Children's Trust Fund
Protecting Michigan's Children

Child Abuse Statistics: Michigan & National

Michigan[1] (FY2019)**:

- ☐ This data represents the number of Child Protective Services investigations for the past ten years. They are: 2009, 71,780; 2010, 78,893; 2011, 83,627; 2012, 91,159; 2013, 87,980, 2014 80,117, 2015 92,729, 2016: 90,356, 2017:90,760, 2018: 100,123, 2019: 99,788 (95,868 assigned for investigation and 3,900 accepted and linked investigations) .
- ☐ In 2018 22% of investigations resulted in evidence of abuse or neglect.[1]
- ☐ Of all disposed of investigations in 2019, a total of 21,448 complaints were confirmed representing 33,060 identified victims.[1]
- ☐ 33% of victims were under the age of four.[1]
- ☐ In approximately 81 percent of all cases, the perpetrator was the parent (biological, adoptive, putative or step-parent).[1]
- ☐ Since the first year that the Five Category Disposition data became available (FY2002), the distribution of investigation dispositions has remained consistent. Twenty-two to twenty-seven percent are category I, II, or III (confirmed - preponderance of evidence), and 72 to 78 percent are category IV or V (no preponderance of evidence). In FY 2019 those percentages were 22 and 78, respectively.[1]
- ☐ In a study by Caldwell & Noor (2005), costs of child abuse in Michigan were estimated at $1,827,694,855. The costs of prevention are a fraction of the costs of abuse. Cost savings ranged from 96% to 98% depending on the prevention model tested.[2]

Nationally: (FY2018)[3]

- ☐ An estimated 678,000 children were victims of maltreatment.
- ☐ An estimated 4.3 million CPS referrals representing 7.8 million children, were received resulting in approximately 3.5 million investigations or assessments.
- ☐ An estimated 1,770 in 2018 (1,720 children in 2017) died from abuse or neglect.
- ☐ In 2018, 62 percent of victims experienced neglect (including medical neglect), 10.7 percent were physically abused, 7 percent were sexually abused, and 2.3 percent of victims experienced various forms of psychological maltreatment, such as threatened abuse, parent's drug/alcohol abuse, etc. A total of 15.5 percent experienced multiple forms of abuse and neglect. Of note, 18 states reported 337 cases of child trafficking or .1 percent.
- ☐ During 2018, approximately 91.7 percent of the child abuse and neglect perpetrators were parent(s), and 22.5 percent were non-parents.
- ☐ The consequences of child abuse cost the country at least $2 trillion annually according to the Center for Disease Control from a 2015 study. The CDC determined that each child fatality represents a $16.6 million cost to the US economy. In 2015, 1,670 children died due to abuse and neglect in the US alone. Each case of non-fatal child maltreatment was estimated to cost the economy $830,928 in 2015 currency.[4]

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[1] MI Department of Health and Human Services' "Children's Protective Services 2019." Please see the report (included in the CAP Month Toolkit) for additional statewide and historical data.
[2] Caldwell, R. & Noor, I. (2005). "The Costs of Child Abuse vs. Child Abuse Prevention: A Multi-year Follow-up in Michigan."
[3] US Department of Health and Human Services Administration for Families and Children 2018 Report
[4] Center for Disease Control (2015)

Children's Protective Services: Comprehensive Report

(FY2019 Appropriation Act - Public Act 207 of 2018)

March 1, 2019

Sec. 514. The department shall make a comprehensive report concerning children's protective services (CPS) to the legislature, including the senate and house policy offices and the state budget director, by March 1 of the current fiscal year, that shall include all of the following:

(a) Statistical information including, but not limited to, all of the following:

(i) The total number of reports of child abuse or child neglect investigated under the child protection law, 1975 PA 238, MCL 722.621 to 722.638, and the number of cases classified under category I or category II and the number of cases classified under category III, category IV, or category V.151

(ii) Characteristics of perpetrators of child abuse or child neglect and the child victims, such as age, relationship, race, and ethnicity and whether the perpetrator exposed the child victim to drug activity, including the manufacture of illicit drugs, that exposed the child victim to substance abuse, a drug house, or methamphetamine.

(iii) The mandatory reporter category in which the individual who made the report fits, or other categorization if the individual is not within a group required to report under the child protection law, 1975 PA 238, MCL 722.621 to 722.638.

(iv) The number of cases that resulted in the separation of the child from the parent or guardian and the period of time of that separation, up to and including termination of parental rights.

(v) For the reported complaints of child abuse or child neglect by teachers, school administrators, and school counselors, the number of cases classified under category I or category II and the number of cases classified under category III, category IV, or category V.

(vi) For the reported complaints of child abuse or child neglect by teachers, school administrators, and school counselors, the number of cases that resulted in separation of the child from the parent or guardian and the period of time of that separation, up to and including termination of parental rights.

(b) New policies related to children's protective services including, but not limited to, major policy changes and court decisions affecting the children's protective services system during the immediately preceding 12-month period.

(c) Statistical information regarding families that were classified in category III, including, but not limited to, all of the following:

(i) The total number of cases classified in category III.

(ii) The number of cases in category III referred to voluntary community services and closed with no additional monitoring.

(iii) The number of cases in category III referred to voluntary community services and monitored for up to 90 days.

(iv) The number of cases in category III for which the department entered more than 1 determination that there was evidence of child abuse or child neglect.

(v) The number of cases in category III that the department reclassified from category III to category II.

(vi) The number of cases in category III that the department reclassified from category III to category I.

(vii) The number of cases in category III that the department reclassified from category III to category I that resulted in a removal.

(d) The department policy, or changes to the department policy, regarding children who have been exposed to the production or manufacture of methamphetamines.

MDHHS
Michigan Department of Health & Human Services

Children's Protective Services: Comprehensive Report

Sec. 514 (a) (i): Total reports investigated/dispositioned by CPS under the Child Protection Law, 1975 PA 238, MCL 722.621 to 722.638 and the number of cases classified under category I, category II, category III, category IV, and category V.

