SUPPLEMENT ARTICLE

Understanding Roles and Improving Reporting and Response Relationships Across Professional Boundaries

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The author has indicated he has no financial relationships relevant to this article to disclose.

ABSTRACT

Child abuse is underreported. The author, a child protective service professional with extensive field and management experience, provides his perspective on some of the barriers that inhibit an effective response to reporting and collaboration between the professionals evaluating and investigating possible child abuse. Then presented are his ideas for improving the collaboration, including recommendations for changes in training, child protective service procedures, child protective service staffing, confidentiality requirements, and the adoption of a Child Advocacy Center (CAC) model.

Pediatrics 2008;122:S6–S9

Most instances in which children in this country are abused or neglected by those responsible for their care are not investigated by state or county child protection agencies. The Third National Incidence Study of Child Abuse and Neglect (NIS-3) revealed that only 28% of children harmed as the result of abuse or neglect were investigated in 1993. Only slightly more than one fourth of the children who were seriously harmed or injured (ie, those most likely to come to the attention of medical professionals) received child protective service (CPS) investigations. Although the NIS-3 did not distinguish between cases that were screened out by CPS hotlines from those that were never reported, because national hotlines screen in 63% of the referrals they receive, it is clear that a substantial portion of the uninvestigated maltreatment cases are not reported.

Although no one can be certain that a CPS referral will result in effective protection for an abuse/neglect victim, one cannot be optimistic about the safety of maltreated children who are not reported. A second finding of the NIS-3 was that the overall incidence of maltreatment increased by two thirds between 1986 and 1993. It is not surprising that a problem that is untreated would worsen. The correlation between almost every social problem and child maltreatment is well documented, as are the attendant costs to the community and individual victims. Obviously, underreporting of child maltreatment is a serious problem.

WHY DO HEALTH CARE PROVIDERS FAIL TO REPORT?

Few members of the community are better situated to identify child maltreatment than are health care providers who treat children. The Child Abuse Recognition Experience Study (CARES) confirmed that, together with other categories of mandated reporters, medical professionals fail to report situations suggestive of abuse/neglect to CPS. CARES suggested some reasons for this failure to report. The most important, and most complex, of these reasons seems to boil down to an overall belief that a CPS referral will not help protect the child victim. This belief is based largely on providers’ previous experience with CPS reporting. Poor communication between CPS and medical providers, fear that reporting will cause families to withdraw their children from medical care, concern that CPS will unnecessarily remove children from their families’ care, concern that reporting will result in time-consuming court testimony for physicians, and uncertainty about exactly what must be reported have also been noted.

In most instances, there is reasonable collaboration between CPS and health care providers, and most often children are effectively protected. Nevertheless, there is some basis for each of the concerns cited. Sometimes CPS does not effectively protect children. Far too often mandated reporters do not get meaningful feedback about what happened as a result of their reports. Some health care providers, especially those in practices where suspicion of maltreatment is rare, may not know what to report. Some families do flee medical care. Sometimes doctors’ schedules are disrupted by their having to spend time in court.

WHY DOES CPS HAVE DIFFICULTY INTERACTING WITH HEALTH CARE PROVIDERS?

Just as it is the perception of many health care providers that it is difficult to work with CPS and that the benefits of doing so are limited, in many cases frontline CPS staff find it very difficult to work with some members of the...
medical community. It is my observation that some of the obstacles perceived by CPS workers are justified. CPS workers complain that some doctors refuse to give them the information needed for investigation. It is not rare for a physician to refuse to give any opinion about the cause of an injury that the physician reported to CPS, with the physician saying something like, “I did my job and reported it to you. It’s your job to investigate and figure out whether it was abuse.”

At the opposite end of the spectrum, CPS workers have often complained to me that doctors want to control decision-making in reported cases. These situations can end in power struggles in which CPS will attempt to maintain control over its decision-making “turf” and the health care provider will contact CPS management, prosecutors, and even the media. This sort of interaction does not bode well for future interactions.

