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IN-the-KNOW...

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Evidence-Based Management

Recurrence of Maltreatment

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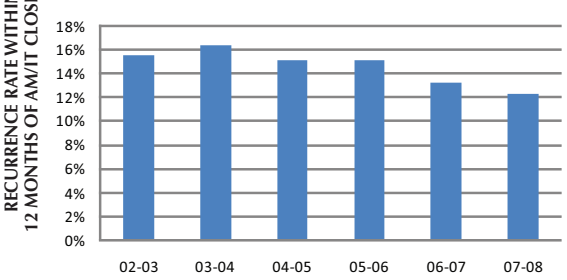
Rates of recurrence is a key indicator of the extent to which child protection and community services are able to protect children from further maltreatment. From a management perspective, tracking rates and examining factors associated with recurrence of maltreatment can help guide program development and decision-making for the types of cases identified as most likely to recur.

MEASURING RATES OF RECURRENCE AT BATSHAW

Our recurrence measure was developed in consultation with a Reference Group comprised of senior BYFC managers and clinicians, supported by the McGill Centre for Research on Children and Families. Building on the National Child Welfare Outcomes Matrix (NOM), recurrence is defined at Batshaw as ***any substantiated report of maltreatment of a child under the Youth Protection Act*** (faits fondés, SDC or SDNC) ***that occurred within 12 months of closing the file at Application des Mesures (AM) or Intervention Terminale (IT)***.

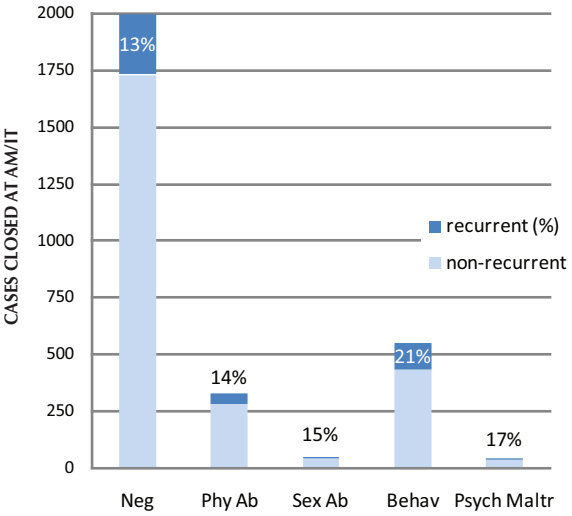
To track these cases we compiled a list of children who received AM or IT services and whose cases were closed for each year between 2002 and 2007 (approximately 500 children per year). Children older than 16 years were excluded since they would have been too old to be re-reported within the follow-up period. These cases were then monitored for any new reports of maltreatment and cases were classified as recurrent if a substantiated report of maltreatment occurred within the 12 month follow-up period.

Chart 1: Rates of recurrence by fiscal year, BYFC 2002-2008



Results reveal that on average 15% of cases recur within a year of closing. The rate appears to be declining over time (see Chart #1); a trend requiring further analyses before concluding a true decline. Rates of post-service recurrence were also examined over longer periods of time; these rates increase to 23% after 24 months and 28% after 36 months of case closure.

Chart 2: Rates of recurrence by reason for service, BYFC 2002-2008



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Recurrence of Maltreatment

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As illustrated in Chart #2, most recurring incidents involve children whose initial reason for receiving services was neglect, followed by behavioral problems and physical abuse; however, the proportion of cases that recur the most often involve behavioral problems (21%).

FURTHER ANALYSES

Other facets of recurring cases continue to be explored and findings reveal:

- Children aged 10-13 years old at the start of AM or IT services recur most often (18%), while children under age one recur least often (11%);
- The rate of recurrence is higher for cases closed after IT services (20%) compared to cases closed at AM (14%);
- 25% of cases where a report of maltreatment was not retained were re-reported and substantiated within 12 months;
- Looking as far back as records are available in PIJ, 15% of recurring cases had received on-going services on 2 or more previous occasions, while only 9% of non-recurring cases had received previous services on 2 or more occasions;
- Cases recurring within the first 12 months recur on average within 116 days of case closure.