There were 96,084 total reports of abuse or neglect assigned for investigation in Fiscal Year (FY) 2018. There were 4,039 cases which were assigned and linked (cases which were added and "linked" in MiSACWIS to active investigations) in FY 2018. There were 95,465 total cases disposed in FY 2018.

Disposed Cases and Classifications	
Category I (preponderance finding with court involvement)	4,432
Category II (preponderance finding with future risk of abuse/neglect which is high or intensive)	6,819
Category III (preponderance finding with future risk of abuse/neglect which is low or moderate)	14,403
Category IV (no preponderance finding)	68,741
Category V (no evidence of abuse/neglect)	1,070
Other	0
Total	**95,465**

***** *Disparity in case disposition totals and investigation totals are the result of case report carry-overs from the previous fiscal year.*

Sec. 514 (a) (ii): Characteristics of perpetrators of abuse or neglect and the child victims.

FY 2018 Victims of Abuse/Neglect by Race and Gender (age 3 and under)							
	White	Black	American Indian	Asian	Native Hawaiian	Unable to determine/ Declined	Grand Total
Female	3,801	2,776	102	27	10	202	6,918
Male	4,185	3,044	109	31	14	203	7,586
Unable to Determine	6	4	0	0	0	1	11
Grand Total	7,992	5,824	211	58	24	406	14,515

Children's Protective Services: Comprehensive Report

FY 2018 Victims of Abuse/Neglect by Race and Gender (age 4 and above)							
	White	Black	American Indian	Asian	Native Hawaiian	Unable to determine	Grand Total
Female	7,813	3,613	195	70	22	33	11,746
Male	7,383	3,755	207	67	21	37	11,470
Unable to Determine	3	3	0	0	0	1	7
Grand Total	15,199	7,371	402	137	43	71	23,223

Victim Relationship to Perpetrator	Total
Adoptive Sibling	26
Adoptive Child	424
Biological Sibling	467
Biological Child	42,959
Child (guardianship)	203
Cousin	81
Foster Child	83
Foster Sibling	4
Grandchild	842
Half Sibling	64
Niece/Nephew	439
Not Related	6,149
Other Relative	204
Putative Child	54
Step Grandchild	48
Step Child	1,602
Step Sibling	16
Unknown	377
Total	**54,042**

Perpetrator Relationship to Victim	Total
Adoptive Parent	443
Adoptive Sibling	24
Aunt/Uncle	459
Biological Parent	42,532
Biological Sibling	392
Cousin	89
Foster Parent	72
Foster Sibling	3
Grandparent	911
Guardian	164
Half Sibling	70
Legal Guardian	22
Not Related	6,352
Other Relative	476
Putative Parent	109
Step Parent	1,606
Step Sibling	24
Unknown	274
Total	**54,022**

** A single perpetrator can have multiple relationships if the individual is a perpetrator to multiple victims.*

Perpetrator by Age	Total
10-20	1,515
21-30	12,732
31-40	10,829
41-50	3,999
51-60	1,244
61-70	325
71-80	75
81-90	10
91+	8
Other	40
Total	**30,777**

Perpetrator by Race	Total
White	20,130
African American	9,615
American Indian	555
Asian	180
Native Hawaiian	41
Unable to Determine	256
Total	**30,777**

Children Victims Exposed to Drug Activity

An enhancement is needed in MiSACWIS (Michigan's State Automated Child Welfare Information System) as this is not currently captured within the system. A request to make a design change to MiSACWIS has been made and will be prioritized.

Sec. 514 (a) (iii): The mandatory reporter category in which the individual who made the report fits, or other categorization if the individual is not within a group required to report under the child protection law, 1975 PA 238, MCL 722.621 to 722.638.

70.1% of all assigned investigations during FY 2018 were reported by mandated reporters. The remaining 29.9% were reported by non-mandated reporters.

69.9% of total complaints made during FY 2018 were reported by mandated reporters. The remaining 30.1% were reported by non-mandated reporters.

**Disparity between the total number of disposed cases for FY 2018 and the total number of reporters is due to multiple factors, including: a referral made during the FY may not have been disposed of during the FY, along with multiple reporters can call in the same complaint, which would be assigned as one investigation with multiple complaint sources.*

Children's Protective Services: Comprehensive Report

Mandated Reporter Category (Cases Assigned for Investigation)	
Audiologist	3
Case Management Staff	0
Childcare Provider	625
Clergy	139
Coroner/Medical Examiner	5
Court Personnel	1,085
Counselor/Therapist	0
Dentist/Registered Dental Hygienist	108
DMH Facility Personnel	141
DMH Facility Social Worker	316
Domestic Violence Provider	77
FIS/ES Worker/Supervisor	718
Friend of the Court	171
Hosp/Clinic Personnel	601
Hosp/Clinic Physician/Physician's Assistant	1,399
Hosp/Clinic Social Worker	9,997
Law Enforcement Personnel	15,796
Licensed Therapist	3,465
Marriage/Family Therapist	454
MDHHS Facility Personnel	160
MDHHS Facility Social Worker	119
Nurse (Not School)	3,017
Other	0
Other Public Social Agency Personnel	1,134
Other Public Social Worker	1,433
Other School Personnel	2,766
Other Social Worker	1,473
Paramedic/EMT	146
Private Agency Social Worker	1,426
Private Physician/Physician Assistant	162
Private Social Agency Personnel	665
Psychologist	485
School Administrator	2,683
School Counselor	5,765
School Nurse	302
Social Services Specialist/Manager (CPS, CFC, etc.)	3,887
Teacher	6,643
Total	**67,366**