Perhaps the most sensitive and seldom-discussed dynamic that I have observed is the perceived class distinction between doctors and CPS workers. Physicians occupy a high status position in our social hierarchy; CPS workers do not. Medical professionals may see CPS workers, sometimes accurately, as being poorly trained and inexperienced. CPS workers often feel, sometimes correctly, that they are treated disrespectfully by physicians (and by professionals from other disciplines). They may be made to wait to talk to the physician and then be spoken to in a dismissive or directive way.

I have seen this issue escalate to the point of eliminating any hope of reasoned interaction when issues of race are interjected. No one is more aware of minority overrepresentation in the child welfare system than are caseworkers who see it every day. There are hospitals that at least seem to report families differentially and along racial lines, thus contributing to this overrepresentation. As a result, I know of cases in which CPS workers have rejected scientifically derived medical opinions concerning minority families rendered by doctors who were deemed racist by the CPS worker.

**WHAT SYSTEMIC ISSUES IMPEDE PRODUCTIVE MEDICAL–CPS COLLABORATION?**

An important and overarching problem with child-maltreatment interventions I have observed is that they tend toward discreet unilateral activities on the part of all participants. Rather than a response that combines the expertise of all involved, there are multiple parallel, but often uncoordinated, efforts. Furthermore, CPS workers, health care providers, police, and others have an understanding (not always an understanding that facilitates an effective process) of his or her role in the response to an abuse/neglect report. This “understanding” is often individually held (eg, different CPS workers from the same agency may have very different views of the role of the CPS worker in a case that involves medical issues). Similarly, role expectations across disciplines vary (eg, different doctors from the same hospital may have very different views of the role of the CPS worker). The result is that no one really knows what to expect from each other. Inevitably, confusion and the belief that others are not doing their job is the result.

The response to child maltreatment can be complex. Those responding are often very busy and often overwhelmed. CPS agencies are notoriously underfunded, which results in CPS workers frequently having workloads that preclude thorough investigations. Everybody is hard to reach. CPS workers are in the field. Doctors are seeing patients. Many situations are identified in emergency departments at night. Although ED doctors and nurses are important informants, it can be close to impossible for CPS workers to contact them. The combination of the complexity of the issue and the legal requirement for rapid decisions engenders a frantic pace maintained by nearly everyone involved and inhibits collaboration.

Frequently misunderstood confidentiality requirements can impede communication. CPS workers obviously need medical information from health care providers. In cases that involve legal action, medical charts are often needed for court. It has often been my experience that medical professionals and institutions are often reluctant to release this information because they fear legal consequences. This breakdown in information sharing seems to have become more problematic since the enactment of the Health Insurance Portability and Accountability Act, notwithstanding its general irrelevance to providing information to CPS agencies in situations related to child abuse and neglect. Sometimes medical institutions require CPS workers to obtain consents from the child’s parent, who often has little to gain from the release of the information. CPS workers are often mystified about what they can and cannot tell health care professionals about protective services cases. Generally, they are unwilling to share information that legally can be released.6,7 Obviously, this often inappropriate reluctance to share information does not foster collaboration.

**WHAT SHOULD MEDICAL/CPS COLLABORATION LOOK LIKE?**

Without question, health care providers must play an important role in the response to many situations that are suggestive of child maltreatment. When there is a physical injury, a condition that may be the result of neglect, or an issue of medical neglect, a medical opinion is often the key to the CPS determination. In the ideal situation, the CPS worker would gather information about the circumstances surrounding the reported incident, including any explanations for the physical presentation, information about relevant time frames (eg, exactly when the child became symptomatic), and relevant information about the scene at which the alleged maltreatment occurred (eg, water temperature, the height of the surface from which a fall may have occurred, and description of an implement allegedly used to strike a child). The CPS worker should consult with the doctor. If the physician needs additional investigative information to support an opinion, the CPS worker should get it. The doctor should then, to the extent possible, render a medical opinion. The opinion should evaluate the plausibility of explanations, the likelihood that the physical presentation was or was not the result of abuse or neglect, and, if it was, who could have been
responsible. In some cases (eg, failure to thrive, serious head injuries, and sexually transmitted diseases in very young children), the medical opinion is nearly always definitive. In other cases, the medical opinion should constitute an important part of an equation used by CPS to make a determination.

