,196**	**1,374,053**	**3,271,249**	**58.0**	**42.0**	**55.1**
Reporting states for reporting both screened-in and screened-out referrals	**45**	**45**	**45**	-	-	-

Attachment 5:
Estimated costs of child maltreatment, by state

Child Victims, 2016 (unduplicated count)		Per cent of national total of child victims	Proportional share of $87.21 billion annual expenditures in US	Estimated cost using CDC&P lifetime cost of $234, 618 per non-fatal case
10157	Alabama	1.512%	$ 1,318,884,685	$ 2,383,015,026
3142	Alaska	0.468%	$ 407,988,154	$ 737,169,756
10841	Arizona	1.614%	$ 1,407,701,966	$ 2,543,493,738
9707	Arkansas	1.445%	$ 1,260,452,263	$ 2,277,436,926
68,663	California	10.223%	$ 8,915,878,619	$ 16,109,575,734
11,226	Colorado	1.671%	$ 1,457,694,149	$ 2,633,821,668
7,803	Connecticut	1.162%	$ 1,013,218,194	$ 1,830,724,254
1,572	Delaware	0.234%	$ 204,123,927	$ 368,819,496
1,366	District of	0.203%	$ 177,374,863	$ 320,488,188
41,894	Florida	6.238%	$ 5,439,928,621	$ 9,829,086,492
21,635	Georgia	3.221%	$ 2,809,300,991	$ 5,075,960,430
1,491	Hawaii	0.222%	$ 193,606,091	$ 349,815,438
1,847	Idaho	0.275%	$ 239,832,629	$ 433,339,446
29,059	Illinois	4.327%	$ 3,773,306,101	$ 6,817,764,462
28,430	Indiana	4.233%	$ 3,691,630,560	$ 6,670,189,740
8,555	Iowa	1.274%	$ 1,110,865,263	$ 2,007,156,990
2,403	Kansas	0.358%	$ 312,029,132	$ 563,787,054
20,010	Kentucky	2.979%	$ 2,598,295,023	$ 4,694,706,180
11,289	Louisiana	1.681%	$ 1,465,874,688	$ 2,648,602,602
3,446	Maine	0.513%	$ 447,462,501	$ 808,493,628
6,993	Maryland	1.041%	$ 908,039,835	$ 1,640,683,674
32,093	Massachusetts	4.778%	$ 4,167,270,474	$ 7,529,595,474
37,293	Michigan	5.553%	$ 4,842,489,570	$ 8,749,609,074
7,941	Minnesota	1.182%	$ 1,031,137,470	$ 1,863,101,538
10,179	Mississippi	1.516%	$ 1,321,741,381	$ 2,388,176,622
5,481	Missouri	0.816%	$ 711,706,898	$ 1,285,941,258
3,116	Montana	0.464%	$ 404,612,059	$ 731,069,688
2,783	Nebraska	0.414%	$ 361,372,066	$ 652,941,894
4,891	Nevada	0.728%	$ 635,095,500	$ 1,147,516,638
905	New Ham	0.135%	$ 117,514,093	$ 212,329,290
8,264	New Jersey	1.230%	$ 1,073,078,964	$ 1,938,883,152
7,526	New Mexico	1.121%	$ 977,249,792	$ 1,765,735,068
65,123	New York	9.696%	$ 8,456,210,234	$ 15,279,028,014
7,134	North Car	1.062%	$ 926,348,660	$ 1,673,764,812
1,805	North Dakota	0.269%	$ 234,378,936	$ 423,485,490
23,635	Ohio	3.519%	$ 3,069,000,643	$ 5,545,196,430
14,308	Oklahoma	2.130%	$ 1,857,891,314	$ 3,356,914,344
11,851	Oregon	1.765%	$ 1,538,850,291	$ 2,780,457,918
4,355	Pennsylvania	0.648%	$ 565,495,993	$ 1,021,761,390
0	Puerto Rico	0.000%	$ -	$ -
2,955	Rhode Isla	0.440%	$ 383,706,237	$ 693,296,190
17,331	South Car	2.580%	$ 2,250,427,339	$ 4,066,164,558
1,246	South Dakota	0.186%	$ 161,792,883	$ 292,334,028
9,665	Tennessee	1.439%	$ 1,254,998,571	$ 2,267,582,970
57,374	Texas	8.543%	$ 7,450,003,931	$ 13,460,973,132
9,614	Utah	1.431%	$ 1,248,376,229	$ 2,255,617,452
822	Vermont	0.122%	$ 106,736,557	$ 192,855,996
5,941	Virginia	0.885%	$ 771,437,818	$ 1,393,865,538
4,725	Washington	0.704%	$ 613,540,429	$ 1,108,570,050
5,938	West Virginia	0.884%	$ 771,048,268	$ 1,393,161,684
4,822	Wisconsin	0.718%	$ 626,135,862	$ 1,131,327,996
977	Wyoming	0.145%	$ 126,863,280	$ 229,221,786
671,622			$ 87,210,000,000	$ 157,574,610,396

Sample comments using Wyoming as an example:

An estimated $127,000 million was spent in our state in 2016 to pay for the costs of child maltreatment.