Non-Mandated Reporter Category (Cases Assigned for Investigation)	
Anonymous	4,621
Birth Match	412
Friend/Neighbor	6,081
Other	2,051
Parent/Sub In Home	2,199
Parent/Sub Out of Home	6,150
Relative	6,742
Sibling	215
Victim	230
Total	**28,701**

Children's Protective Services: Comprehensive Report

Mandated Reporter Category (All Cases)	
Audiologist	4
Case Management Staff	1
Childcare Provider	1,314
Clergy	334
Coroner/Medical Examiner	13
Court Personnel	1,938
Counselor/Therapist	0
Dentist/Registered Dental Hygienist	151
DMH Facility Personnel	318
DMH Facility Social Worker	675
Domestic Violence Provider	137
FIS/ES Worker/Supervisor	1,388
Friend of the Court	384
Hosp/Clinic Personnel	1,128
Hosp/Clinic Physician/Physician's Assistant	2,622
Hosp/Clinic Social Worker	16,636
Law Enforcement Personnel	23,629
Licensed Therapist	7,722
Marriage/Family Therapist	1,015
MDHHS Facility Personnel	304
MDHHS Facility Social Worker	214
Nurse (Not School)	5,878
Other	95
Other Public Social Agency Personnel	2,436
Other Public Social Worker	3,067
Other School Personnel	4,898
Other Social Worker	3,164
Paramedic/EMT	235
Private Agency Social Worker	3,438
Private Physician/Physician Assistant	311
Private Social Agency Personnel	1,591
Psychologist	1,041
School Administrator	5,425
School Counselor	9,777
School Nurse	447
Social Services Specialist/Manager (CPS, CFC, etc.)	6,032
Teacher	11,955
Total	**119,717**

Non-Mandated Reporter Category (All Cases)	
Anonymous	8,003
Birth Match	1,061
Friend/Neighbor	9,893
Other	3,860
Parent/Sub In Home	4,664
Parent/Sub Out of Home	11,791
Relative	11,705
Sibling	325
Victim	369
Total	**51,671**

Children's Protective Services: Comprehensive Report

Sec. 514 (a) (iv): Cases involving child separation from parent or legal guardian.

In FY 2018, 6,969 children were separated from a parent or legal guardian. The period of time of the separation of a child from the parent or guardian is not captured through the CPS program; however, the status of these separated children at the close of FY 2018 can be determined. Of the 6,969 children who were separated, 969 had their case closed after either returning home or to another planned living arrangement, 6,000 children had an active foster care case at the end of the fiscal year and 359 cases resulted in termination of parental rights of both parents.

Sec. 514 (a) (v): Disposition categories for complaints made by teachers, school administrators, and counselors.

For the reported assigned complaints of abuse or neglect by teachers, school administrators, and school counselors, 15,188 investigations occurred. Of the 15,188 cases, 259 were classified as category I cases, 773 were classified as category II cases, 1,282 were classified as category III cases, 12,738 were classified as category IV cases, and 135 were classified as category V cases. There was one case with an unknown status.

Sec. 514 (a) (vi): Cases involving child separation from parent or legal guardian specific to cases reported by teachers, school administrators, and counselors.

For the reported assigned complaints of abuse or neglect by teachers, school administrators and school counselors, 466 cases resulted in separation of the child from the parent or guardian and 25 cases resulted in termination of parental rights. The period of time of the separation of a child from the parent or guardian is not captured through the CPS program; however, the status of these separated children at the close of FY 2018 can be determined. Seventy-two (72) cases were closed during FY 2018 and 394 remained open at the end of the fiscal year.

Sec. 514 (b): New policies related to children's protective services including, but not limited to, major policy changes and court decisions affecting the children's protective services system during the immediately preceding 12-month period are listed below:

Coordination with Prosecuting Attorney and Law Enforcement: PSM 712-3
Part of this policy was made obsolete as LEIN information is now covered under SRM 700, titled Law Enforcement Information Network.

Intake – Minimal Priority Response Criteria: PSM 712-4
Policy was updated to clarify the definition of commencement.

CPS Intake – Special Cases: PSM 712-6
Policy was updated to provide clarification to the assignment of CPS-MIC cases and also to CPS-MIC investigations.

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CPS Investigation – General Instructions and Checklist: PSM 713-1
Policy was amended to include instructions on contacting non-custodial parents. Guidance regarding not maintaining recordings of interviews at Child Assessment Centers was also added.

Medical Examination and Assessment: PSM 713-4
Policy was updated to include for whom a medical examination must be requested for. This change also removed siblings of the alleged victim in certain situations. Policy was updated to provide additional information regarding medically fragile children. In addition, guidance and direction was added regarding engaging with parents to obtain a medical examination.

Completion of Field Investigation: PSM 713-9
Policy was updated to include additional types of allowances for investigation extension requests. Policy was also clarified regarding face to face contacts regarding overdue cases, as well as submission of investigation.

Child Abuse and Neglect Central Registry: PSM 713-13
To reflect legal clarification, licensed foster parents, owners, operators, volunteers, or employees of licensed or registered child care organizations must be listed on Central Registry in any case in which there is a preponderance of evidence of child abuse and/or neglect, when the victim is not their own child.

Family Court: Petitions, Hearings, and Court Orders: PSM 715-3
Policy was updated to indicate CPS supervisors must review and approve petitions filed for removal of children. Policy was updated to address new legislation clarified by In RE Gach. Clarifying directions were added regarding parents securing a Power of Attorney. Policy was added to guide field staff regarding mediation proceedings.

CPS Coordination with Foster Care: PSM 715-4
Timeframes regarding case responsibility were updated. Previously, cases would be maintained by foster care if the children were returned home within the first twenty-one days. This was changed to seven days.

Complaints Involving Substances: PSM 716-7
Clear direction for worker safety was added to reinforce the importance of workers obtaining law enforcement assistance on cases involving potentially dangerous substances. Direction on assignments were added regarding infants born and testing positive for substances. Direction regarding when verification of medication is needed and how to complete this task was added.