Ultimately, it is CPS that must determine whether to classify an incident as abuse or neglect. When there are medical considerations, this decision should be made with careful consideration of the health care provider’s input. Similarly, it is generally CPS’ responsibility to make decisions about what, if any, protective action is to be initiated. Again, involved medical professionals should be made aware of these plans. When there is disagreement about any decision, the medical provider should have access to a prearranged forum (eg, access to CPS supervisory staff or multidisciplinary staffing) to ensure that all perspectives have been adequately taken into account in making such important decisions.

HOW DO WE GET FROM HERE TO THERE?
Of course, there are many cases in which CPS workers and medical professionals work together effectively to protect children. I have observed all too often, however, that the identified barriers hamper interactions between health care providers and CPS workers. In many instances, CPS workers believe that medical providers are not interested in, or available for, real collaboration. They have had experiences in which they are denied information or assessment vital for them to do their job. In some cases, medical professionals have attempted to micromanage the CPS response. Most CPS workers have had experiences with health care providers who have been personally difficult, even insulting. As a result, some CPS workers avoid working in collaboration with the medical community.

I speculate that health care providers react to the CPS workers’ avoidance by engaging in the very behaviors that cause it: by failing to provide needed information, seeking to direct decisions that are in CPS’ domain, and treating CPS workers in a manner that is less respectful. The maladaptive nature of many interactions between CPS and medical providers are cyclically reinforcing. All of these barriers are exacerbated by systemic issues including the “siloing” of bureaucratic and professional responses, understaffing, and the perception of class and racial division. Of course, this has a deleterious effect on the quality of the effort to protect children. One symptom of this process is that, as the CARES revealed, some health care providers attempt to opt out of the system and simply stop reporting.1,4

There are several fairly obvious things that would help counteract these problems (summarized in Table 1).

### Training
The first solution usually mentioned is training. If more doctors had an accurate understanding of exactly what should be reported and a better appreciation of the role of CPS, working relationships would most likely improve. Similarly, training for CPS workers about working with health care providers and about information that is important to the provider when formulating an opinion would certainly be useful. Although training would help, it is not a panacea. Suspicion of child maltreatment is comparatively rare in most settings.6 CPS procedures and staff change frequently. An enormous amount of ongoing training would be required, and its benefit would be limited. In my experience, the most serious barriers to collaboration have to do with deeply seated opinions and attitudes that are not likely to be changed much by training.

### CPS Procedures
Generally speaking, there is great benefit to CPS agencies’ development and use of highly prescriptive and detailed procedures. Such procedures can be written to require medical consultation, including consultation with specialists in identified cases (eg, burns, head trauma, and sexual abuse). They can also include guidance related to giving appropriate weight to information gathered from professionals including, and especially, medical professionals. However, it is one thing to institute prescriptive procedures and another for an agency to actually follow them. Even if followed, I doubt that any procedural requirement is likely to have much effect on attitudinal barriers.

### CPS Staffing
Clearly, better-staffed CPS agencies would allow CPS workers more time to seek and use medical information and gather scene and other information that is important when making a medical assessment. Achieving more reasonable workloads for CPS workers may make it more possible to improve levels of collaboration but would not ensure any improvement in collaboration.

### Confidentiality Requirements
State and federal confidentiality requirements could be clarified to diminish uncertainty about the propriety of sharing relevant information between CPS and medical providers. It is my opinion that there is good reason to seriously consider some general relaxation of confidentiality requirements.

