ASSESSMENT AND PREVENTION OF CHILDREN AT RISK OF ABUSE OR NEGLECT

by

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A Senior Honors Project Presented to the

Honors College

East Carolina University

In Partial Fulfillment of the

Requirements for

Graduation with Honors

by

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Greenville, NC

May 2016

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Introduction

According to the Child Abuse Prevention and Treatment Act (CAPTA) (2010), child maltreatment is defined 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; (p. 6).

Child abuse and neglect includes physical, sexual, psychological, medical, and educational maltreatment, which can be either intentional or unintentional (Jackson, Kissoon, & Greene, 2015). Physical abuse of a child is any physical act, ranging from shoving to smothering, that can harm a child. Child sexual abuse is any form of sexual exploitation of a child. Psychological abuse is the act of emotionally terrorizing the child, including embarrassing, degrading, or frightening the child. Less known is medical abuse, which is the induction or falsification of illness symptoms by the caregiver, thus requiring unnecessary medical interventions or hospitalizations of the child (Jackson et al., 2015).

Physical neglect is the inability or the disregard to provide basic physical needs, such as food, housing, or clothing. Psychological neglect is the failure to meet basic emotional needs and can include isolating or ignoring the child. Similarly, medical and educational neglect is the lack of ability or the omission of ensuring the medical and educational needs of the child are met, such as failure to take the child to the hospital when needed or withholding the child from attending school (Jackson et al., 2015). Hence, child neglect can be due to lack of financial ability or due to an intentional disregard of child needs.

In most cases, children suffer from several types of maltreatment either simultaneously or throughout their childhood. Moreover, all forms of child maltreatment, whether abuse or neglect,

have a lasting negative impact on the child (Putnam-Hornstein, Webster, Needell, & Magruder, 2011). Child maltreatment can affect the child cognitively, developmentally, physically, emotionally, socially, and behaviorally. Unfortunately, all forms of child abuse and neglect are far too prevalent. Hence, the purpose of this project is to compare current assessment and identification practices for children at-risk of maltreatment with best practice strategies.

Background and Significance

The U.S. Department of Health and Human Services (USDHHS, 2015) reported that the estimated number of child maltreatment victims nationally was 679,000. The same report identified that 1,520 children died as a result of child maltreatment. These national rates indicate that by 18 years of age, 1 in 8 children will have a substantiated report of maltreatment (Jackson et al., 2015). Considering these rates are based only on reported cases to Child Protective Services (CPS), the full extent of the problem is underestimated.

When children have been assessed and identified as maltreated, the U.S. health and social service system struggles to prevent repeat child maltreatment and child fatalities. According to the National Child Abuse and Neglect Data System (NCANDS), of the children with substantiated physical abuse reports in 2006, almost one-third had a previously substantiated report (Dakil, Flores, Cox, & Lin, 2012). Furthermore, prior to a child abuse fatality, the child welfare system has been aware of previous child maltreatment cases involving the same child (Douglas, 2013). In fact, the child welfare system was aware of these cases on average ten months prior to a fatality and a case worker had met with the children about seven days before the fatality (Douglas, 2013). Therefore, children with a history of maltreatment are still at risk for abuse, so there is a gap or delay in services that needs to be addressed.

Children most at risk for maltreatment fatalities are under one year of age (Douglas, 2013). Klevens and Leeb (2010) reported the most common cause of child abuse fatality is head trauma. The most common cause of child neglect resulting in fatality was supervisory neglect (Welch & Bonner, 2013). Supervisory neglect is defined as insufficient supervision which may or may not cause harm to a child.

It is imperative to reduce the number of child maltreatment cases and there is a need for earlier assessment, recognition, and effective intervention. There are numerous elements that are currently considered risk factors for child maltreatment including: teenage and/or single parent, poverty, unemployment, lack of social support, substance abuse, chronic illness of child, intimate partner violence, major stress, and lack of government support (Lane, 2014).

