Episode 17 – Clinicians' critical role in protecting children from abuse

Intro music: 0:00

Podcast introduction: 0:09

Every so often, an enforcement case comes through the medical board that just delivers a punch to the gut. I'm thinking of one that the North Carolina Medical Board discussed not too long ago. A parent takes her toddler to the pediatrician's office.

The child has bruises and injuries. What happened here? The pediatrician asks. Mom explains it away as a normal toddler rambunctiousness, jumping on the bed, tumbling on wobbly toddler legs. And the pediatrician accepts that explanation, except it isn't the truth.

In reality, the child's other caregiver is responsible for the injuries, and soon that caregiver goes too far. This time, the child dies. I'm Jean Fisher Brinkley and this is MedBoard Matters. Thank you for joining me.

On this episode, we are taking a look at the safety net in North Carolina that's designed to catch child maltreatment, hopefully before it ends in tragedy. Specifically, we're going to talk about the legal requirements in our state to report suspected child abuse and neglect.

Under state law, anyone who believes that a child may be a victim of abuse or neglect is obligated to report it, but the system isn't foolproof. People like the pediatrician in our case don't always report, even when there are clear warning signs. When the Board reviewed the case I described, it opened up a lengthy and emotional discussion. Board members wondered how well medical professionals understand the obligation to report? And most of all, they wondered how and why a clinician could fail to report in the face of what seemed to many to be a textbook case of abuse.

That Board discussion directly led to this episode, which will explore some possible answers to those questions. Granted, this is a difficult topic to tackle just days before Christmas, but we did not want to let 2021 come to a close without shining some light on this important topic. I hope you'll stay with me.

Child Abuse Panel Discussion: 2:11

JFB: I am delighted to welcome some of the state's foremost experts in addressing child maltreatment. Melinda Manning is an attorney and trained social worker who is director of UNC Hospital's Beacon Program. She coordinates a multidisciplinary team that provides support to patients and hospital employees experiencing child abuse, domestic violence, sexual assault, vulnerable adult abuse, and human trafficking. Also joining me is Dr. Molly Berkoff. She is a pediatrician who specializes in addressing child abuse with both the UNC School of Medicine and with Wake County Human Services. In addition, Dr. Berkoff is the Medical Director for the North Carolina Child Medical Evaluation Program. And finally, I want to welcome back Dr. Karen Burke-Haynes NCMB's Chief Medical Officer and a regular guest on MedBoard Matters. Before joining the staff of the Board, Dr. Haynes practiced pediatrics in

private practice for more than 25 years. I feel like I have the right people in the virtual room to shed some light on recognizing and reporting child abuse and neglect. Thank you all for joining me.

JFB: Let's start by discussing the legal obligation in North Carolina for medical professionals to report suspected child abuse and neglect. What does the law require of clinicians and who specifically is subject to it? Melinda Manning?

MM: So, I'll start off by saying what North Carolina has is actually what's known as universal reporting, which means that most of the reporting obligations actually apply to everyone. So, whether you're in your clinical role or as a private citizen, these obligations still apply. And I think that's really important to point out at first. Not all states have universal reporting. So, we really have two statutes that we need to mention. The first one is the one that I think most people are familiar with and that is reporting to child protective services. And what the law really says is that if a person or an institution has cause to suspect either abuse or neglect, then there's an obligation to report. And I think a lot of people understand the kind of abuse part. I think what gets missed a lot of times is the neglect. But the thing is also important to note is that North Carolina two years ago actually passed a second reporting statute that I think a lot of folks are not familiar with. Because it took effect in December 2019, right before COVID hit. And this one actually kind of expands reporting obligations. It says that certain crimes against juveniles have to be reported, not just to the CPS, but to law enforcement.

JFB: And how familiar do you think clinicians are with the reporting requirements?

MM: Just based on my rather limited experience, I think it really varies. We certainly do work with clinicians that are very well versed, really understand it and make regular reports. While I think there's a lot of folks that don't. I actually had a clinician say to me a couple of months ago that only social workers have to report, and I had to correct this person and say, no, actually, that's not the case that everybody has to report. I think that the new reporting statute again since it's only been in effect two years, I think is not very well understood at all. In fact, the law is actually kind of murky the way it's written, and there just hasn't been a lot of training on it. So, I think it's really important that we get out there and start to do some more training on kind of the obligations under it in particular.

JFB: Dr. Berkoff, did you have a perspective?