Policy was updated to indicate children testing positive for substance upon birth was no longer child abuse or neglect, in and of itself. Workers must demonstrate parental incapacity or other negative impacts to the child.

Children's Protective Services: Comprehensive Report

Sec. 514 (c): The information required under section 8d(5) of the Child Protection Law, 1975 PA 238, MCL 722.628d, pertains to information regarding families that were classified in category III.

Category III cases are typically identified as having two distinct sub-classifications which require referring to voluntary community service and close, or referring to voluntary community service and reassessing risk within for 90 days. In FY 2018 there were no cases that had an unknown/other option selected. In FY 2018, there were 18,686 identified victims in all category III cases. There were 4,514 victims which were identified as having more than one confirmed maltreatment.

Category III Options	Total
90-day monitoring	3,746
Open/Close	10,668
Other	0
Grand Total	14,414

Category Escalations	Total
III to II	120
III to I	53
II to I	164
Grand Total	337

**An enhancement was recently created in MiSACWIS (Michigan's State Automated Child Welfare Information System) to allow category III case escalations to be completed in the system. This enhancement was released on 12/27/2017 and is partial FY data. Prior to the release, this information was unable to be captured in MiSACWIS.*

For the 337 cases which were escalated during FY 2018, 53 cases were escalated from category III to category I and 19 children were removed. Of the 164 cases escalated from category II to category I, 83 children were removed.

Sec. 514 (d): CPS Policy regarding methamphetamine exposure.

The department did not make any changes to CPS policy regarding children who have been exposed to the production or manufacturing of methamphetamine during FY 2018. MDHHS policy requires all complaints regarding children who have been exposed to the production or manufacture of methamphetamines be assigned for investigation. The Michigan Child Protection Law (CPL) (MCL 722.623 and 722.628) requires MDHHS to refer to the prosecutor and law enforcement within 24 hours of receipt of all complaints

with allegations that indicate potential violations of the public health code involving methamphetamine (MCL 333.7401c). The CPL, Section 17, requires MDHHS to file a petition for court jurisdiction within 24 hours of determining a preponderance of evidence exists that a child has been exposed to or had contact with methamphetamine. The department must also obtain a medical examination of all child victims and any other children residing in the household when a child has been exposed to or had contact with methamphetamine.

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Accessing Local, County-based CAN Statistics

To access county-based child abuse and neglect statistics, we encourage grantees to utilize KIDS COUNT.

Michigan Data:
The steps to acquire the Michigan data are:

- Go to http://datacenter.kidscount.org/
- Either enter the state desired in the *Location* section or;
- Click the State of Michigan in the *Choose a State* section which will take the user to the home page for the Michigan Data.
- Note: There are other tabs on this page including *Data by Topic*.
- On the left side of the screen the user may sort for the desired information by several variables, including local Michigan areas (cities, counties, congressional districts), topics and data provider. The screen will automatically update based upon the information chosen.
- The center screen area will default to state data.

National Data:
The latest data is from: http://www.acf.hhs.gov/programs/cb/research-data-technology/statistics-research/child-maltreatment

- This page will provide a number of links to child maltreatment reports. Choose the desired one and click.
- The right side of the page provides additional resource material links.

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The Protective Factors

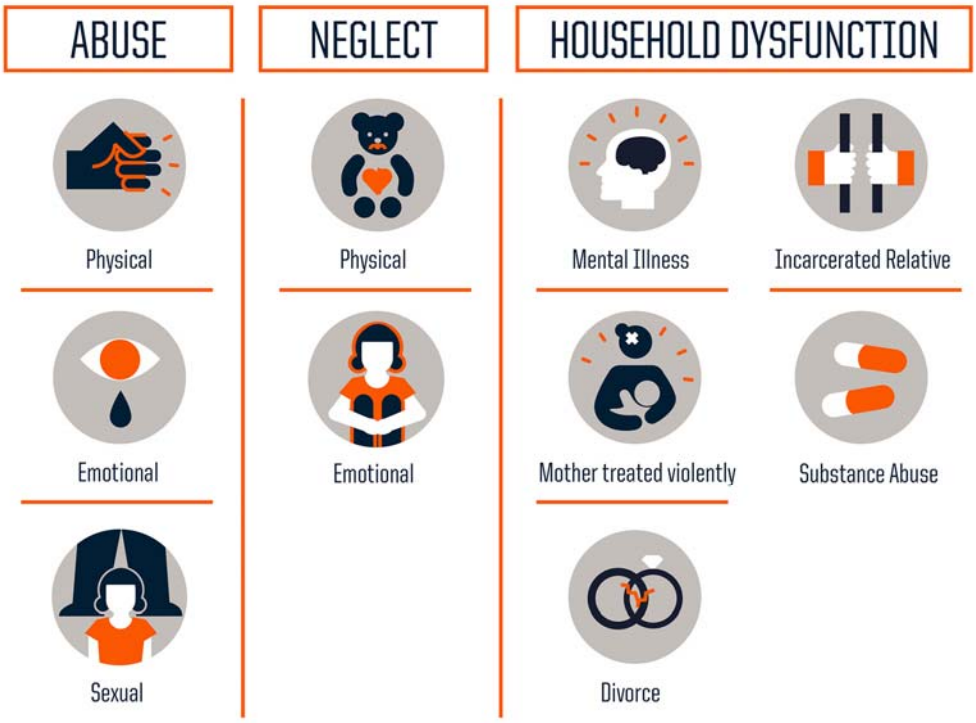
When relating stories of successful prevention strategies, it is important to connect the dots from the program to the prevention of child abuse. Given the public's overwhelming tendency to think about child abuse in its worst forms, the term "child abuse prevention" is still not well understood and is mainly thought of in terms of solely reporting incidents of child abuse and neglect. There is still a lot of opportunity to educate the public regarding known effective prevention strategies.