Literature Review

The literature review was conducted using electronic databases, including CINAHL, PubMed, and Science Direct. These databases were used to find scholarly and peer-reviewed articles from the years 2010 to 2015. Primary search parameters included: "child maltreatment risk factors," "child abuse risk factors," "child abuse and substance use," "child abuse and education," "child abuse and domestic violence," and "child maltreatment recognition." Over one-hundred articles were assessed and limited to twenty articles which applied to the research topic. Moreover, articles were limited to those in which the studies had taken place within the U.S. Journal articles included experimental studies, quasi-experimental studies, correlational studies, longitudinal studies, and literature reviews. Of the twenty articles chosen, all of them pertained to child maltreatment. This literature review used an organizing framework with the following seven categories: parental substance use, parental education, intimate partner violence, lack of financial resources, public support, social support, and intervention strategies.

Parental Substance Use

Parental substance use is a well-documented risk factor of child maltreatment (Appleyard, Berlin, Rosanbalm, & Dodge, 2011; Dakil et al., 2012; Freisthler, Holmes, & Wolf, 2014). In one of the first studies of its kind, over 3,000 caregivers were surveyed to determine the relationship between alcohol use and physical abuse (Freisthler et al., 2014). Individuals who used alcohol also used physical abuse considerably more than those who abstained from alcohol or infrequently used alcohol (Freisthler et al., 2014). The authors further looked into dose-response models, which similarly found that parents who drink more often in certain settings, such as bars and parties, were more likely to use physical abuse (Freisthler et al., 2014).

Appleyard et al. (2011) conducted a community based and longitudinal study which included 499 mothers who were interviewed and their CPS involvement tracked. Significant results revealed a strong association between maternal substance use and child maltreatment (Appleyard et al., 2011). The results remained significant even after including and excluding other variables, such as mental health problems. Since problems such as substance abuse and mental health often coexist, previous studies which investigated the effects of alcohol on abuse have been limited by the unknown contribution of mental health. However, this study investigated both variables and ensured that the results weren't affected by the possible correlation between mental health and substance use problems, but in fact substance use had a direct effect on abuse rates (Appleyard et al., 2011).

In an analysis of NCANDS data from 2006 with over 100,000 cases, Dakil et al. (2012) reported a significant relationship between parents who used drugs or alcohol, or both, and child physical abuse. This study was the first of its kind to evaluate child physical abuse risk factors by using a national data set. Numerous other studies confirmed this strong, significant relationship

between parental substance use and child maltreatment (Douglas, 2013; Dubowitz et al., 2011; Welch & Bonner, 2013; Whitt-Woosley, Sprang, & Gustman, 2014).

Substance use has been thought to negatively impact parenting judgement, awareness, and motor skills, along with many other factors. For example, impaired judgement can result in the inability to perform the correct action, such as save a child from drowning, poisoning, or other accidents. Impaired judgement can also result in the purchase of drugs or alcohol in place of food for the family (Appleyard et al., 2011).

Parental Education

Putnam-Hornstein et al. (2011) utilized a public health approach to evaluate child maltreatment using a secondary analysis of almost 300,000 child maltreatment cases. Almost 20% of the children reported for maltreatment had a mother with less than a high school education (Putnam-Hornstein et al., 2011). This is compared to about 11% of children who were reported having a mother with some college education, and only 3% of children whose mother had a college degree (Putnam-Hornstein et al., 2011). Likewise evaluating mother's educational level, Butler (2013) completed a secondary analysis of a national sample of 1,087 girls. A major finding was as mothers level of education increased (greater than 12 years) the risk of sexual assault decreased. Numerous studies had similar findings (Cancian, Yang, & Slack, 2013; Dubowitz, 2011; Rodriguez & Tucker, 2015; Whitt-Woosley, 2014).

Domestic and Intimate Partner Violence

Domestic violence (DV) and intimate partner violence (IPV) is another major risk factor (Douglas, 2013). In a secondary analysis of 1,125 families, investigators found that domestic violence was significantly associated with substantiated CPS reports (Duffy, Hughes, Asnes, & Leventhal, 2015). This study was also the first of its kind, as it focused on families involved in a

home visiting program who were already recognized as high risk families. Dakil et al. (2012) demonstrated that a family was over four times more likely to have a substantiated physical abuse report when domestic violence was involved compared to unsubstantiated reports. Also, when comparing fatal to high risk, non-fatal cases, there is the recognition of IPV as a risk factor (Whitt-Woosley et al., 2014). In a study, comparing 50 fatal child abuse cases to 50 high risk cases, investigators found that both groups had a high percent of IPV (Whitt-Woosley et al., 2014). However, the fatal case group had 39% IPV referrals compared to the non-fatal group having 17% IPV referrals (Whitt-Woosley, 2014).

