Published in final edited form as:

Acad Pediatr. 2020 ; 20(1): 46–54. doi:10.1016/j.acap.2019.06.004.

We have all been working in our own little silos forever: Exploring a cross-sector response to child maltreatment

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Abstract

Objectives: A Child Protective Services (CPS) investigation for maltreatment signals risk for childhood toxic stress and poor health outcomes. Despite this, communication between child welfare and health care professionals is rare. We present a qualitative exploration of experiences with, barriers to, and hopes for cross-sector collaboration for children with suspected maltreatment.

Methods: We conducted focus groups with child welfare and health care professionals participating in a cross-sector learning collaborative to improve care for children at high risk for toxic stress. Participants were asked to describe two phenomena: identifying and responding to childhood adversities in their professional settings and cross-sector collaboration in cases of suspected maltreatment. Analysis included an iterative process of reading, coding and comparing themes across groups.

Results: Health care professionals shared positive experiences in screening for social risks in clinic, while child welfare professionals expressed mixed attitudes towards social risk screening during CPS investigations. Consistent with prior research, health care professionals reported limited communication with CPS caseworkers about patients, but suggested that relationships with child welfare professionals might reduce these barriers. Child welfare professionals described the poor quality of information provided in referrals from medical settings. Caseworkers also recognized that improved communication could support better understanding of maltreatment concerns and sharing of outcomes of CPS investigation.

Conclusions: Our project extends previously published research by describing potential benefits of child welfare and child health care collaboration in cases of suspected maltreatment. Lack of effective cross-sector communication and concerns about confidentiality present significant barriers to uptake of these collaborative practices.

Keywords

Adverse Childhood Experiences; Child Abuse; Child Protective Services; Primary Care

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Conflict of interest: Dr. Campbell's institution receives financial compensation for expert witness testimony provided in cases of suspected child abuse for which she is subpoenaed to testify.

INTRODUCTION

One in every 3 children in the United States will be investigated for suspicion of child maltreatment, and one in 8 will be identified as a victim of maltreatment during his or her childhood.^{1,2} Despite mandated child welfare involvement, many of these children remain at increased risk for exposure to childhood adversities, including parental substance abuse, mental illness, family violence, and repeated episodes of abuse.^{3–6} Decades of research have established associations linking this cumulative burden of childhood adversities to toxic stress and poor longitudinal health outcomes. More recent research suggests that adverse health outcomes associated with childhood adversities may be ameliorated through health care interventions that treat the effects of prior adversities and prevent accumulation of additional adversities.^{7–10}

Recognition of suspected child maltreatment and the response of Child Protective Services (CPS) offer unique opportunities to weave a strong safety net that will support a family in crisis and build resilience for a child at risk for ongoing adversities. Unfortunately, such opportunities are often missed. Primary health care providers may be so focused on appropriate identification and reporting of suspected maltreatment that they overlook the chance to identify and respond to social needs in a vulnerable family. Child welfare caseworkers may be so focused on investigation of the facts specific to the allegation of maltreatment that they fail to recognize and refer for social needs that may appear tangential to the central question of maltreatment.¹¹ Primary health care providers are not trained to ask about child welfare involvement in a household despite the prevalence of this experience across the country, and may never learn of outcomes for children who they have referred to CPS.^{12,13} Similarly, child welfare caseworkers rarely engage with primary health care providers during a CPS investigation, despite the possibility that this provider is well-positioned to intervene when a child with a history of maltreatment presents with new or evolving symptoms of toxic stress.

These siloed responses to suspected child maltreatment represent a critical barrier to improving the safety and well-being for children with a history of suspected maltreatment. In an effort to improve communication and collaboration across these traditional silos, we developed a nine-month learning collaborative that brought together child health care and child welfare professionals practicing in one region of our state. The “Collaborating for Care Around Childhood Adversities and Toxic Stress” project engaged these historically separate professional cultures to improve recognition of and response to toxic stress in children seen in their daily practices. The project also provided an innovative testing ground for changes in policy and practice intended to improve cross-sector communication around children referred by health care providers to child welfare for suspected maltreatment.