For years, researchers have been studying the common risk factors among families experiencing abuse and neglect and the protective factors among families who are under stress. There is growing interest in understanding the complex ways, for how both factors can affect the incidence and consequences of abuse and neglect within the context of a child's family, community, and society. Research has found that successful interventions must reduce risk factors and promote protective factors to ensure the well-being of children and families.

- Protective factors are positive attributes that strengthen *all* families. A universal approach helps get needed support to families that may not meet the criteria for "at-risk" services, but who are dealing with stressors that could lead them to abuse or neglect.
- Focusing on protective factors, which are attributes that families themselves often want to build, helps service providers develop positive relationships with parents. Parents then feel more comfortable seeking out extra support if needed. This positive relationship is especially critical for parents who may be reluctant to disclose concerns or identify behaviors or circumstances that may place their families at risk.
- When service providers work with families to increase protective factors, they also help families build and draw on natural support networks within their family and community. These networks are critical to families' long-term success.

Click on the Resource Guide
https://www.childwelfare.gov/preventing/preventionmonth/resource-guide/

Adverse Childhood Experiences (ACEs)



35% of people in Michigan have 4 or more ACEs….You are not alone!*

Learn your number—make a difference.

*Michigan behavioral Risk Factor Survey ACE Study

Could your past be affecting your current health?

So, what are ACES?

- They are difficult experiences that you had when you were young.

Why do they matter?

- Because they put you at risk for things like heart disease, depression, addiction, and more.

Why should I learn about ACES?

- Because they help you understand how your life and experiences shape who you are and they help you let go of self-blame.

What do I do if I have had ACES?

- Find a trusted person to talk to, take care of yourself, find help when you need it.

Can you bounce back if you have had ACES?

- Definitely. There is always hope and things to do to bounce back.

Keeping the Family Strong

Every family has strengths, and every family faces challenges. When you are under stress-the car breaks down, you or your partner lose a job, a child's behavior is difficult, or even when the family is experiencing a positive change, such as moving into a new home-sometimes it takes a little extra help to get through the day.

Protective factors are the strengths and resources that families draw on when life gets difficult. Building on these strengths is a proven way to keep the family strong and prevent child abuse and neglect. This tip sheet describes six key protective factors and some simple ways you can build these factors in your own family.

Protective Factor and What it Means	What You Can Do
Nurturing and Attachment: Our family shows how much we love each other.	* Take a few minute at the end of each day to connect with your children with a hug, a smile, a song or a few minutes of listening and talking. * Find ways to engage your children while completing everyday tasks (meals, shopping, driving in the car). Talk about what you are doing, ask them questions, or play simple games (such as "I Spy").
Knowledge of Parenting and Child Development: I know parenting is part natural and part learned. I am always learning new things about raising children and what they can do at different ages.	* Explore parenting questions with your family doctor, child's teacher, family or friends. * Subscribe to a magazine, website, or online newsletter about child development. * Take a parenting class or attend a parent support group. * Sit and observe what your child can and cannot do. * Share what you learn with anyone who cares for your child.
Parental Resilience: I have courage during stress and the ability to bounce back from challenges.	* Take quiet time to reenergize: Take a bath, write, sing, laugh, play, drink a cup of tea. * Do some physical exercise: Walk, stretch, do yoga, lift weights, dance. * Share your feelings with someone you trust. * Surround yourself with people who support you and make you feel good about yourself.
Social Connections: I have friends, family and neighbors who help out and provide emotional support.	* Participate in neighborhood activities such as a potluck dinners, street fairs, picnics or block parties. * Join a playgroup or online support group of parents with children of similar ages. * Find a church, temple or mosque that welcomes and support parents.
Concrete Supports: Our family can meet our day-to-day needs, including housing, food, health care, education, and counseling. I know where to find help if I need it.	* Make a list of people or places to call for support. * Ask the director of your child's school to host a Community Resource Night, so you (and other parents) can see what help your community offers. * Dial "2-1-1" find out about organizations that support families in your area.
Social and Emotional Competence of Children: My children know they are loved, feel they belong, and are able to get along with others.	* Provide regular routines, especially for young children. Make sure everyone who cares for your child is aware of your routines around mealtimes, naps and bedtimes. * Talk with your children about how important feelings are. * Teach and encourage children to solve problems in age-appropriate ways.

This tip sheet was created with information from experts in national organizations that work to prevent child maltreatment and promote well-being, including the Strengthening Families Initiatives in New Jersey, Alaska, and Tennessee. Preventing Child Maltreatment and Promoting Well-Being: A Network for Action. Local information was added.