Lack of Financial Resources

Financial problems, and unemployment, are also major risk factors for child maltreatment (Cancian et al., 2013; Douglas & Mohn, 2014; Eckenrode, Smith, McCarthy, & Dineen, 2014). Eckenrode et al. (2014) observed the relationship between child maltreatment rates and income inequality at a county level. The authors, in the first study of its kind, demonstrated a significant relationship between the two variables: as income inequality increased at a county level, child maltreatment county rates also increased (Eckenrode et al., 2014). The use of county level data is important to note and useful as many programs, such as the Supplemental Nutrition Assistance Program, are implemented at a county level (Eckenrode et al., 2014).

Cancian et al. (2013) examined the effects of additional child support income on maltreatment rates. In the original design, one group received full child support, while the other group received partial child support. The investigators also found that families who received full child support were less likely to have a child screened for maltreatment (Cancian et al., 2013).

While comparing fatal to non-fatal child maltreatment cases, Douglas and Mohn (2014) found that the fatal child abuse cases were significantly more likely to have financial problems.

Numerous studies similarly revealed a correlation between financial problems and risk for maltreatment (Butler, 2013; Freisthler et al., 2014; Putnam-Hornstein et al., 2011; Rodriguez & Tucker, 2015).

Several researchers reported that caregivers of families involved with child maltreatment were often unemployed (Douglas, 2013; Whitt-Woosley et al., 2014). According to Douglas (2013), of families who had a child maltreatment fatality, two-thirds experienced unemployment regularly. Likewise, in another study, among the fatal case group and non-fatal case group, both had caregivers who were often unemployed (Whitt-Woosley et al., 2014).

Public Support

Another area of risk consistent in the literature is the use or lack of public support. Douglas and Mohn (2014), determined that child maltreatment fatality cases were significantly less likely to receive case management, court-appointed representatives, or foster care. Moreover, these families were less likely to receive mental health and substance abuse services, education and training, and information and referrals (Douglas and Mohn 2014). Whitt-Woosley et al. (2014) also found that referrals were hardly made and were made less often for fatal child abuse cases compared to non-fatal child abuse cases. However, fatal groups had less prior welfare involvement, thus the welfare system had less of a chance to intervene (Whitt-Woosley et al., 2014).

Dakil et al. (2012) likewise found that only a small number of families with substantiated physical abuse reports received the following services: foster care, substance abuse counseling, education, and employment, along with other services. Interestingly, Douglas (2013) found similar results, but in addition found that in families with a prior child maltreatment fatality, many weren’t utilizing the referral services.

Social Support

Social support is critical to the success of any family for several reasons including helping to create a safe environment for children. Douglas and Mohn (2014) found that caregivers involved with a child maltreatment fatality were significantly less likely to have family support. Douglas (2013) similarly found that social isolation was a common issue with families who experience a child maltreatment fatality. Moreover, Rodriguez and Tucker (2015) found that more social support was shown to moderate distress and child abuse risk.

In contrast, Freisthler et al. (2014) differentiated between emotional, tangible, and social support. In the context of this study social support refers to social companionship, such as spending time with others doing leisurely activities. It was found that physical abuse occurred less often when the caregivers had more emotional and tangible support; however, physical abuse occurred more often when the caregivers had more social support (Freisthler & et al., 2014). Thus not all types of support are equally protective.

Intervention Strategies

Not all health professionals are prepared in assessment, identification, and referral of child abuse and neglect cases. Jackson et al. (2015) describe several physical signs, injury mechanisms, and differences in developmental milestones to look for when assessing a child for maltreatment. For example, the more mobile the child is, the more likely the child is to have bruises obtained from accidents. In a systematic review of 11 intervention trials, behavioral interventions and risk assessments decreased child maltreatment rates, while home visits overall decreased child maltreatment rates as well, however, the results varied slightly (Nelson, Selph, Bougatsos, & Blazina, 2013).