MB: I think that physicians don't receive universal education, at least even in North Carolina medical schools or at the institutions or practices that they work with . So, it's important to be able to read a little bit more and spend some time digesting exactly what the responsibilities are. And it's confusing to know that there's two different reporting systems, so to become familiar with that and to have a policy or a process in your practice. So, you know what to do when a crisis situation arises and who you're responsible for reporting to is really important.

JFB: Let's get down to specifics about how a clinician should recognize when a report needs to be made. What are the signs and signals that might suggest abuse or neglect? Dr. Berkoff?

MB: So, there are specific types of cases scenarios in which a physician may be more suspicious of concerns for abuse or neglect. So, if a young child comes in with an injury, for example, and that injurie is not developmentally plausible or if there's no explanation at all for an injury, then that would raise a

concern or suspicion for abuse or neglect. There's other types of mnemonics and teachings that we use in child abuse pediatrics to help guide clinicians and understanding what injuries may be atypical. So, things that don't typically occur from usual play, for example, the TEN4 mnemonic, which helps to describe injuries and atypical locations for children under four years of age. So, ten the T stands for torso, e stands for ear and n stands for neck. Or if there's any bruising in a young child under four months of age who's not independently mobile, that would raise a concern or suspicion for abuse or neglect. And if the family of the caregivers don't have an explanation that makes sense for that injury, then that would be something that would be reported to Child Protective Services. Some children and adolescents or school aged children don't have any signs or symptoms about abuse or neglect that you can easily detect. And so, it's important then, to have tools or screening measures that could be applied in your practice to seek and to find out information about that child's environment and their experiences. And there's also many signs and symptoms that can overlap with other forms of stress for a child, things that might not be maltreatment. So again, it's really important for clinicians to be able to feel comfortable asking specific questions and open ended questions to children and families when they see things that could be nonspecific, like a change in behavior, a child being more hyper vigilant or not being doing well at school, or a child who's fearful to go home, for example at the end of the day from school.

JFB: Dr. Haynes, did you have a perspective?

KBH: I would simply say that my practical experience aligns very nicely with what Dr. Berkoff has shared so far. So, I think regarding a new level of insight, I had not actually been aware of and appreciate hearing the idea of thinking through the notion of abuse neglect as a factor to describe, for instance, in our middle schoolers or high schoolers, the change in behaviors, change in school performance. We tend to attribute it to a lot of other things. It's good to know that there may actually then be a tool that would help cover that area in the course of doing a workup on a child as being admitted for their routine physical, for instance. So, I appreciated hearing that.

JFB: You all are raising a really good point. I imagine abuse is not always obvious. How much evidence does a clinician need to justify making a report? In other words, how sure do you need to be? Melinda Manning?

MM: The law states, you merely need to have cause or suspect. So, it's really just a suspicion. So, it's actually a very low bar. And I think that's one barrier to a lot of folks reporting is that they believe they have to absolutely know that the child is being abused, neglected or, you know, doesn't have a caregiver. And the reality is that you don't have to know that you merely need to suspect it.

KBH: I'll add to that 100%. That that is a steep learning curve on a steep bar for many clinicians to move past. Certainly, my years and residency are a bit remote, but nonetheless I do remember having to make it over that hurdle in establishing my practice. There was a sense that we needed to be masters of and have a clear diagnostic certainty that something represented an injury or injury pattern, or other matter represented actual abuse. And it took quite some time and a little bit of hand-wringing to get to the point that if you think it, you report it. So, I'll simply say that the bar that you have to go over as a clinician is pretty high and understanding that it's suspicion only. The cases that we've seen here at the

Board actually reflect that. It's the suspicion that we're looking for and all too often clinicians try to make a decision and a diagnosis within their group or within themselves.

JFB: Dr. Berkoff?

MB: Yea, I'll add further to that. I think one of the concerns that I had when I started practicing in the field of child abuse pediatrics is that I would hear widely that we couldn't report unless we had direct proof, or we confirmed that the child had been abused or neglected. And it's important for clinicians to understand that's not true. We are not the individual group that is deciding whether or not a child has been abused or neglected, or it is dependent. That is at the hands of child welfare or Child Protective Services to do. And so, if we have a suspicion, that means that we don't have to prove it and we just need to carry that suspicion forward to the appropriate agency.

JFB: Is there any sort of consequence for a clinician if they get it wrong and it turns out there is no abuse? Dr. Berkoff.

MB: So as long as the report to Child Protective Services was made in good faith, then there are no repercussions that come from the legal system. However, there could be repercussions that a clinician is worried about, such as losing their patient and not having them continue to follow up in their practice. And that's why one of the things that we teach our medical students and residents at UNC is to, when you have the opportunity to tell a family why you're making the report to CPS, it's helpful to do that to engage them in the process and help explain why you believe this will be beneficial for their family to keep their family safe and healthy.