Source:
http://www.preventchildabuse.org/images/research/pcaa_cost_report_2012_gelles_perlman.pdf

The 977 victims of child maltreatment in 2016 will cost our economy more than a quarter billion dollars over their lifetime, applying the cost estimates published by the Centers for Disease Control and Prevention.

Source:
http://www.sciencedirect.com/science/article/pii/S0145213411003140

Attachment 6:
CDC Technical Package on Preventing Child Maltreatment

https://www.cdc.gov/violenceprevention/pdf/can-prevention-technical-package.pdf

Highlight on Neglect Prevention

Strengthen Economic Supports for Families

Rationale

Policies that improve the socioeconomic conditions of families tend to have the largest impacts on health.[34] Strong empirical evidence consistently links low income to children's development, academic achievement, and health,[35,36] including exposure to child abuse and neglect.[37] Policies that strengthen household financial security can reduce child abuse and neglect by improving parents' ability to satisfy children's basic needs (e.g., food, shelter, medical care), provide developmentally appropriate child care, and improve parental mental health.

Policies can change the context for families by improving the balance between work and family ("family-friendly work"), thereby allowing parents to provide the necessary care for children and increasing the likelihood that children experience safe, stable, nurturing relationships and environments. Studies show several "family-friendly" work policies reduce risk factors for child abuse and neglect, such as stress and depression.

Approaches

Economic supports for families can be strengthened by targeting household financial security and family-friendly work.

Strengthening household financial security can reduce child abuse and neglect by improving parents' ability to satisfy children's basic needs (e.g., food, shelter, medical care), provide developmentally appropriate child care, and reduce parental stress and depression, both risk factors for child abuse and neglect.[37] Strengthening household financial security may also reduce children's exposure to crowding and contribute to residential stability and stability in child care arrangements. Household financial security can be strengthened in various ways:

- **Child support payments:** States can modify how Temporary Assistance for Needy Families (TANF) benefits are affected by child support payments. In many states, the child support payments are used by the state to reimburse itself, but states may also elect to allow some or all of the child support payment to be passed on to the custodial parent and child without any reduction in the TANF benefits. Allowing child support payments to be passed on to the custodial parent in part or in full without reducing TANF benefits increases household income.

- **Tax credits** for families with children (e.g., state and federal Earned Income Tax Credit, EITC) help low income families increase their income while incentivizing work or offsetting the costs of child-rearing. The federal EITC is a refundable credit originally designed to encourage work by offsetting the impact of federal taxes on low-income families. The amount of the credit varies depending on income earned through work, marital status, and the number of qualifying children. State EITC's are usually based on a percentage of the federal EITC and vary in their eligibility and funding amounts; approximately half of the states in the U.S. have enacted EITCs.[38]

- **State options for managing federal nutrition assistance programs:** The Supplemental Nutrition Assistance Program (SNAP) is a federally funded program managed by the U.S. Department of Agriculture (USDA) that provides cash benefits, which can only be used to purchase food, to low income households. States have several options that can facilitate access to SNAP (e.g., online application; frequency or simplicity with which households report household income or work hours; whether child support is considered in income calculations; disqualifications imposed).[39] SNAP benefits help low income parents meet children's basic needs for food. Because SNAP benefits allow a parent's income from other sources to be used on things besides food, SNAP decreases family poverty and poverty among children.[40] SNAP also reduces the severity of food insecurity.[41]

- **Assisted housing mobility**: States can choose to use the U.S. Housing and Urban Development's Community Development Block Grant (CDBG) money to purchase properties in low poverty neighborhoods and lease them to low income families at lower rent.[42] Alternatively, states can use Section 8 Housing Choice Voucher funds and condition their use to rentals in low poverty neighborhoods, while at the same time coupling them with measures that prevent discriminating against Section 8 voucher holders.[42] Assisted housing mobility through these programs enables families from high poverty neighborhoods to relocate to more stable, better resourced, and safer communities while saving on rent. These savings can be used for other necessities.

- **Subsidized child care** provides vouchers, lower cost child care, or cash transfers to low-income families to off-set the cost of quality, full-time child care. Subsidized child care improves low income families' economic well-being by reducing child-care costs; many parents receiving subsidies report that the subsidies enhance their financial well-being.[43] States can elect to raise income threshold limits to expand eligibility and consider household expenses when calculating eligibility; expand the definition of approved activities to include training, education, job search time, rest hours (for parents working second or third shifts), and temporary leave; increase the amount of the subsidy, provide increases based on the quality of care provided, and improve monitoring of quality; have graduated phase-out periods that would allow clients to slowly earn their way off the program rather than face a blunt income threshold; simplify the application process and shorten wait times for subsidy approval; simplify the verification process, the reapplication process, and reduce the frequency of recertification to improve continuity of child care; and increase the number of providers with non-standard hours (e.g., evenings, weekends) or incentivize providers to provide extended hours.