Olds et al. (2014) conducted a randomized clinical trial with 1,138 women in highly disadvantaged regions of Tennessee to evaluate the effectiveness of home visiting programs on maternal and child mortality. It was found that home visits resulted in a decrease in child mortality from preventable causes (Olds et al., 2014). Guterman et al. (2013) conducted a study in the Southeast U.S. and evaluated pre and post intervention data of 101 families. The authors found that a home based parent aide intervention group had a decrease in risk of physical abuse. Furthermore, the intervention also decreased the mothers' levels of depression and stress (Guterman et al, 2013). Schaeffer, Swenson, Tuerk, and Henggeler (2013), investigated the effect of Multisystemic Therapy-Building Stronger Families (MST-BSF) treatment which included numerous interventions and home visiting. Mothers in the intervention group had three times less subsequent substantiated child maltreatment reports compared to the control group (Schaeffer et al., 2013).

Summary of Literature Review

Though the research has provided key risk factors, there are still gaps in the literature. For substance use, the research is still unclear to the direction of the relationship between substance use and maltreatment: are parents who are under the influence of a substance more likely to maltreat their child, or does a parent who maltreats their child then use a substance as a means to cope with their actions? Also, few investigators can answer the question why low educational level is a risk factor. Douglas (2013) posited that lack of education may lead to inappropriate expectations of children. Parental education is also linked to income, another risk factor, so a pathway may exist from education to income to maltreatment.

Proposal Questions

Four questions will be the focus of this program evaluation. They are:

1. What are the most common risk factors for child maltreatment?
2. What are the current assessment practices for identifying at-risk children?
3. What interventions are being used to address child maltreatment?
4. Do systems level barriers limit effective interventions for families at risk?

Planned Project Outcomes

The objectives for this program evaluation were:

1. Complete a record audit on postpartum women and infants to assess risk factors for child maltreatment by February 20, 2016.
2. Conduct home visits with RN preceptor to assess for at-risk children by February 17, 2016.
3. Interview 3-4 key informants regarding risks and prevention of child maltreatment by February 20, 2016.
4. Review the 2012-2014 Child Fatality Task Force (CFTF) cases to determine existing risk factors associated with child fatalities by February 13, 2016.

Methodology

Program Design

A program evaluation was conducted to compare one program in a local health department with best practice strategies for the prevention of child maltreatment. During a 7-week community health clinical practicum, supervised home visits were made with a public health nurse (PHN) preceptor; cases from the 2012-2014 Child Fatality Task Force (CFTF) were reviewed; and key informants were interviewed. Part of the CFTF is the Child Fatality Prevention Team (CFPT), which in this county, investigates the deaths of children that result from suspected abuse or neglect when a report of maltreatment was made about the child or the

child's family, within the past year, or the child or child's family received protective services in the past year. Key informants included a health director, child coordinator for children and pregnancy management, and TEDI BEAR Children's Advocacy Center employee.

Sample and Setting

The target population was post-partum women and their infants enrolled in the home-visiting program at the county health department. In the county, the population consists of: 54.4% White, 31.9% Black or African American, and 11.1% Hispanic or Latino (United States Census Bureau, 2014). According to the NC Department of Health and Human Services (NCDHHS) (2015), the birth rate was 11.7/1000 for White mothers, 13.7/1000 for Black mothers, and 23.8/1000 for Hispanic mothers. The percentage of live births to unmarried mothers was 25.4% for White mothers, 73.3% for Black mothers, and 56.1% for Hispanic mothers. Furthermore, the county had 65.3% births to mothers insured by Medicaid and Medicaid moms and 62.1% births to mothers enrolled in WIC, compared to NC which had 55.9% and 43.5% births respectively (NCDHHS, 2015).

A windshield survey, one component of a community assessment, completed prior to the program evaluation, revealed findings to better understand the population and community. The region relies heavily on agriculture. In the county there are single-family houses, mobile home parks, and public housing. There is a public bus service in the county seat, which has 5 routes with 6-8 stops each. This bus service provides in county and out of county medical trips to in-state hospitals or clinics. A variety of health resources are available, such as: the community hospital, a psychiatric hospital, the health department, physician offices, pediatric clinics, one mobile dental unit, two free clinics for the uninsured, and school-based health clinics. There are numerous billboards advertising healthy choices. The community has a soup kitchen which

serves approximately 200 families six days a week with a hot nutritionally-balanced meal. The department of social services provides programs, such as Medicaid and the Supplemental Nutrition Assistance Program. The health department offers multiple programs and services to the community.