This report details the qualitative experiences of both child welfare and health care professionals enrolled in this learning collaborative. Our objective was to identify barriers to and opportunities for further cross-sector collaboration in caring for children with child welfare involvement. In addition, we explored shared and divergent perspectives on

responding to social needs and toxic stress in families of children with suspected maltreatment.

METHODS

Context:

Between May 2014 and January 2015, the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) sponsored a learning collaborative developed to improve cross-sector response to childhood adversities and toxic stress. Traditionally, the learning collaborative framework provides health care professionals with knowledge and tools drawn from evidence-based clinical guidelines to implement and track changes in practice with the goal of improving care for a specific clinical problem, such as asthma, obesity, or mental health. For this cross-sector learning collaborative, nine primary care practices and one regional child welfare agency office came together for two half-day learning sessions. Developed by UPIQ leaders with ongoing input from child welfare leaders for the state and region, content at the learning sessions included the science related to childhood adversities and toxic stress, concepts of the pediatric medical home, and comparative practices of child health care and welfare professionals.

Individual quality improvement projects focused on improved screening for and response to childhood adversities and symptoms of toxic stress in both the primary health care and the child welfare setting. Participants from both professional settings were introduced to the Safe Environment for Every Kid (SEEK) questionnaire, an evidence-based clinical tool used to identify childhood adversities and social needs, and the Traumatic Experiences Questionnaire (TEQ), a brief screener for childhood trauma and trauma-associated symptoms developed by local mental health partners engaged in the learning collaborative.¹⁴ In addition to individual practice efforts, the learning collaborative included 2 changes in practice intended to encourage collaboration between health care and child welfare participants. First, CPS referrals initiated from health care providers participating in the learning collaborative were directed to CPS caseworkers in the participating child welfare office to improve communication during case investigation. Additionally, review of existing law by leaders in the state child welfare agency uncovered an exception to strict limitations on information sharing in cases of suspected child maltreatment referred by health care providers. This allowed development and piloting of a “medical referent closure letter,” a formal letter providing a meaningful summary of findings and recommendations arising from the CPS investigation. This letter was sent to medical referents involved in the learning collaborative.

Design:

To address the study objectives, we conducted four focus groups using a modified phenomenological approach between January and March 2015. To reduce bias introduced by perceived or real hierarchy within and across professional disciplines, focus groups were divided by profession and professional role (child welfare groups of supervisors and caseworkers, and child health care groups of physicians and clinic staff).

Procedures:

Caseworker and CPS supervisor focus groups were conducted in person. Physician and clinic staff focus groups were conducted via GoToMeeting, an online communication platform that enables group discussion and screen sharing. Virtual focus groups are increasingly accepted as a means of bringing together participants who could not otherwise participate due to constraints of time or geography.^{15,16} All groups were facilitated by a qualitative researcher [AW], who was assisted by the UPIQ project manager. A focus group guide was developed by the researchers [KC, AW] with feedback from child welfare partners. Participants were asked to describe experiences related to two separate phenomena associated with the learning collaborative: (1) identifying and responding to childhood adversities experienced by children seen in their professional practice settings and (2) cross-sector collaboration in cases of suspected maltreatment.

IRB:

IRB approval was obtained from the University of Utah and the Utah Department of Human Services.

Recruiting:

Focus group samples were drawn from participants of the learning collaborative. Informed consent was obtained prior to each focus group.

Analysis:

A digital recording was made at each focus group and transcribed. Each transcription was reviewed for coding and analysis. Specific topic areas were noted as they came up in discussion, providing an initial list of topic areas. With these initial topic areas in mind, two investigators (KC and AW) independently read each transcript and identified topics discussed within and across the different focus groups. Topics addressed by at least 4 people within or across the combined groups were set aside as themes for further exploration. Axial coding of themes was accomplished by rereading text quotes within each theme, assuring consistency across themes and identifying distinct perspectives on each theme between participant groups. Investigators involved in the analysis discussed themes and interpretations to achieve consensus.

RESULTS**Participants:**

Focus groups consisted of all child welfare supervisors participating in the learning collaborative (2 men), 8 child welfare caseworkers (7 women and 1 man), 5 physicians (3 women and 2 men), and 5 medical staff (all women, including 2 medical assistants, 1 registered nurse, 1 office manager and 1 care coordinator).