DIFFERENCES IN RATES OF REPORTED RECURRENCE

There are significant differences in the way rates of recurrence are calculated and reported in different jurisdictions. These variations can be a factor of: 1) the period of time over which data are collected; 2) the types of events that are counted as recurrent; and 3) the types of cases that are considered to be at risk of recurrence. In addition, many jurisdictions report recurrence *retrospectively*, using data on families who have an open file and looking back in time. This measure over-estimates chronic situations (i.e. children with multiple recurring incidents of maltreatment) and fails to take into consideration families who are never re-reported. The Québec Ministry of Health and Social Services, for example, measures recurrence rates retrospectively: using their method, our recurrence rate is in the range of 40%, significantly higher than our reported rate of 15%.

Considerable time and effort on the part of the Reference Group has gone into comparing the various definitions, concluding that the base recurrence measure should focus on a *prospective* count that tracks cases forward over a defined period of time, capturing both recurring and non-recurring cases.

CONCLUSIONS

The results of the analyses are generally encouraging: the vast majority (85%) of children who received AM or IT services at BYFC do not return because of a new substantiated report of maltreatment within the first 12 months of their case closing. It is equally important to note that a return is not necessarily a negative outcome, since in some cases this could be a request for help from a family facing new challenges. Nevertheless, for many of these recurring cases one must question whether a more effective intervention would have prevented the recurring event. As we analyze the recurring cases further, and as comparable recurrence data becomes available in other jurisdictions, we will be in a better position to determine whether adjustments to our programs and services may be required to ensure that as many children as possible continue to be safe and thrive after receiving services from BYFC.

This indicator of child safety should be used by youth protection managers to *enhance* decision-making, programming, and policy development, rather than to guide individual clinical decision-making. Together with other outcome indicators, it helps provide an overview of the complex issues common to families involved with child protection services, and should not be examined in isolation. ITK

Youth Protection Response to Sexual Abuse

The following is a summary of a Thesis completed by Elizabeth Fast for the McGill University Masters in Social Work program.

Child sexual abuse (CSA) cases are evaluated by youth protection workers less frequently than other types of abuse allegations, making up only 3% of all investigated cases of abuse and neglect in Canada (CIS, 2003). It is therefore difficult for any one youth protection worker to develop an in-depth knowledge of the dynamics and characteristics of sexual abuse.

The nature of CSA differs greatly from physical abuse and neglect in that such acts are due primarily to the perpetrator's distortions in thinking, thus adding to the overall complexity of these cases. Research indicates that between 40-50% of sexual offenders will re-offend in their lifetime if not treated, and although well-designed treatment can reduce recidivism, life circumstances can affect the chances of new offences. How, then, should Youth Protection workers intervene with victims and their families? In particular, how should living and visiting arrangements be managed between children and offenders, particularly if that person is a close relative? What type of treatment, if any, can protect children from re-victimization?

There is surprisingly little research regarding the effects of allowing or disallowing contact between victims and offenders in cases of CSA, and there is no definitive set of guidelines for determining when contact would be appropriate or when it is strongly contra-indicated. In a review of the literature, however, the author came across seven major factors that should be incorporated into agency decisions concerning treatment recommendations and restrictions of contact between victims and offenders. These are considered "best practice" guidelines:

(1) Type of abuse – Sexually abusive acts range on a continuum from exhibitionism to intercourse, and an offender's behaviors will often progress over time in scope and severity along this continuum. Children who are not victims of any of these acts but have contacts with an alleged offender should also be considered *at risk*.

(2) Caregiver's response to allegations – The more protective and responsive a non-offending caregiver becomes after learning of the abuse, the safer the child will be. High risk factors include parents who refuse to believe the abuse has occurred, create stories to explain what happened, and do not acknowledge the protection needs of the child.

(3) Offender's relationship to victim – Generally, restrictions on contact are easier to impose if the offender has no legal or biological relationship to the child. If the offender was living with the child at the time of the abuse and and/or the offender is a family member, decisions around restrictions of contact become more important.