JFB: Dr. Haynes, you have a follow up?

KBH: So, what I hear you saying, Dr. Berkoff, is that perhaps the best way to engage this process is directly to not, for instance, allow a family to leave the office and then do the reporting quietly, but to have a script or have an approach. Have a plan for how to engage families in that conversation and simply state it for what it is and explaining what the goal and intention is.

MB: I think that's best practice is to make sure the family understands the why behind what you're doing. Now there are some situations that are so difficult that that may not be possible, but I think when it is possible, it's important to have a script in your head and to be able to have a process that you can explain to families so that families understand this is applied to all of your patients and that they can have a good understanding as to what you hope to accomplish for this, that their family is safe and healthy.

JFB: I love the idea of a script. Could it be something as simple as, "I see this pattern of injuries or this pattern of behavior and when this is present, I have an obligation to report it"?

MB: Yeah, it could be something as simple as that, and it's something as easy to repeat as that to families. I think getting comfortable as a clinician with why you have to make a report to Child Protective Services and what you understand the reasons are behind that, are really important to share when you're able to when the situation is not escalated to a point where it's difficult to do that. I think that can then end with having the best outcome for families.

JFB: Let's talk about the logistics of making a report. How does the clinician initiate one? Melinda Manning?

MM: I could start to tackle that one. And I do. Yeah, I do see. I think people are…can be fearful, particularly if they've never made one before. So, if they're making a report to Child Protective Services, they simply need to call that for the county that the child resides in. And generally, it is done over the phone, and they do always have someone available 24/7 because sometimes there are emergency situations with that. The CPS worker is going to ask the clinician a series of questions. Some questions they are not going to have answers for, and it's perfectly fine to say I don't know. We will add it's not always necessarily short process because there are a lot of set questions that a CPS worker has to go through with that. So, it is helpful if the clinician has some kind of basic information on hand, like the child's name, contact address, contact information for the family, et cetera that can be helpful to have. If they're making reports to law enforcement, it's not going to be quite the same. There's not going to be as many set questions that the officer will ask them. But if they're making reports to law enforcement, they should generally call the law enforcement, again of the jurisdiction where the child resides, and just kind of give the basic information that they have.

JFB: OK, let's talk about the specific details that need to be in the report to facilitate an appropriate investigation. Dr. Berkoff?

MB: So, there are a lot of required items that CPS in particular will ask during the intake process. And many of these are demographic information like the address of the family, the age of the child, the siblings, the parents' age, their place of employment, the school of the child, that sort of thing. But what is really most important is for the clinician to clarify why they're making the report. So, for example, if you are taking care of a four month old infant who woke up and the parents found them in their crib with their leg broken, you wouldn't just say I'm making a report on this four month old infant with a broken leg. It's more important for you to say, “I'm making a report for concerns of physical abuse for this child who has no history of trauma and now has a broken leg,” because that gives a lot more guidance and information to Child Protective Services as to what you're worried about and the why behind it, and that it also helps to trigger the type of response that CPS is going to do. So, they may come out immediately and assess that patient and that family to ensure that child safety. However, if you call in a report on that same infant and just put information about the fact that that baby has a broken leg, and maybe it's assumed that that is a concern for neglect, that family and infant may not get a response from CPS immediately. It may take a little bit longer, and therefore the safety of that child may not be ensured in the timeframe that you believe is reasonable. So, giving a lot of details and specific information about why you're worried and what made you have the suspicion for maltreatment is really critical.

JFB: And Dr. Haynes?

KBH: Dr. Berkoff, what I hear you also emphasizing is the in terms of the clinical assessment going on that our licenses need to be thinking about and is this child safe to go home? Is that a fair statement that that should be a part of the analysis for injuries like the one you just mentioned; a broken extremity in a…in a non-mobile child?

MB: Yes, I think it's important to think about your level of concern as a clinician for that child safety. Can I send them home safely? If you've made a report to Child Protective Services, at that point in time, you don't know if Child Protective Services has accepted the report for investigation. And so, there is a process behind the scenes that Child Protective Services, where they're making a decision about whether or not they're accepting that case for an investigation and then, if so, how long it's going to take for them to respond to do an assessment or an investigation with that family. And so, we don't have the ability, right, as we're making a report as clinicians to understand what that timeframe is or even if Child Protective Services is going to be involved. So also, when you make a report, it would be helpful to ask when can I find out if the report was accepted and how can I understand when you're going to respond to work with this family if it has been accepted?