Themes:

We identified themes that emerged within the two over-arching phenomena, or experiences, addressed by focus group participants. Participants spoke to us about experiences of

screening for social risks and toxic stress as well as experiences with cross-sector collaboration for children involved with CPS due to suspected maltreatment.

Experience #1: Screening for social risk, childhood adversity, and toxic stress (table 1). The perceived value of identifying and responding to social risks, childhood adversities, and toxic stress with a standard screener varied across participant groups. While physicians and clinic staff described largely positive outcomes associated with using both the SEEK and TEQ screeners, child welfare supervisors and caseworkers held diverse opinions regarding the utility of such screeners in CPS casework.

Open up that dialogue: Experiences with screening in a primary care setting.

—Physicians recognized a shift in their interactions with families as a result of the screening process. They were surprised both by the openness of their patients' caregivers and by the number and types of unmet needs faced by many of their families. Several acknowledged that they did not always feel that they could offer useful interventions, but they recognized that universal screening for childhood adversities and toxic stress “opened up a conversation” or “planted a seed” for future interactions with families in the clinic setting. Many clinic staff initially understood the screeners only as instruments to identify cases of suspected child maltreatment. The participatory process of selecting and trialing a screening instrument contributed to an evolution of these views as staff began to recognize the prevalence of childhood adversities and toxic stress in their clinics. As with the physician group, clinic staff came to understand that the screening process led to conversations with patients that would otherwise not occur. A shared experience unique to this focus group was that the process helped them to work more collaboratively with families when a CPS referral from the clinic was needed, explaining that this referral was “one thing we do to help” such families in need.

Do you have a smoke detector? Experiences with screening in child welfare investigations.

—The two CPS supervisors had divergent perspectives on efforts to introduce the SEEK screener for childhood adversity into CPS casework. One supervisor contemplated the strangeness of asking about smoke detectors in a household referred for overwhelming dysfunction. His colleague disagreed, suggesting that discussing tangible needs identified in the screener could help to win the trust of parents living in chaotic circumstances and to make small but real contributions to child safety. Both reflected that screening for social risk and household needs might contribute to building a safety net for children with suspected maltreatment, but that access to promised resources would be essential to developing and maintaining trust with families. Unlike their supervisors, CPS caseworkers did not comment on the use of a standard screener in their practice. It is possible that caseworkers perceived and/or experienced challenges to implementation of these screeners within the established protocols of a CPS investigation for suspected maltreatment. However, caseworkers did recognize the value of screening for household risk and for toxic stress by medical referents, however, suggesting that more information about these concerns in a referral for suspected maltreatment helped them to better understand the needs of a family during the investigation.

Experience #2: Cross-sector collaboration in cases of suspected maltreatment (Table 2). Participants spoke at length about the challenges and promises of improving collaboration between the two professional cultures. These conversations highlighted differences in definitions, expectations, and communication that must be overcome to improve this process.

People have different ideas: Mismatched expectations between child health care and child welfare.—This experience was most prominently reflected by CPS caseworkers, who shared stories of encounters with medical referents with unrealistic expectations of child welfare response to referred cases. There was a common perception that physicians expected caseworkers to “solve” child maltreatment concerns by providing services or removing a child from a home even in cases where these interventions were not supported by law or policy. Supervisors and caseworkers were both surprised by how little understanding health care professionals had of the child welfare system, and wished, in retrospect, that more time in the learning collaborative had been dedicated to this cross-sector training. While many medical providers expressed gratitude for improved understanding of the system, others confirmed the mismatch in expectations shared by child welfare colleagues. One provider expressed an expectation for CPS involvement in response to perceived risk rather than suspected maltreatment, noting that, “They mostly just take on problems where there’s already been abuse or injury or a problem, and that’s the only thing I kind of find frustrating.”