Family-friendly work policies change the context for families by improving the balance between work and family while ensuring economic security. This makes it easier for parents to provide necessary care for children.

- **Livable wages** allow working parents enough income to cover the costs of living and provide for their children's basic needs (e.g., food, shelter, appropriate child and medical care), reducing the likelihood of child neglect. Its impacts on parental mental health may also improve parenting behaviors.

- **Paid leave** provides income replacement to workers on leave for family caregiving, bonding with a new child **(paid parental leave)**, or personal leave taken to recover from a serious health condition **(paid sick leave)** or get rested and re-energized **(paid vacation).** Paid leave can reduce risk factors for child abuse and neglect (e.g., parental stress).

- **Flexible and consistent schedules** provide workers with a predictable pattern of work and/or allow for adaptability within the work environment. Flexible schedules include flexibility in work scheduling (e.g., compressed work weeks, flexible beginning/ending times to work day, flexibility in scheduling shifts and breaks to allow for child care coverage), flexibility in the number of hours worked (e.g., part-time work), and flexibility in the workplace location (e.g., home office, satellite location, alternate location). Inconsistent schedules or shiftwork can make it challenging to balance work and family responsibilities, which includes obtaining stable child care and access to child care assistance.[44]

Potential Outcomes

- Improvements in children's health, development, and health insurance coverage
- Reductions in physical abuse of children
- Reductions in child neglect
- Reductions in unintentional or undetermined causes of childhood injury
- Reductions in maternal depression and parental stress
- Reductions in adolescent risky health behaviors
- Reductions in chronic disease among adults and leading causes of death

Attachment 7:
APSAC Advisor Article on Differential Response

APSAC Advisor Special Issue: Differential Response

Judith S. Rycus, PhD, MSW - Guest Editor

Introduction

Differential response (DR), variously called alternative response (AR), family assessment response (FAR), or multiple track response, developed concurrently with other systemic reforms to incorporate family-centered, strengths-based practices into public child protective services (CPS). The original goal of DR was to augment the capacity of CPS systems to provide more effective and less intrusive services to lower-risk families who had been referred to CPS for suspicion of child maltreatment. To achieve this end, at the time families were screened in or accepted for follow up by the CPS agency, they were assigned to either a traditional CPS track or an alternative response track, purportedly based on a determination of the family's risk level and the safety of the children being referred.

As my colleagues and I observed the implementation of DR programs throughout the country, we developed significant concerns about the validity of the outcome research supporting the intervention, the safety of children being served in alternative tracks, and the ethics of diverting CPS resources from the higher-risk families they were intended to serve to lower-risk families in alternative tracks. In 2011 we completed an in-depth assessment of the then-available outcome research and program literature on DR and wrote a policy white paper, titled "Issues in Differential Response," which was published in the journal *Research on Social Work Practice* in September, 2013, along with nine invited articles in response to our policy paper and a final article that articulated our response to the respondents.

In the 5 years since we completed our original research analysis, there has been continuing controversy about the strengths, benefits, problems, and challenges of DR programming. Some jurisdictions continue to profess confidence in and operate DR programs, while others have made significant changes to their operations or have abandoned DR entirely. Some jurisdictions undertook deeper explorations of their programming and ultimately reinstated fundamental CPS interventions that DR advocates had characterized as being hostile and unfriendly to families. In the research arena, outcome data remain inconclusive. Recent research continues to raise issues that have been largely unaddressed, creating ongoing skepticism about the validity of the "evidence-based" moniker that has been widely used to describe DR programming.

In this special issue of the *APSAC Advisor*, our goal is to provide a snapshot of perspectives on the issues and challenges associated with DR. Our guest authors include academicians, researchers, and direct service professionals still grappling with the question of whether and how to maintain the constructive, family strengthening components of DR without putting children at increased risk of harm. We hope to introduce a wider professional audience to the remaining issues and questions. We also encourage APSAC members to become better educated about DR, enabling them to work more effectively in their own jurisdictions to promote empirically sound programming to ensure that all families are well served and that children remain safe from harm.

The 11 articles from the September, 2013, issue of *Research on Social Work Practice* are available on the Sage Publications Web site: http://rsw.sagepub.com/content/23/5.toc

The original policy white paper, "Issues in Differential Response," can also be downloaded from: http://www.ihs-trainet.com/assets/HughesRycusDifferentialResponse.pdf

Readers may request further information or contact the authors through the Editor of this Advisor issue at JSRycus@aol.com.

About the Guest Editor

Judith S. Rycus, PhD, MSW, is co-founder, Program Director, and Director of International Child Welfare for the Institute for Human Services and the North American Resource Center for Child Welfare in Columbus, Ohio. She is a program manager, policy analyst, trainer, organizational consultant, and strategic change agent working with governmental and non-governmental organizations serving maltreated children and their families.

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Special Issue: Differential Response

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