All of these steps would be useful in improving the collaborative context. If, however, the primary barrier to CPS-medical partnership is that too many medical and

### TABLE 1  Steps Proposed to Improve the Collaboration Between Professionals Evaluating and Investigating Suspected Abuse

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<tr>
<th>Step</th>
<th>Description</th>
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<tr>
<td>1.</td>
<td>Expand training to include education about the roles of the other professionals involved in the evaluation and/or investigation of suspected child abuse.</td>
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<tr>
<td>2.</td>
<td>Change CPS procedures to require medical consultation for those specific allegations of abuse that include medical assessment.</td>
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<td>3.</td>
<td>Reduce CPS workload to allow sufficient time for an adequate investigation including time to investigate scene, discussion with medical professionals, etc.</td>
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<tr>
<td>4.</td>
<td>Clarify confidentiality requirements to allow for relevant information sharing between CPS and medical providers.</td>
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<tr>
<td>5.</td>
<td>Establish teams of medical, CPS, and law enforcement professionals.</td>
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CPS professionals do not believe that collaboration will be of benefit to them or to abused and neglected children, the best solution may be to build structures that foster, maybe even force, collaboration. This solution may require a fundamental rethinking of the CPS process. A model that explicitly identifies the roles of the most important participants of the CPS response (CPS, doctors, and police) and structures the response around these roles might be more effective than one in which the participants respond in a parallel but unilateral way. Such a model could better distribute authority and responsibility according to expertise.

**Child Advocacy Centers**

The partnership between CPS workers and police officers investigating allegations of sexual abuse has improved markedly where well-conceived child advocacy centers have been established. At child advocacy centers, police and CPS work as a team. They are often colocated at the centers, which can substantially enhance the sense of partnership. In addition to and partly as a result of the improved collaboration, it is my observation that outcomes for children improve. A similar approach can be applied to serious abuse and neglect. Nationally, child advocacy centers are involving physicians more regularly and are beginning to handle some physical abuse cases.

This approach would involve a structured multidisciplinary response. Child advocacy centers would become responsible for investigations of additional forms of child maltreatment (eg, those that involve younger victims with some physical indication of maltreatment). Advocacy centers would be staffed by additional CPS workers and police investigators to accommodate the increased caseload. Physicians with specialized interest in and knowledge of child abuse and neglect would be associated with child advocacy centers; they may be located at the centers. Every investigation would mandate consultation with the specialized physician. This consultation could involve review of medical charts, contact between the consulting and treating physicians, and physical examination conducted by the consulting physician. Ideally, the consulting physician would be affiliated with a pediatric hospital and would have access to other specialists, because pediatric hospitals have been shown to identify child abuse more frequently than nonpediatric hospitals. The consulting physician would have the authority to direct that additional investigative information be gathered by CPS investigators. The consulting physician would be apprised of the intended outcome of CPS investigations before they become final and would have a meaningful forum in which determinations could be questioned.

I believe that this collaborative response would almost certainly improve the quality of child protection. Decisions would be made by using more reliable information. Scientific and evidence-based information would receive the consideration it deserves. Police and CPS activities would be more specialized. Activities associated with the response would be coordinated. The system would gain credibility in the medical community, because there would be assurance that medical information is appropriately considered. Children would be protected more effectively. The most important barrier to CPS-medical corroboration could be ameliorated. The likelihood of health care providers’ failure to report suspicions of child abuse or neglect would be diminished.

Moving to such a system would not be easy. CPS and police agencies would have to move (or at least dedicate) additional staff to advocacy centers. Major staffing increases should not be necessary because, presumably, CPS and police already respond to the identified cases. Physicians interested and experienced in abuse/neglect would have to be recruited and trained, which is something that would probably be easier to accomplish in cities than in rural areas. Issues of potential liability for consulting physicians would need to be resolved. A method for controlling consulting physicians’ criminal and family court time would be needed. There would certainly be a need to increase physical space at advocacy centers where there is staff colocation. Maybe most important, CPS agencies would have to accept a somewhat revised role, including slightly reduced authority (an incursion into its turf) in the process.

Despite these issues, it is my opinion that improvement in the quality of child protection would easily justify the cost and effort.

**REFERENCES**


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*Pediatrics* 2008;122;S6

DOI: 10.1542/peds.2008-0715D

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