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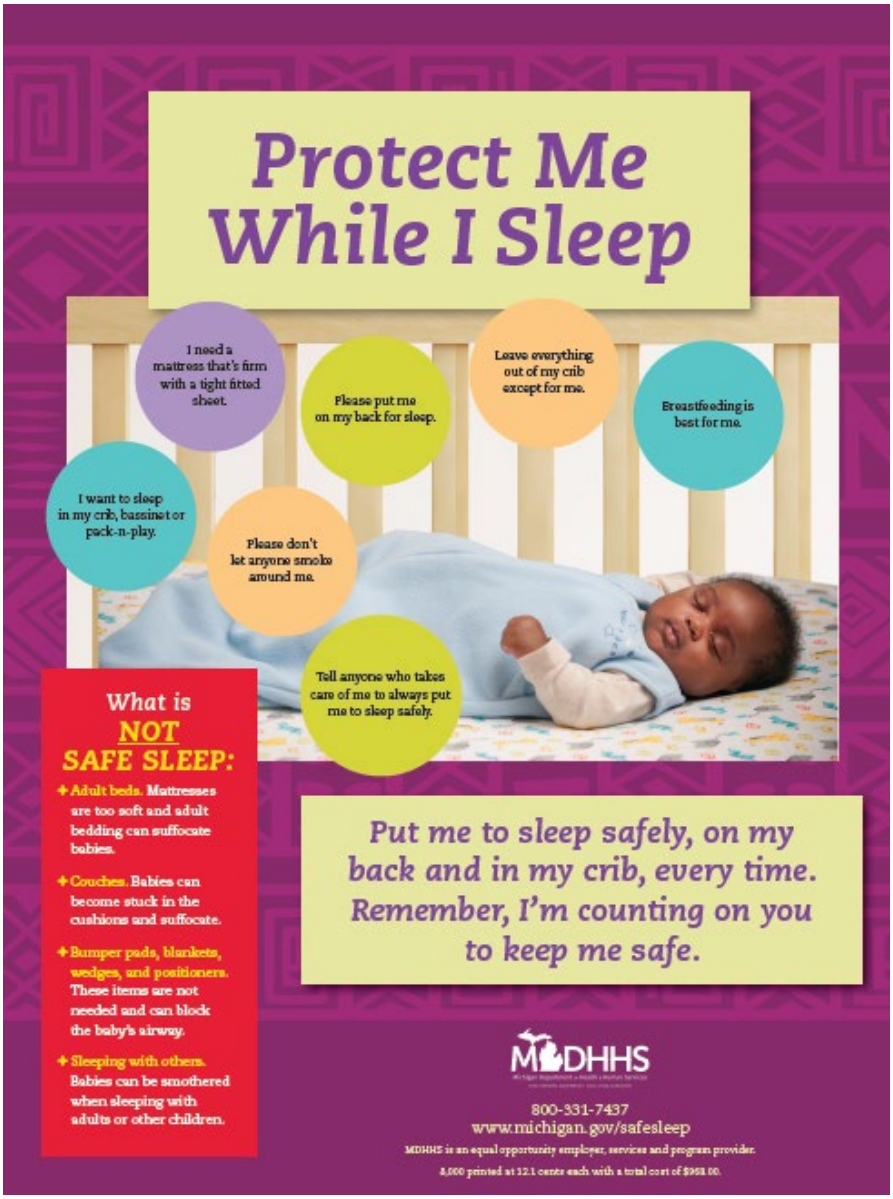
Safe Sleep

Sleep-related infant mortality is a leading cause of preventable infant deaths in Michigan. Based on 2017 data, Michigan ranked 38th among states for overall infant mortality with an infant mortality rate of 6.8 deaths per 1,000 live births (1). In 2017, 123 Michigan babies died of sleep-related causes, this is approximately one infant every three days (2). When categorizing based on cause of death, sleep-related infant deaths have been the third leading infant death category for the last several years (a,3).

[a] Categories include: perinatal conditions, congenital anomaly, sleep-related infant deaths, injury, infection and other.
Data Sources: 1. Centers for Disease Control and Prevention, National Center for Health Statistics, Infant Mortality Rates by State, 2017. 2. Michigan Public Health Institute, Sudden Unexplained Infant Death Case Registry, 2017. 3. Michigan Department of Health and Human Services, Division for Vital Records and Health Statistics, 2010-2017.

Michigan babies have suffocated while sleeping in adult beds, sharing a bed with an adult or child, sleeping alone or with a parent on furniture (e.g. sofa, stuffed chair, rocking chairs, etc.), and sleeping with pillows, cushions, and blankets.



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Additionally:

- It is recommended that infants sleep in the parents' room, close to the parents' bed, but on a separate and approved crib or portable surface designed for infants, ideally for the first year of life, but at least for the first 6 months.
- Consider offering a pacifier at nap time and bedtime.
- Avoid alcohol and illicit drug use during pregnancy and after birth.
- Pregnant women should obtain regular prenatal care.
- Infants should be immunized in accordance with recommendations of the AAP and Centers for Disease Control and Prevention.
- Avoid the use of commercial devices that are inconsistent with safe sleep recommendations including, wedges and positioners.
- Do not use home cardiorespiratory monitors as a strategy to reduce the risk of SUID.
- Encourage "Tummy Time;" it's important to practice supervised tummy time while your baby is awake to build strong neck and shoulder muscles.
- There is no evidence to recommend swaddling as a strategy to reduce the risk of SUIDS.
- Make sure everyone caring for your baby knows these guidelines, including babysitters, friends, and family members.

Suggested Activities to Promote Safe Sleep in Your Communities:

Information Distribution:

- Distribute free resource pamphlets, brochures, posters and other materials at fairs, conferences and other applicable venues, including restrooms.
- Distribute written information and other related materials (e.g. sleep sacks, pack and plays, fitted crib sheets, onesies, etc.) to the Health Department, DHHS, hospitals, baby pantries, parent support groups and applicable others.
- Share information links and videos through social media.

Community Outreach:

- Outreach to university and other student education programs for future awareness and learning opportunities.
- Outreach and coordinate services with WIC (Women Infants and Children), GSRP (Great Start Readiness Program), PAM (Parenting Awareness Michigan) and Head Start.
- Reach out to pediatricians, fatherhood initiatives, other relatives (e.g. grandparents).
- Establish working relationships with retail stores.
- Create and conduct Safe Sleep parent surveys with self-addressed postcards, coded by township and seek 65% response rate about their knowledge of and compliance with Safe Sleep practices.

Education and Training:

- Conduct awareness sessions at teen mom groups, birthing classes, homeless/transitional housing.

- Provide information and training at local baby pantries.
- Educate day care staff on Safe Sleep principles and practices.
- Provide new mom bags with Safe Sleep information at a 1 time home visit with educator.
- Conduct Safe Sleep training at the same time when the hospital does the Period of Purple Crying or other infant head trauma prevention training.
- Provide Safe Sleep training along with infant head trauma prevention training at middle and high school child development or life skills classes.
- Support MIHP (Maternal Infant Health Program) classes to child care providers.
- Add a Safe Sleep component to the Safe Baby (Baby Think it Over) Program.

