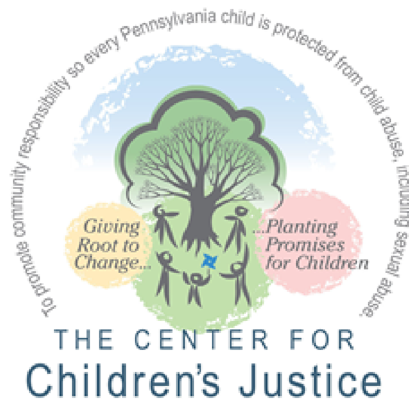

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Protecting Pennsylvania's Children: child abuse pediatricians as essential partners

A meeting between child abuse pediatricians and Pennsylvania Auditor General Eugene DePasquale facilitated by the Center for Children's Justice (C4CJ)
February 15, 2018

Purpose: A dialogue about the role and importance of specially trained physicians in the course of diagnosing, reporting and treating child abuse and neglect.

Brief background: In recent years, Pennsylvania has more fully recognized the important role of physicians and other health care providers in protecting children. In 2012, the Pennsylvania General Assembly created a Task Force on Child Protection comprised of 11 members, 2 of whom were board certified child abuse pediatricians. In many ways, Pennsylvania's Child Protective Services Law (CPSL) recognizes the important role of health care providers in protecting children. Still in many ways state law and practice continues to undervalue and underutilize specially trained health care providers.

Observations from the February 2018 meeting (as recorded by C4CJ):

- The clinicians engaged in the conversation with the Auditor General represent "hundreds of years of child abuse expertise in the field of pediatrics."
- Pediatricians with a clinical expertise in child abuse are "clinicians first," but also act as educators and researchers committed to "pushing the envelope on best practices."
- The need for "collaboration" can't be overstated. "Pediatricians have a wealth of knowledge related to childhood development, injury mechanism and injury epidemiology" and the expertise of the physician differs from that of social workers. Both perspectives and levels of expertise are needed to protect children.
- The physicians acknowledged that part of what influences when (if) a child is connected to a medical evaluation is how such a connection takes "extra time" for child welfare workers to take a child to the doctor or a hospital. There is already "incredible caseload pressure" and the child welfare workforce may be thinking that securing a "medical opinion" then adds to their workload and makes their job "harder."

- Collaboration and engagement of medical expertise is "not only good for children, but also families." CYS "under-recognizes when child abuse exists, but they also can over-diagnose it when it doesn't exist." With effective collaboration the CYS worker can gain insight from the medical professional about what is "normal childhood development" and that invites another "check and balance" that hopefully will reduce the incidence of appeal hearings to have CYS decisions reversed.
- Overall, many clinicians have "great relationships" with many county children and youth agencies across the Commonwealth. Still it remains quite "variant" and it takes "time and individuals to build these relationships."
- Those gathered raised concerns that there is "no statewide approach to promoting collaboration between child abuse pediatricians and county children and youth (CYS) agencies. Also, there is a need for "more uniform statewide expectations and response" by which clinicians will be respected as "key partners."
- It is "critical" for child protection to be understood and developed (in statute, practice and funding) from an "interdisciplinary" approach. There shouldn't be any further delay in breaking "down barriers" that have been institutionalized within health, law enforcement, child welfare and the courts.
- Pennsylvania has enacted more than 2 dozen laws that evolved from the Task Force, but they "are the first step, they represent significant improvement in how we define child abuse and allow for and mandate improved work, but they are only a first step." Also there have been "consequences" including in how "overwhelmed" the system is.
- One law enacted was intended to foster increased and effective communication between physicians and child welfare professionals, but everyday practice is still very influenced by the overall "culture."
- Many of the physicians and their colleagues are serving in an "epicenter of the opioid crisis." The opioid crisis hasn't just left the child welfare workforce "overworked and underfunded."
- There are added challenges in many remote counties they may not have any "history" of or understanding about how to engage clinicians and in fact some of these communities may not even have a practicing pediatrician. There needs to be more understanding in child welfare about the "resources" that are available to them and the value of relying on such resources.
- Concerns were addressed about how child welfare decisions are being overturned on appeal and some county agencies and medical professionals are facing litigation. This litigation is not stemming from making a report, but instead the decisions being made after a report has been made (e.g., remove a child from the home). All agreed that it is "hard to overstate" the effect of such civil rights-related lawsuits and how it feels like CYS and clinicians are "damned if they do and damned if they don't act."
- Florida's Child Protection Teams and creation of a statewide Medical Director as well as laws and practices from other states were highlighted. A key discussion point was how so much is driven by what exists in statute, including when a child "must" be examined by a specially trained medical professional.

References to the health care provider within Pennsylvania's Child Protective Services Law (CPSL)

Pennsylvania's Child Protective Services Law (CPSL) recognizes the important role of health care providers in protecting children:

- Section 6311 (Persons required to report suspected child abuse) requires licensed-health care professionals to report when they have reasonable cause to suspect a child is a victim of child abuse.
- Section 6314 outlines the responsibilities of mandated reporters, including physicians, to take photographs or order medical tests when treating a child who is the subject of a child abuse report.
- Section 6315 authorizes a treating medical provider or medical facility to take a child into time-limited protective custody if this custody "is immediately necessary to protect the child."
- Section 6340.1 (Exchange of information) promotes sharing of information between medical practitioners and child welfare professionals in circumstances where one (or both) of these parties have information that may "negatively affect the medical health of a child." This information sharing can occur, without parental permission and with respect to either a child protective services report or general protective services referral.
- Section 6365 (Services for prevention, investigation and treatment of child abuse) has long required a multidisciplinary approach to the investigation of child abuse when it is also alleged that the child is a victim of a crime.[1] The CPSL outlines the purpose of this investigative team – known today as the multidisciplinary investigative team (MDIT). The CPSL stipulates that this team "shall consist of those individuals and agencies responsible for investigating the abuse or for providing services to the child and shall at a minimum include a health care provider, county caseworker and law enforcement official."
- Section 6368 related to investigations of suspected child abuse provides the authority for a medical practitioner "to arrange for further medical tests" when there "is reasonable cause to suspect there is a history of prior or current abuse."
- Section 6386 requires that health care providers "involved in the delivery or care of a child under one year age who is born and identified as affected by" prenatal drug exposure to make a referral of the infant to the county CYS agency toward the development of a plan of safe care for the infant and his/her mother.
- "Available medical evidence" is one of the ways in which a child welfare agency can substantiate a report as an indicated report of child abuse.

[1] Act 127 of 1998 retrieved at http://www.legis.state.pa.us/cfdocs/Legis/LI/uconsCheck.cfm?txtType=HTM&yr=1998&sessInd=0&smthLwInd=0&act=127