Something’s lost in translation: Challenges to effective cross-sector communication.—Frustration with efficient and effective communication between child welfare and child health care professionals was common. These frustrations were identified at each point of interaction between the two groups. All focus groups commented on common experiences with miscommunication during the initial referral process. These contributed to outcomes ranging from minor irritation with the intake process to significant barriers to child protection efforts due to misunderstanding of medical concerns related to maltreatment. Child welfare professionals described challenges with contacting referring health care professionals, as required by practice guidelines in medically referred cases, to gather key pieces of information during the early stages of an investigation. This lack of direct communication was compounded by inaccurate, vague, or conflicting information provided by medical referents or their proxies. Finally, child health care professionals consistently requested more meaningful information regarding the outcome of an investigation in order to better understand the CPS interventions made to support their patients and their families, and how they might address the situation in future encounters. One child welfare supervisor described an “aha moment” during the learning collaborative when he recognized the value of communication between child welfare and a child’s medical home when CPS interventions result in foster placement.

A really compromised situation: Confidentiality concerns in collaborative efforts.—Both professional groups had substantial fear of violations of patient and client privacy in cross-sector communications. Just as health care providers felt that child welfare caseworkers failed to recognize their concerns in this arena, child welfare professionals

expressed frustration with physicians and clinic staff who seemed insensitive to the need to protect information obtained during CPS investigations. Child welfare supervisors were acutely aware of the need to balance collaborative care for children with the protection of parental rights to privacy in child welfare cases.

That open line of communication: The promise of cross-sector collaboration.

—Despite these challenges, our participants shared optimism regarding the potential for cross-sector collaboration in the care of children and families referred to CPS for suspected maltreatment. Individual stories of success were presented as examples of how systems worked well together for the benefit of children. Communication with pediatricians by child welfare workers clarified the “Mongolian spots” that had been mistakenly identified as bruises by non-medical providers. Calls to CPS for high-risk families resulted in referrals to community resources previously unknown to child health care teams. These small victories drove enthusiasm for continued efforts to better define and codify communications across sectors even after the learning collaborative was completed.

DISCUSSION

Despite rising recognition of longitudinal health risks present in the child welfare population, there has been little if any systematic effort to improve collaboration between child welfare and child health care professionals. This report summarizes the qualitative experiences of one cross-sector community coming together to begin to break down the real and perceived silos that prevent collaboration around shared goals of improving outcomes for children living with childhood adversities and toxic stress.

This learning collaborative grew from a shared desire to address adverse childhood experiences and social determinants of health within child health care and child welfare practices. Both professional groups implemented some form of systematic screening for these concerns. Health care professionals expressed surprise at the prevalence of food, housing, and economic insecurity among families in their practices and satisfaction with being able to work with families to address these issues. Their experiences reinforce prior research describing largely positive responses from child health care providers who have implemented screening and referral for social risk from pediatric clinics.^{17,18} Our findings expand on the impact of such screenings in the context of suspected child maltreatment, highlighting how identification of social risk by the medical referent might support more constructive interventions from child welfare when shared with CPS caseworkers. The potential significance of this collaborative practice was revealed by child welfare caseworkers and supervisors, who recognized that social risks may be overlooked in the course of a CPS investigation if not perceived to be directly relevant to the question of maltreatment. Improved recognition of these social needs may inform the post-investigation resources provided by a child welfare agency in order to prevent future instances of maltreatment and resolve the conditions “that brought the children and family to the attention of the agency.”¹⁹

Experiences described by primary care focus group participants also supported previously published research, with expressions of frustration over the lack of information provided to

them about CPS involvement with their patients.^{13,20,21} Our findings suggest that personal relationships with child welfare professionals, as facilitated by the joint learning collaborative, may help to break down some of these barriers. Our project extends previously published research by highlighting the child welfare counterpoint to these experiences. Child welfare professionals consistently noted barriers to speaking directly with a referring medical provider, and the poor quality of information commonly provided in the “telephone game” of referrals transmitted from physician to medical assistant to social worker to CPS intake worker. Paralleling the experiences of health care providers, caseworkers and supervisors described how direct, open, and respectful communications could improve understanding of the medical team’s maltreatment concerns as well as the outcomes of child welfare involvement with a case. While our participants shared hopes for a more collaborative approach in the care of this high-risk pediatric population, both child health care and child welfare professionals shared concerns related to real and perceived expectations of confidentiality for these children and their families.