Equipment and Other Giveaways

- Give away crib sets with education at pregnancy centers.
- Support crib and/or pack and play resource programs.
- Print onesies (with writing that says "If you can read this flip me over", "This side up") and give away with baby bag.

Marketing

- Create and distribute press releases, op-ed pieces, etc.
- Create and utilize Facebook, websites other social media messaging.

Resources:

American Academy of Pediatrics: http://www.aap.org/en-us/about-the-aap/aap-press-room/pages/AAP-Expands-Guidelines-for-Infant-Sleep-Safety-and-SIDS-Risk-Reduction.aspx

Center for Disease Control: https://www.cdc.gov/nchs/pressroom/sosmap/infant_mortality_rates/infant_mortality.htm.

A Parent's Guide to Safe Sleep: http://www.healthychildcare.org/pdf/sidsparentsafesleep.pdf

Consumer Product Safety Commission: http://www.cpsc.gov/en/Safety-Education/Safety-Education-Centers/cribs/

Cribs for Kids: http://www.cribsforkids.org/educational-materials/

Halo Company: https://www.halosleep.com/ (CTF receives no benefit as a result of any business conducted with the Halo Company.)

Healthy Childcare America: http://www.healthychildcare.org/sids.html

Keeping Babies Safe: http://www.keepingbabiessafe.org/

Safe to Sleep Public Education Campaign: http://www.nichd.nih.gov/sts/news/etoolkit/Pages/default.aspx

State of Michigan Safe Sleep website: www.michigan.gov/safesleep

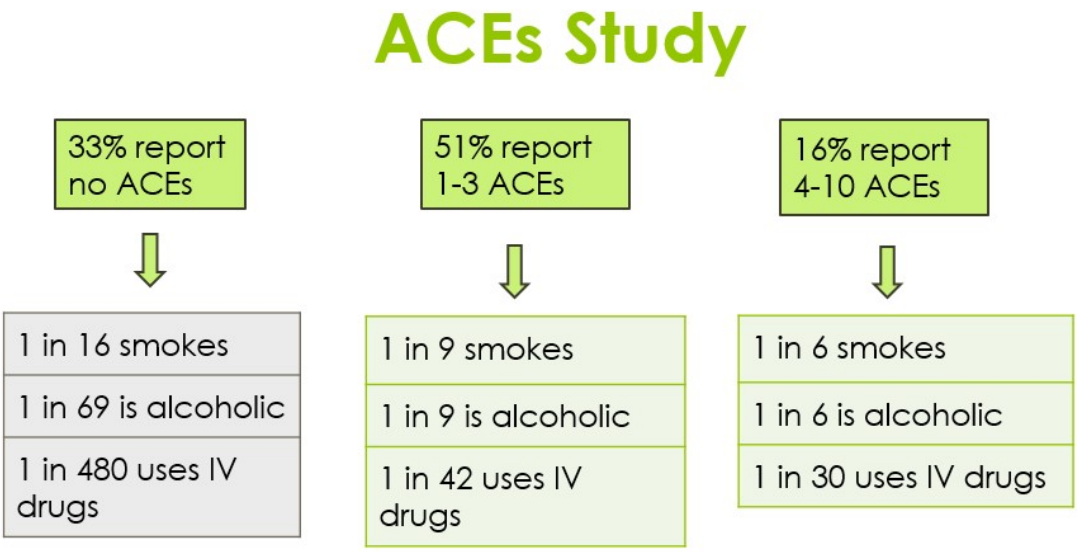
Substance Use Disorders

The purpose of this document is to help CTF Local Councils and other like-minded organizations in addressing the interconnected relationship between substance use disorders and child abuse and neglect. This is a helpful tool that includes information to incorporate substance use disorder content into primary child maltreatment prevention. Addressing child maltreatment reduces risk for substance use disorders and promotes recovery.

Substance Use Disorders and the Case for Primary Child Maltreatment Prevention:

- According to Barnard and McKeganey (2004) problem drug use can negatively impact parenting and providing a nurturing home environment. Further, Magura and Laudet (1996) found that substance abusers, including those in recovery can benefit from comprehensive family-centered services.
- Dr. Kendler conducting a study (2002) at the Medical College of Virginia Commonwealth University in Richmond found that "Overall, childhood sexual abuse was more strongly associated with drug or alcohol dependence than with any of the psychiatric disorders."
- Author Neil Swan (1998) wrote, “as many as two-thirds of all people in treatment for drug abuse report that they were physically, sexually, or emotionally abused during childhood, research shows.”
- According to research findings of Kisha Radliff (2012) of Ohio State University “…youth who bully others might be more likely to also try substance use. The reverse could also be true in that youth who use substances might be more likely to bully others.”
- A June, 2018 SAMHSA newsletter article states that there is a clear relation between childhood trauma and substance abuse. They cite a study on childhood abuse, neglect, and household dysfunction and the risk of illicit drug use. With each adverse childhood experience documented this increased the likelihood of early initiation into illicit drug use by 2- to 4-fold. (Dube et al, 2003).

ACEs and Substance Use Disorders:



***How to combat?* = RESILIENCE**

For additional ACES and Resilience information see toolkit pieces, *The Protective Factors* and *ACEs and the Protective Factors*.

Substance Use Disorders Statistics

In 2008, poisoning surpassed motor vehicle crashes to become the leading cause of injury death in the United States. Since 2003, over 90% of all poisonings have involved drugs, with the largest increase in poisonings related to opioid analgesics (pain relievers). A similar national pattern has also been seen in Michigan with poisonings exceeding motor vehicle crashes to become the leading cause of injury death in Michigan in 2009.

In 2016, 20.4 percent of Michigan adults smoked. Nationally, the rate was 17.1 percent. In 2017, 10.5 percent of high school students smoked on at least one day in the past 30 days. Nationally, the rate was 8.8 percent. In 2015, 2.9 percent of adults used e-cigarettes, 1.6 percent used smokeless tobacco and 2.5 percent smoked cigars.