The population of the county is 124,456, of which 23.3% are reported to live at the federal poverty level, compared to 14.8% of the US population. For persons living in the county above the age of 25, 82.2% graduated high school and 17.2% received a bachelor's degree, compared to 86.3% and 29.3% of the US population respectively (United States Census Bureau, 2014). According to Kids Count Data Center (2016), compared to the US, NC ranks: 40 out of 50 for median family income among households with children; 37 out of 50 for percent of children in poverty; 33 out of 50 for children not in excellent or very good health; 41 out of 50 for infant mortality; and, 30 out of 50 for children confirmed by CPS as maltreatment victims. Based on the primary and secondary data, the local issues, including lower socioeconomic status and negative health outcomes, are worse than at a national level.

Data Collection

This project connects to the core functions of public health, assessment, policy development, and assurance, through home visits, a record audit, interviews with key informants, and case review. A representative from the CFTF committee was contacted and an appointment was made to review the cases. All case files from 2012-2014 were reviewed. Based on the literature review, an audit tool was developed. The audit categories included: age, education level, unemployment, substance use, IPV, abused as child, mental health disorders/depression/anxiety, single parent, unwanted child, number of adults living in the home, social support, public support/referrals, premature delivery, home visit, and other. The RN

preceptor selected records from 11/12/2015 to 01/26/2016 were closed. This is because these were the most recent charts with completed information at the time. The audit was completed by 02/23/2016. Key informant interviews were conducted at the health department or via phone call and took 30-40 minutes each. During interviews brief notes were taken. Questions included: Can you describe the degree to which child abuse occurs in your community?, What is your role in preventing child abuse and neglect?, What do you believe are the risk factors for child maltreatment?, What agencies are effective in the prevention of child abuse and neglect?, Describe some of the barriers that work against the best efforts to prevent child abuse and neglect?, and What do you think needs to be done to address the barriers? Finally, during home visits with postpartum women and their newborns in collaboration with the assigned RN preceptor observations were noted.

To evaluate the CFTF cases, data was organized by type of fatality and associated risk factor(s). In the record audit, risk factors (as defined by the literature) for each post-partum and newborn record were identified. Data from the CFTF cases was integrated with the data from the record audit. Data from key informant interviews and observations from home visits further informed the findings.

Findings

A total of 59 CFTF cases from 2012 to 2014 were reviewed. Of the 59 cases, 37 were unpreventable events at the time, such as illness, birth defect, or premature rupture of the membranes (PROM). Out of this 37, 12 were due to PROM, of which at least 8 mothers had a risk factor for PROM and at least 7 received late or no prenatal care (PNC). Of the remaining 22 cases, 2 deaths were self-inflicted, 7 were inflicted by a family member or stranger, and 13 involved neglect.

For the record audit, 58 with complete information were reviewed. Of the 58 charts, 26 (44.8%) of the clients were twenty-one years old or younger. Thirty-one (53.4%) did not finish high school; 16 (27.6%) finished high school or earned their GED, but received no college; 10 (17.2%) had some college; and only 1 (1.7%) graduated from college. Forty-four (75.9%) clients were unemployed, while 7 (12.1%) were employed and 7 (12.1%) were students. Forty-eight (82.8%) women were single, while 9 (15.5%) were married, and 1 (1.7%) was separated. Forty-three (74.1%) received late PNC. Thirty-five (60.3%) homes had more than 4 people living there. Thirteen (22.4%) smoked before or during pregnancy; and, 14 (24.1%) used a substance or drank alcohol before or during pregnancy. Eight (13.8%) were sexually assaulted or raped as a child. Six (10.3%) reported suffering from depression. When asked "thinking back to just before you got pregnant, how did you feel about becoming pregnant" 13 (22.4%) responded "I don't know," 15 (25.9%) responded "I wanted to be pregnant later," and 3 (5.2%) responded "I did not want to be pregnant then or any time in the future." The population consisted of 23 (39.7%) Black non-Hispanic, 1 (1.7%) Black Hispanic, 12 (20.7%) White non-Hispanic, and 22 (37.9%) White Hispanic.