JFB: What are some of the possible consequences for the family of the child after a report of suspected abuse or neglect is made? Dr. Berkoff?

MB: So not every report that's made to Child Protective Services by a medical professional will be accepted for an investigation or assessment. So that's one thing that we have to remember that it's not automatic that CPS will become involved in a family's life just because we made a report. So that's one possible outcome. The most extreme outcome is that a child will be removed and placed in foster care. But that's not as common as CPS, continuing either to work with the family or to have a finding recommending that they'll provide services for the family. So, things that could be mental health support for the parents or the children, for example, or maybe even not continuing involvement at all. So, the different levels of involvement could be that CPS does not work with a family, so they screen the report out or they could work with the family over the course of a month or so during their timeframes and find out that there's no evidence of abuse or neglect. And so, they stop being involved, or they could continue involvement in what's called in-home services, or the more extreme outcome could be that the child is placed in foster care.

JFB: So, there's a whole spectrum?

MB: That's correct.

JFB: Is there any way to assess how well medical professionals are doing as a group at reporting suspected abuse and neglect? Dr. Berkoff?

MB: So medical providers are a large group of providers making reports in North Carolina and nationally. There is a concern that some of the influence of socioeconomic status or race ethnicity will impact whether or not a provider makes a report. There's been different types of studies published in *Pediatrics* as one of the main journals in the field of pediatrics that talks about vignettes or scenarios that were provided to different medical providers to see the outcome for whether or not they would make a report. And there has been an association between children of lower socioeconomic status being more likely to, or families with lower SES being more likely to have reports made even with the same injury.

JFB: Dr. Haynes, did you have a follow up?

KBH: Dr. Berkoff, what's our remedy for this?

MB: I think it's really important to look in your community as to who's the expert in child abuse in addition to Child Protective Services. So, is there a child advocacy center, which is an organization that's typically a nonprofit in the community that helps to coordinate a response between medical providers, law enforcement, CPS and other stakeholders about the investigation or assessment of abuse and neglect in the community? To see what kind of outreach or educational services they have. To come and talk to you in your practice. To provide resources and teachings to help with making folks more comfortable with identifying what their suspicion of abuse or neglect is. Defining it and having a good response within your practice or your organization and being able to understand how to make reports based on factual information. So, it's an infant with an unexplained fracture, and it doesn't matter what their socioeconomic background is or their race/ethnicity.

JFB: I'd like to dig into this a bit more. I wanted to talk with you all about barriers to reporting. Why wouldn't a clinician make a report if he or she suspected a child might be in danger? Dr. Haynes, I'd love to hear your perspective.

KBH: Thank you, Jean. What comes to mind immediately is the concept of Therapeutic Alliance. As clinicians, we're trained to establish a rapport with families. There's really strong data to indicate that your ability to impact change in a household and health behaviors and health practices and so forth is truly contingent upon your ability to help that family align with you and your goals and for you as a clinician to align with that family. So, the term that we use this therapeutic alliance. There's effort and energy that goes into establishing that because in the end, there's strong data to show that the long term outcomes of health interactions are better when that rapport is there, the trust and the regard is there. It is not a difficult stretch to recognize that then in the context of perhaps a well-established alliance, let's say a family you might have known for five years, ten years, you develop, or a year, a particularly strong connection, and then something happens. You then, as a licensee, are in a position to have to pause and address potential bias within yourself to manage that situation in a way that actually requires detachment and to do, as Dr. Berkoff has indicated, to look at the facts, just the facts and then do what needs to be done. It's a very difficult space to occupy, particularly if you don't have a protocol, if you don't have a practice, if you don't have a script, if you're not prepared, I can easily see a clinician deferring.

JFB: Dr. Berkoff anything to add? (20:45)

MB: There's a lot of published literature that talks about why clinicians don't make report. Some is time. It takes a lot of time to make a report. You're worried. Maybe you're a rural practitioner and there aren't any other pediatricians or family practice doctors in your area. And if this family gets mad at you and doesn't want to see you again, maybe their child won't have pediatric care moving forward. That's a concern as well. I see occasionally people believe that somebody else will make the report. So, if I send this child to the emergency department, I don't have to make the report because I'm in private practice and it's very busy and I don't have the resources, but the emergency department will. And so, there's a false assumption sometimes that somebody else will make the report and then it actually doesn't happen at all.