LIMITATIONS

As a qualitative study of experiences and perspectives of participants in a single learning collaborative, our findings are best seen as a call for future research and quality improvement across traditionally siloed sectors. Interpretation of our findings must be considered within the constraints of the study design. Participants were recruited for the focus groups only from those from pediatric practices that volunteered to participate in the learning collaborative and the child welfare office that participated in the learning collaborative. This reflects a potential selection bias for those primary care providers with an established interest in childhood adversities and toxic stress. The focus group consisted of a small number of physicians and their office staff, as well as CPS caseworkers and supervisors who practice in the Utah. This sample should not be considered representative of all child health care or child welfare professionals. While UPIQ worked alongside child welfare leadership in the development of this program, the learning collaborative structure and quality improvement methodologies are rooted in a medical model that did not always translate easily to the practices and policies of a large, strongly regulated state agency. This may have contributed to experiences of frustration or confusion among child welfare participants in our focus groups. While beyond the scope of the current manuscript, these experiences have constructively informed subsequent collaborations with our child welfare colleagues.

Despite these limitations, we were reassured to note that many of the themes we identified reinforced prior research, suggesting that the experiences and perspectives of our participants may be shared by others across the U.S. Finally, qualitative research is subject to the bias of those conducting the analyses. This was addressed through a systematic analysis approach. While no formal participant check was conducted, the findings have been presented in multiple forums and “ring true” to both child health care and child welfare audiences.

LASTING IMPACT

“I think that one of the big things that’s came out of this is that closure letter, you know?... It really engages those doctors so they can say, okay. Good. I’m still [moving] in the right direction and we’ll still continue to work with the family.” Cross-sector experiences from this learning collaborative resulted in new understanding of the promise offered by improved communication between child welfare and child health care. Since completion of the collaborative, Utah DCFS has adopted a new CPS practice policy requiring that a letter mailed by caseworkers to referring health care providers provide a meaningful summary of outcomes and recommendations arising from the investigation for suspected maltreatment. Evaluation of implementation and impact of this policy is ongoing.

Acknowledgements:

The authors thank the Children’s Center for allowing child health care providers and child protective services caseworkers to use the Trauma Experiences Questionnaire (TEQ) as part of the quality improvement project described in this manuscript. The Utah Division of Child and Family Services as well as the Pediatric Practices partnering with the Utah Pediatric Partnership to Improve Healthcare Quality (UPIQ) deserve thanks for active participation in this unusual quality improvement project. Finally, we thank our focus group participants for sharing their experiences and opinions with us.

Funding source: This work was supported by a Children’s Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstrations grant (1Z0C030547-01-0) awarded by the Centers for Medicare and Medicaid Services (CMS) to the Utah Medicaid Program (PI Norlin). Additional funding was provided by the Eunice Kennedy Shriver National Institute of Child Health and Human Development of the National Institutes of Health under award number K23HD059850 (PI Campbell). The Traumatic Experiences Questionnaire used in the Learning Collaborative was developed through funding provided by a Substance Abuse and Mental Health Services Authority grant (SM059489) through the National Child Traumatic Stress Initiative for Community Treatment and Service Centers (PI Goldsmith). The content is solely the responsibility of the authors and does not represent official views of the CMS, the Utah Medicaid Program, SAMHSA or the NIH.

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What's New:

Prior research describes physician frustration with CPS response to suspected child maltreatment. Our research balances these findings by connecting the perspectives of child welfare and child health care professionals and exploring opportunities for collaborative care of children with CPS involvement.

Table 1:

Screening for social risk, childhood adversity, and toxic stress

THEME	SOURCE	QUOTE
Open up that dialogue: Screening for childhood adversities and toxic stress in child welfare practice	Physicians	<i>MD2: It was a real eye-opener to me how many people were always very honest in answering those questions, and it led to certainly longer conversations. Sometimes it was just getting something either a handout with available food pantries if people were feeling food insecure, or making sure that they had other resources just to help them. Sometimes we don't have easy answers for those families that are just under financial stress. But sometimes just the availability to talk about it a little bit and understand it helped those patients know that they could talk to us about it and bring it up in the future. I think we'll see longer lasting effects from these questionnaires because families are going to be more open with us about the real struggles in their lives rather than just how healthy their child is and if they're growing and developing normally. I hope it helps open up that conversation in the future.</i>
		<i>MD1: One out of every 20 families that fill out the questionnaires have some problem. And it's usually small problems of financial stresses, access to food pantries, things that are fairly simple to deliver. We don't have any follow-up [to prove that it] lessens the stress in family enough to make a big difference, but it feels like we're making a difference. And again, it feels like we're opening a conversation to that family so that they understand that we may be able to help them in the future.</i>
		<i>MD5: I don't really care if they're ready to reveal anything to me or not on that screen. I just know that now I've started that conversation, and my hope is it plants that seed so that then they say, 'You know, she asked me about that and now I think I can go talk to her.'</i>
	Clinic Staff	<i>CS2: We thought [the learning collaborative] was more dealing with DCFS and having better reporting, which was definitely part of it. But after we got into discussing screenings and trying to find the right screen for a clinic, which I think we did, it was a little bit more exciting being able to [understand] that these kiddos go through these things that we sometimes don't realize.</i>
		<i>CS1: I love to have that kind of a conversation because [the parents] know what's coming and [think], 'You know what? These people from DCFS are really on your side they have the same goal as healthy kid, healthy family. Their goal isn't to walk in and take your kid away. Their goal is to help you be the best parent you can.' So that they don't feel threatened, but they instead embrace the situation and go, okay yeah, I'll take whatever resources I can get here.</i>
		<i>CS3: We had just...had some situations in clinic where we had to contact DCFS and learned about things in homes that were surprising. So it seemed like, 'Oh, yeah, we should probably be universally screening for these things.' It seemed really timely.</i>
		<i>CS2: [It] was good, I think, for those [parents] that were positive or had questions to open up that dialogue with the doctor or with the nurse. Like, questions that maybe wouldn't get asked. Or things that wouldn't really be thought about to kind of bring those to light a little bit better and that has really changed the direction of some of our appointments and our referrals.</i>
Do you have a smoke detector? Screening for childhood adversities and toxic stress in child welfare practice	Supervisors	<i>Sup1: Some of the questions on there were, you know, 'Do you have a smoke detector?... Our families are, I hate to say, so far beyond that, but they are. They're so far beyond, 'Does someone smoke in your house?'. ...That's the least of our concerns in a lot of our cases....I mean we have feces all over the floor, we have mold, we have stuff like that. A smoke detector sometimes is on the very back of the list. You know what I mean?</i>
		<i>Sup2: If we're able to provide them a resource, a positive thing, while we're telling them, you need to do something about the house...we've helped to build one protective factor by helping them with a resource.</i>
		<i>Sup2: Do we have the resources to get these guys a smoke detector if they don't have one? If I'm asking that question, can I do anything about it?"</i>
		<i>Sup1: The more information we can give to any outside people, especially if it's a medical concern, the better. Because they're just so at risk, you know? They just don't have a broken arm. They don't have the money, they don't have transportation, they don't have the food, they don't have – that's just the clients that we work with, you know?</i>
	Caseworkers	<i>CW5: [Physician screening] can help us to know what resources are needed. I mean, I don't know that it necessarily helps in making a supported or unsupported finding [of child maltreatment].</i>
		<i>CW1: More information's better than little, you know? We can dig through that and figure out what will help and what won't. If we have less, then it's not as much to go on.</i>

THEME	SOURCE	QUOTE
		<i>CW4: That's like the follow-up questions that we do call to ask..., 'Is this one of those families you're worried about, or is this a completely normal family that's just having an off incident? I think that opinion matters.'</i>

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Table 2:

Cross-sector collaboration in cases of suspected child maltreatment

THEME	SOURCE	QUOTE
People have different ideas Mismatched expectations between child health care and child welfare	Child welfare	<i>CW1: I think it would be nice if doctors knew how our process worked better... I think a lot of times, teachers and doctors think that we don't do anything...people don't understand how our processes work and what we can and can't do as far as supporting cases and not supporting and giving services. I think a lot of times, teachers and medical professionals think that we don't do anything but you know, with specific cases, there's not a lot we can do a lot of the time.</i>
		<i>CW4: they have an assumption that we should be removing the kid because of what happened. And they don't realize the amount of legal stuff that has to be—I mean—we have to reach certain levels of evidence to get it to court. And then parents have to admit to that petition or we go to trial and it could get dismissed. To remove a kid, we have to get a warrant signed...A crime has to happen before we can do anything.</i>
		<i>CW2: People have different ideas of what abuse is. Different levels, different criteria. We're bound by policy about what we can support in an abuse or neglect case, and the referent might think differently, but sometimes we don't have a choice.</i>
		<i>Sup2: It was interesting to see how little most of the doctors actually understood about our responsibilities, and what we could and could not do.</i>
	Child health care	<i>MD2: What I find sometimes frustrating is that there's not enough of concern on the side of Child Protective Services and CPS for the situation. I think I call during situations where I'm afraid that they are getting out of hand or that there's going to be a confrontation, and CPS says, 'Well there's not really anything to open a case for that. We kind of have to see if something happens.' I think that's because they're so busy or have such a big caseload that they don't take on things if there's a risk for problems. They mostly just take on problems where there's already been abuse or injury or a problem, and that's the only thing I kind of find frustrating. I think we should be using those services more proactively to help families and reduce risk and reduce stress rather than only using them when there's already been injury.</i>
Something's lost in translation: Challenges to effective cross-sector collaboration at each stage of investigation	Referral/ Intake	<i>MD5: I never have everything they want...they often ask for social security of the mother. I don't know what the social security number of the mother is. But now I think I've done it so many times, I pretty much know all that they're going to ask and do my best to get that. But I very rarely have everything that they need.</i>
		<i>CS1: I know that they're going to want to know the patient's demographic information, who they live with, those people's names, dates of birth, school information...they always ask—not always, they for the most part ask. I try my best to find that information so that I'm not digging through the chart to go, 'Oh, shoot, I don't know the answer to that question.'</i>
		<i>Sup1: If it's not the doctor and us communicating directly—like the doctor told the social worker, it was a social worker and something's lost in translation, so it went from doctor to [hospital] social worker to intake to us and so—it was changed significantly.</i>
		<i>CW2: It's important that the information's current and correct. Like correct contact information, really. CW4: Yes, that's another issue with doctors. CW2: [They] grab random addresses. I don't know where they get them sometimes. CW1: Here's all the addresses that they've had in their file CW5: When the child was born eight years ago. CW2: They've moved eight times.... CW4: I don't understand that, because every time I go to the doctor, that's the first question they ask me. Are you still here? And is this still your phone number? And I think that they would want that just for chasing you down to get the money out of you... [Laughter] CW4: It seems to be a common trend with reports that we get from medical providers, that the address isn't right, and it does us no good because it takes a lot of time. And a lot of times we don't find them then, which makes us nervous if a doctor's calling in worried about this kid and we can't find him. We end up having to close the case and nothing gets done and it's over something stupid like an address.</i>
	Investigation	<i>CW5: When you get [a referral] from a doctor, you assume that information is accurate and correct. So ...you can't in touch with the referent, who at this point was the doctor, you know, so I call the doctor, they don't answer, so I then go confront the family about this information that's not even accurate and the doctor later tells me the next day, 'Oh, that's not what I said' or 'that's not what happened.'</i>
		<i>CW4: You call the clinic and we get the recorded message. And you've got to sit and listen to the recorded message and then you've got to pick, well, which one of these do I want to</i>