Three key informants were interviewed. All interviewees reported a belief that child maltreatment was moderate to moderately high in this community. Key informants spoke about risk factors including: lack of education, engagement, supervision, and support; parental substance abuse, depression, and low self-worth; and, poverty, transient living, and teenage parents. Agencies that are effective or should be effective in the prevention of child abuse and neglect are: health department, daycares, law enforcement, Department of Social Services (DSS), hospitals, private pediatricians, community action agencies, churches, and Emergency Medical Services. One interviewee discussed the "invisible" children, those children who are overlooked.

For example, when departments investigate IPV, the child may not be evaluated. A high no show rate, little parental follow through, and parents interested in tangible items but not education are some barriers that work against the efforts to prevent maltreatment. Some other barriers are lack of education and accountability, as well as the legal system. To address these barriers professionals need to be motivational, empathetic, and have effective communication skills. It's necessary to meet the family where they are and address the family priorities. Furthermore, evidenced based research interventions, funding, and community education and awareness are necessary.

Out of 19 home visits scheduled during the 7-week community health clinical rotation in which the nursing student was involved in weekly home visits, 3 mothers either refused a visit or weren't home, and the other 16 had one or more risk factor as defined by the literature. In one case the family was referred to Care Coordination for Children (CC4C).

Discussion

These findings suggest that child maltreatment in the community is being addressed through the CFTF, various health department programs, including home visitation, department of social services, and a variety of educational programs. The CFTF was started in NC to reduce child death and maltreatment, as well as increase the healthy development of children. The prevention team determines system problems and makes recommendations, which are then given to the state. Fatalities related to late or no PNC or PROM, were of particular concern. If a mother received late or no PNC, then there may not have been time or opportunity to address other risk factors for PROM. Of the 37 fatalities that were unpreventable, there were more cases of late PNC. Therefore, early PNC should be a focus on future prevention efforts. Other interventions that may be considered are parenting classes to include what to do in emergency

situations; improved mental health and drug rehabilitation services; support services for fathers; and comprehensive referral and follow-up. Recommendations by the CFTF already noted were: to continue funding the Horizons program pregnant and postpartum women affected by substance use, to continue funding to DSS, and fund perinatal health promotion efforts such as 17P injections.

Regarding the record audit, all records had documented enrollment in the Medicaid program and a majority of the records documented receipt of WIC services. The majority of cases the mother: was 21 years old or younger, did not finish high school, unemployed, single, and lived in a home with more than 4 adults. These are risk factors based upon the literature. A majority also entered into prenatal care later, a risk factor found in the CFTF case review. A combined 53.4% of mothers either unsure about the current pregnancy, wanted to be pregnant later, or didn't want to be pregnant at all, another risk factor for child maltreatment. Based on the literature and CFTF case review, there were several families at risk of child maltreatment. Currently all post-partum mother and infants receive one postpartum home-visit, some families might benefit from additional home visits. An evaluation of home visit scheduling procedure may help to eliminate the visits where the mother is not at home.

Based on the key informant interviews, it was discovered there are already several resources for families, including many free parenting programs and free child care programs. Though there are several different programs, their availability may be limited or they are underutilized. For example, one free parenting program for children with challenging behaviors offered free child care, free meals, and gas cards for participation. This program filled quickly and space was limited. Another free program at the library which offered an opportunity for child development through story time, music, and arts, seemed to be underutilized. Since parents have

an interest in tangible items, there needs to be funding for more placements in the programs which offer tangible items or funding for the other programs that provide incentives. This county has a *Young Moms Connect* program that is a highly effective support program for new and young mothers. Nurses could encourage acceptance of these resources, using clear descriptions of the benefits, during the postpartum home visit.

There may be a need to train teachers, law enforcements, health care professionals, and DSS staff on current risk factors as defined by the literature. Early PNC is of paramount importance, and a community-wide healthy mother and infant campaign may bring mothers into prenatal care in the first trimester for early assessment of risk factors. This county could benefit from a unified plan to reduce child fatalities in the county.

Conclusion

The state of child maltreatment is a reflection of community health. This county is making great strides in addressing this issue. Community forums on the prevention of child maltreatment, increased post-partum home visits, and a unified county-wide approach to child abuse prevention would go far toward elimination of child maltreatment. Additional research is necessary to evaluate the effectiveness of various interventions for preventing child abuse and neglect.

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