JFB: That's a great point. Let's talk about how clinicians can get better at this. What are some practical steps a clinician, regardless of practice setting, can take to strengthen their ability to recognize and report child abuse? Dr. Berkoff,

MB: There's lots of good resources in North Carolina. Prevent Child Abuse North Carolina has a free online training about recognizing and responding to child maltreatment. I think that's an excellent tool that clinicians can access. I do also…I think because there's a lot of investment in our state to build up the capacity for things like child advocacy centers that are a multidisciplinary, coordinated system of professionals that work in this area that help to bring all the information together to determine if a child has been abused or neglected. Reaching out to a child advocacy center, if there's one in your community to come, give a talk to attend one of their trainings would be an excellent opportunity as well. And also, most of the larger children's hospitals in our state have teams that Melinda heads that are responsible for education and outreach for clinicians about child abuse and neglect and knowing that no and knowing those teams and how to contact them is really helpful.

JFB: Melinda, would you like to say a little bit more about what resources are available?

MM: Absolutely. And again, I think it comes down to time. I think what we unfortunately hear a lot of is that we don't have time to make reports and we also don't have time to engage in training. I think it's one of these things, you need to make time. For your clinicians to engage in that training so that when they do get a case, because they will get a case at some point, and it's not just pediatricians that need really need this training. And so here at UNC health is that anyone can either call us for training or also call us for consultation if they want to discuss the case to see whether or not to report.

JFB: I'm sensitive to the comment about clinicians being very busy and practices not feeling they have the time to train their entire medical staff. But if they trained one or two people who could then become the champions and pull together resources for their colleagues, it might be a lot more manageable. OK. I wanted to end by asking you all for some final words of encouragement and support for medical professionals who may not feel entirely confident in their ability to recognize and report. Dr. Berkoff, your thoughts?

MB: Well, I think it's important to keep child abuse and neglect on your differential and to be able to consider it when there is a concern for a child who has an unexplained injury or who has been missing a lot of appointments at your practice or hasn't been coming in for the medical care that you deem to be appropriate for management of their chronic disease or their preventive health care needs. In that same vein, I do think it's also really important for clinicians to think about what kind of child abuse prevention programs that they can actually include in their practice. It's important for clinicians to understand what resources we have available to connect families to services that they may not know about, and that may become extremely beneficial for keeping them safe and healthy. So NC360 is one of those that the state funds and knowing how to activate that and how to connect families to housing resources, to mental health support, to whatever the need is for that family because prevention is really what we should all be striving to do. And hopefully that is what we're focusing on a lot in the future in our practices.

JFB: Melinda Manning?

MM: What I tell my social work students is when in doubt you need to report. And again, many reports are screened out. But if your gut tells you to report, that's probably what you need to do.

JFB: And Dr. Haynes?

KBH: I would add from the perspective of practice from being inside the practice to be intentional. Don't allow the fear of getting it wrong to stop you from taking that next step forward to investing and setting up a practice protocol. That is how we operationalize ways of getting things done in busy practices. It's great to have a carved out space to have these conversations, but when it's boots on the ground and you have a support staff around you, there has to be a high level of intentionality about preparing your team to support you in accomplishing the task.

JFB: Great. Thank you all so very much for talking with me.

Key Takeaways: 27:04

I know our panelists covered a lot of information, so I'm just going to recap some of the most important takeaways. First, North Carolina has universal reporting for child abuse and neglect. That means that anyone who suspects child abuse or neglect, including any clinicians, not just a pediatrician, is obligated to report. Next, state law requires reporting to two agencies. When reporting, you'll need to contact Child Protective Services in your county and local law enforcement in the jurisdiction where the child lives. If your practice does not already have protocols in place for recognizing and reporting child abuse or neglect, it's time to create them. Consider tasking one or more individuals in your practice with becoming the in-house experts on reporting. Responsibilities could include creating a contact list for child protective services and law enforcement agencies in your area, drafting a simple script to use when raising the issue of abuse or neglect with families, and identifying training opportunities. If you need a little help getting started. Be sure to visit www.ncmedboard.org/podcast and visit the show page for this episode to find links to helpful resources.

Podcast wrap-up: 28:23

Well, that brings us to the end of another episode of MedBoard Matters, thank you for listening. I hope you learned something and that you feel more prepared to address child abuse and neglect. I'd love to hear how some of our listeners handle this delicate aspect of medical practice. Do you already have a plan in place? Do you find the system confusing? Are you struggling to figure out how to integrate this into your workflow? Send your thoughts to us at podcast@ncmedboard.org. If you found this episode worthwhile, do us a favor and share it with your colleagues. Consider it a little Christmas present to the production team here at MedBoard Matters and have a safe and peaceful holiday.