THEME	SOURCE	QUOTE
Author Manuscript		<i>pick to talk to the doctor? 'Cause talking to the doctor isn't an option. I usually go for the nurse line. Sometimes they answer that, sometimes they don't. You leave a message. You don't get a call back. You leave a message and you do get a call back and a lot of times, they're like, 'Well we can't tell you anything.'</i>
		<i>CW7: I actually tried to call the doctor and the nurse said they would have the doctor call me back and they never called me back. But I needed help—I had a short time frame because it came in as a red tag. By the time I finally got to the girl to talk to her, she said she didn't have the bruises anymore...I didn't find out until later the doctor said that he never saw them, either. He only went by the verbal, what the girl said.</i>
		<i>MD5: We'll get a letter from CPS saying, 'Thank you for your call or whatever, bye, bye.' And then it's like, 'For which kid? Who are they sending a letter about?'</i>
		<i>CS2: We'll follow up with the patient, and as far as documentation that we get back from CPS, the only thing we've ever gotten back was a letter saying that, well, three different letters. We'll get a letter saying that we received your referral. It's being reviewed. We've received your referral and did an investigation and found no evidence that there's anything going on, or we received a referral and the case was closed. Those are the three letters that we've gotten from CPS.</i>
		<i>Sup2: One of the doctors that we were sitting with and talking with said, he had a family in his practice and all of a sudden, there was somebody else bringing the child in for a visit. Nobody told him—child had been put in foster care. So that was an a-ha moment for me saying, 'Okay, we're needing to make sure we're communicating with these guys.'</i>
Author Manuscript	All	<i>MD6: We had a really interesting one come up last time, where the caseworker wanted to communicate by email... We're using email from [our health system], and the worker would not sign up for an account and kept sending me PHI-unencrypted emails. I felt like I was in a really compromised situation.</i>
		<i>CW1: We had the chance to talk with the providers...I think that's when they finally wrapped their brain around the fact of the confidentiality and where our hands got tied on certain things. They were getting frustrated with trying to communicate with us about things and we were getting frustrated because we couldn't voice those things to them.</i>
		<i>Sup1: I was worried about our parents' rights, too. I mean, I'm a parent myself and I don't necessarily want specific information going to my doctor. You know, and we have to advocate for our parents, as well. And so that was a big part of it for me, as well.</i>
		<i>Sup2: We've been limited in what we can tell doctors or any other referent. They make a report to us and then we do our assessment and then we just tell them, 'Oh, the investigation is closed.' That doesn't help them.</i>
		<i>Sup 1: I think the medical side really struggles with the confidentiality side. You definitely sense that, but they understand it, too. I mean, they're very intelligent people. They understand some of that reasoning...But it's a struggle for us, too. You know? 'Cause we want, God, that's why we do this job, is for our families to better themselves and to keep kids safe, you know?</i>
Author Manuscript	Child health care	<i>MD1: It really helped us solidify some relationships with CPS. In the past, I had personally though that [it] was the call of last resort. And now we tend to call them early and chat about families before they're in too much of a struggle.</i>
		<i>MD4: I got a letter from CPS to follow up on a case where they'd actually gone in and done some preventive strategies and I was really pleased that they were taking that on. I've seen them do this in a couple of cases recently.</i>
		<i>CS1: We did have one situation where it was kind of an ongoing thing... There wasn't really necessarily any evidence of abuse or anything like that, but we were afraid that if we didn't do something, it would turn into a case like that. So then we had our social worker involved...and she was able to do a call out to DCFS as a preventative measure...[It] was really awesome to see that.</i>
	Child welfare	<i>CW3: Some doctors are better than others. I just had a case just recently, I needed to talk to a doctor at the [University] behavioral clinic. So I called and she was out of town and I left a message. She called me back the day that they said she'd be back and I didn't answer my phone, because we're hard to get a hold of, too. But she said, "When you call me back, please tell the staff to page me. I'm going to tell them all that when you call to page me because I know your time's important." So they paged her and she called me back within five minutes.</i>
		<i>Sup2: We all have been working in our own little silos forever. I was wanting to see how we could integrate that and get away from that kind of thought process.</i>

THEME	SOURCE	QUOTE
		<p><i><u>Sup2</u>: I think that one of the big things that's came out of this is that closure letter, you know? Because there's always been that bit of confidentiality, and so the closure letter that they got approved for the UPIQ project, you know, gives more information about the particular child.</i></p> <p><i><u>Sup1</u>: And the finding...</i></p> <p><i><u>Sup2</u>: And the finding, and that we're referring them for services. It really engages those doctors so they can say, okay. Good. I'm still in the right direction and we'll still continue to work with the family.</i></p> <p><i><u>Sup1</u>: I think it'd be good if we could use that letter for all our professional reference. If we could send out a letter like that and if that comes, if that's what comes out of this, it would be awesome.</i></p>