(4) Treatment of child – Victims of CSA who receive treatment generally have better outcomes; however, some children show positive changes without treatment, possibly due to the support of the non-offending caregiver and/or the relationship of the victim to the perpetrator. Parental involvement in abuse-specific therapy seems to be particularly important in the recovery process for both the parents and the child.

(5) Treatment of non-offending caregiver – Research has shown that mutual support groups for non-offending parents may help them cope with feelings of shock and isolation. When a child is considered *at risk* of sexual abuse, educational counseling is suggested for caregivers unable or unwilling to grasp the potential risk.

(6) Treatment of offender – Although sex offenders will always pose a risk to children, it may be reduced with treatment. In *at risk* situations, specific sex offender assessments are appropriate only when the offender has a known history of acknowledged inappropriate sexual behaviour or if they have been convicted of an offence. When the risk is less clear, such as when an individual has been charged but not yet convicted, a parent-child or family assessment conducted by someone with expertise in risk and sex offender assessments may be a more appropriate tool.

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Youth Protection Response to Sexual Abuse

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(7) Restrictions of contact between victim and offender – Decisions regarding access to the child should consider the relationship of the offender to the child, their physical location with respect to the child, their ability to gain physical access, and willingness and ability of other family members to control this access.

STUDY UNDERTAKEN AT BATSHAW (2005-2006)

The author engaged in a study to determine the number of children at Batshaw who were investigated for sexual abuse in 2005 and 2006; the characteristics of victims, offenders, and caregivers; and the extent to which agency decisions in these cases were based on the best practice guidelines described above.

The author found that of all investigated reports, 1.9% were for allegations of sexual abuse, and 1.2% were for *at risk* situations. The overall substantiation rate was 94%. In the great majority of cases the offender was the father, parent's partner, or sibling. About 20% of non-offending parents were not supportive of their children immediately following disclosure and 20% were ambivalent. The study further revealed that best practice guidelines were followed in almost 90% of recommendations for treatment, and in 70% of recommendations concerning restrictions of contact.

Despite the fact that CSA comprise such a small percentage of the overall number of cases, the complexity of their dynamics calls for a response which is informed by best practice. The results of the study demonstrate true efforts on the part of workers to adhere to best practice, and show only a limited need for practice shifts in certain cases. ITK

BYFC Sexual Abuse Clinical Integration Group

A Clinical Integration Group (CIG) is made up of individuals who share a particular interest in a clinical issue that affects the well-being of the children and families we serve. Its overall purpose is to promote within BYFC the development and the integration of knowledge into clinical practice. Sources of knowledge include the literature, research findings, clinical experience as well as administrative data. There are presently two clinical integration groups running at Batshaw in the areas of Sexual Abuse and Conjugal Violence.

One important mandate of the Sexual Abuse CIG is to provide case consultation throughout BYFC regarding the management of sexual abuse issues. This process has been formed with the goal of supporting staff and developing evidence-based, best practice in these situations. A consultation is generally requested when there is uncertainty about the best approach to take or when validating or interpreting symptoms in a given situation. The process is open to all workers and their managers or coordinators who provide services to a client or resource. Consultations are not a substitute for clinical supervision; however, the worker will be provided with suggested approaches and interventions.

Consultation Forms are available from Chantal Bergeron (6 Weredale – ext. 1118). **Case consultations will occur at 6 Weredale every third Wednesday of the month from 9:30 to 12:00.** For more information, please contact your CIG representative, or Lise Milne at **lise.milne@mcgill.ca**. ITK

- All material featured in ***In the Know*** is available in Batshaw's library. For complete copies of any material please contact Janet Sand at janet_sand@ssss.gouv.qc.ca
- Have you read any interesting and relevant articles or books recently? Let us know and we may include it in a future edition - lise.milne@mcgill.ca
- If you have any comments or questions about ***In the Know***, you may direct them to Claude_laurendeau@ssss.gouv.qc.ca. We welcome your feedback!

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