In 2017, 14.8 percent of high school students used e-cigarettes, 6.3 percent used smokeless tobacco and 9.2 percent smoked cigars on at least one day in the past 30 days. Nationally, the rates were 13.2 percent, 5.5 percent and 8.0 percent, respectively. (https://truthinitiative.org/tobacco-use-michigan)

Stats from the 2017 Michigan Epidemiological Profile in regards to alcohol abuse by youth include:

1. Between 2006 and 2015, alcohol-related traffic crashes involving at least one driver, 16 to 20 years of age, who had been drinking, caused an annual average of 149 deaths and serious injuries.
2. In 2016, 697 youths 16 to 20 years of age, were admitted to treatment for alcohol as the primary drug of abuse in Michigan, accounting for 20.2% of all substance abuse treatment admissions.

Stats from the 2017 Michigan Epidemiological Profile in regards to prescription medication/opiates include:

3. Prescription drug-related mortality has increased significantly for all age groups from 2005 to 2015. For 16-20 year old rates more than doubled, going from 2.1 to 5.2 from 2005 to 2015.
4. The percent of youth who reported prescription drugs as their primary drug of abuse at admission has steadily increased from 2006 to 2016, with an overall increase of 96% during that time period.
5. This is not prescription drug specific - The rate of drug-related traffic crash deaths among youth increased 136% from 2006 to 2015. The rate of drug-related traffic crash serious injuries only increased 5% from 2006 to 2015.

The number of U.S. newborns diagnosed with symptoms of drug withdrawal nearly tripled in 10 years due to increasing opiate use among pregnant women. These newborns with Neonatal Withdrawal Syndrome (NWS, also know as Neonatal Abstinence Syndrome, NAS) are more likely to have trouble breathing, low birth weight, feeding difficulties and seizures. A recent study by MDHHS documents this problem in Michigan and highlights the increased costs due to their longer hospital stays.
Neonatal Drug Withdrawal among Michigan Infants Fact Sheet

Finding Quality Treatment For Substance Use Disorders - SAMHSA

FOR A DRUG OR ALCOHOL USE EMERGENCY, CALL 911 OR GO TO THE NEAREST EMERGENCY ROOM

Three Steps to Accessing Care

1. **If you have insurance:** Contact your insurer. Ask about your coverage and whether they have a network of preferred providers for you to use. **If you don't have insurance:** Each state has funding to provide treatment for people without insurance coverage. Find where to call for information about payment for services at **https://www.samhsa.gov/sites/default/files/ssa-directory.pdf.**
2. Review the websites of the providers and see if they have the five signs of quality treatment detailed below.
3. Call for an appointment. Many programs offer walk-in services. Look for programs that can get you or a family member into treatment quickly.

Treatment Locators

- *Substance Use and Mental Health Treatment Locator:* https://findtreatment.samhsa.gov/
- 1-800-662-HELP (4357)
- 1-800-487-4899 (TTY)
- *Alcohol Treatment Navigator:* https://alcoholtreatment.niaaa.nih.gov/

Five Signs of Quality Treatment

You can use these questions to help decide about the quality of a treatment provider and the types of services offered. Quality programs should offer a full range of services accepted as effective in treatment and recovery from substance use disorders and should be matched to a person's needs.

1. **Accreditation:** Has the program been licensed or certified by the state? Is the program currently in good standing in the state? Are the staff qualified? Good quality programs will have a good inspection record and both the program and the staff should have received training in treatment of substance use and mental disorders and be licensed or registered in the state. Does the program conduct satisfaction surveys? Can they show you how people using their services have rated them?
2. **Medication**: Does the program offer FDA approved medication for recovery from alcohol and opioid use disorders? At this point in time, there are no FDA approved medications to help to prevent relapse from other problem substances.
3. **Evidence-Based Practices:** Does the program offer treatments that have been proven to be effective in treating substance use disorders including medication management therapies, such as motivational therapy, cognitive behavioral therapy, drug and alcohol counseling, education about the risks of drug and alcohol use, and peer support? Does the program either provide or help to obtain medical care for physical health issues?
4. **Families:** Does the program include family members in the treatment process? Family members have an important role in understanding the impact of addiction on families and providing support.
5. **Supports:** Does the program provide ongoing treatment and supports beyond just treating the substance issues? For many people addiction is a chronic condition and requires ongoing medication and supports. Quality programs provide treatment for the long term which may include ongoing counseling or recovery coaching and support and,

helps in meeting other basic needs like sober housing, employment supports, and continued family involvement.

SAMHSA's mission is to reduce the impact of substance abuse and mental illness on America's communities.
1-877-SAMHSA-7
(1-877-726-4727)
1-800-487-4889 (TDD) www.samhsa.gov

Resources:

https://www.dea.gov/factsheets

https://www.michigan.gov/mdhhs/0,5885,7-339-71548_54783_54784_57850---,00.html

https://www.michigan.gov/documents/mdch/NWS_FactSheet_final_6.25.13_431275_7.pdf (NAS Baby stats)

https://www.mlive.com/news/index.ssf/2016/07/michigans_largest_counties_ran_1.html

https://www.hhs.gov/ash/oah/facts-and-stats/national-and-state-data-sheets/adolescents-and-substance-abuse/michigan/index.html

https://www.childwelfare.gov/pubPDFs/subabuse_childmal.pdf (Substance Abuse and Child Maltreatment)

https://www.childwelfare.gov/pubs/factsheets/parentalsubabuse/

https://www.drugabuse.gov/news-events/news-releases/2016/03/childs-first-eight-years-critical-substance-abuse-prevention

https://www.michigan.gov/documents/PIHPDIRECTOR_97962_7.pdf

https://www.michigan.gov/mdhhs/0,5885,7-339-71550_2941_4871_29888_48562_60514---,00.html

http://www.talksooner.org/partners/