Working with DCF: Mandated Reporter Update: What you and Your Staff Need to Know!

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Teleconference Objectives

• Participants will:
  – Understand the mandated reporting statues on suspected child maltreatment and the protection of good faith reporters.
  – Review the possible penalties for failure to report suspected child maltreatment.
  – Recognize the support systems available to help pediatric providers fulfill their roles as mandated reporters.
  – Understand biases in and barriers to appropriate reporting of suspected child maltreatment.
  – Understand the best practices recommendations for mandated reporters.
Introduction

- Reporting suspected child maltreatment is hard.
  - Sometimes it is not clear whether it is or is not maltreatment.
  - Sometimes other concerns get in the way, like worrying about the consequences of a report.
  - Sometimes just thinking about a child being maltreated is distressing.
But There is Good News!

• The mandated reported statute can actually help you to make the right decision.

• You are protected by the statute if you report in good faith.

• There is an evidence basis on the subject of reporting that can really help.

• There are resources in our state that you can turn to when you need help.
What Must be Reported?

Mandated Reporters are required to report or cause a report to be made when, in the ordinary course of their employment or profession, they have reasonable cause to suspect or believe that a child under the age of 18 has been abused, neglected or is placed in imminent risk of serious harm (CGS 17a-101a).

A Mandated Reporter must report any suspicion to DCF or law enforcement regardless of the identity of the alleged perpetrator.
Recent Changes

- A legislative response to a report issued by the Offices of the Child Advocate and Attorney General which identified flaws in the way child abuse and neglect in schools is identified, reported and investigated.
Failing to Report and/or Delayed Reporting

- Any person, official, or institution required by the law to report a case of suspected child abuse/neglect or imminent risk of serious harm who willfully fails to do so:
  
  a. may be liable for civil damages caused by such failure
  
  b. shall be fined between $500-2500
  
  c. shall be required to attend an educational training program
  
  d. DCF to notify Chief State’s Attorney
Immunity and False Reporting

- **Immunity** – Any person, institutions, or agency which in *good faith makes or in good faith does not make the report* pursuant to *(17a-101a to 17a-101d)* inclusive shall be immune from any liability, civil, or criminal charges.

- **False Reporting** – Any person who knowingly makes a false report of child abuse/neglect or imminent risk of serious harm shall be criminally fined not more than $2000 or imprisoned not more than one year or both.
Bias in Reporting of Suspected Maltreatment

Bias is a real potential pitfall and it is well established in the medical literature.
Bias: Missed Cases

Jenny study of missed cases of abusive head trauma:

• To characterize head injured children in whom diagnosis of abusive head trauma (AHT) was unrecognized and the consequences of the missed diagnoses.

• Race: 37.4% of cases of AHT in white children were missed versus 19% of cases of AHT in non-white children.

• Family composition: 40.2% of missed cases were children from intact families versus 18.7% of missed cases who were children whose parents were not living together.

Jenny et al. 1999
Bias: Over Calling Abuse

- To determine whether there are racial differences in the evaluation and CPS reporting of young children hospitalized for fractures.
- Retrospective chart review of cases of skull or long bone fracture in children younger than 3 years.
- Outcomes of interest were ordering skeletal surveys and filing reports of suspected child abuse.
- Minority children were significantly more likely to have a skeletal survey ordered compared to white children.
- Minority children were significantly more likely to be reported to CPS for suspected abuse than white children.

Lane et al. 2002
Illustrative Case

- 11-month-old previously well full term infant with a black eye, bruising over his buttocks and multiple acute fractures.

- Full work-up for occult injury:
  2. Brain MRI: subgaleal hematoma.
Illustrative Case

- At 5 months of age, diagnosed with eczema and given 1% hydrocortisone cream.
- At 8 months of age, given Elocon cream for eczema.
- At 9 months of age, seen with bruises and skin breakdown over buttocks.
- Two weeks later seen with severe bruising and skin breakdown on buttocks; mother reported using Elocon BID on diaper area. Advised to stop Elocon. Screening labs sent for possible bleeding diathesis. Abuse considered but family "seemed okay."
Illustrative Case

- Two days later, seen with bruising; call to dermatologist who confirms that steroid cream can cause easy bruising.
- One week later seen with bruising and abrasions over his perineum.
- One month later presented with black eye, buttock bruising, extremity edema and diagnosed with abuse.
- Child abuse diagnosed and child placed for safety.
Bias: Lessons Learned

• Bias is real and it can influence level of suspicion and decision making in the setting of possible abuse.

• Be careful of “appropriate” families: intact, concerned, care seeking.

• When abuse is on your differential, remove it only when diagnostic testing rules it out.

• Remember the mandated reporting laws.
Barriers to Reporting Suspected Maltreatment

Barriers are real potential pitfalls and they are well established in the medical literature.
Barriers: Would Abuse be Suspected and Not Reported?

• To determine how frequently primary care clinicians reported suspected physical child abuse, the levels of suspicion associated with reporting, and what factors influenced reporting to child protective services.

• Prospective observational study of clinicians who evaluated injured children (PROS).

• Clinicians did not report 27% of injuries thought to be likely or very likely to be due to child abuse, and 76% of injuries thought to be possibly caused by child abuse.

• The authors concluded that “clinicians apparently apply various interpretations to the legal mandate to report when there is a reasonable suspicion of child abuse.”

Flaherty et al. 2008
Barriers: Why Would Abuse be Suspected and Not Reported?

- Telephone surveys of primary care pediatric clinicians identified a sample of clinicians who suspected abuse but did not report it.

- Clinicians who suspected but did not report were interviewed and factors that influenced a decision not to report were identified.

Jones et al. 2008
Barriers: Why Would Abuse be Suspected and Not Reported?

- Familiarity with the family: clinicians who had a high suspicion of abuse but did not report cited a high degree of familiarity with a family.

- Available resources: clinicians who had a high suspicion of abuse but did not report used available consultants significantly less frequently than those who did report.

Jones et al. 2008
Barriers: Why Would Abuse be Suspected and Not Reported?

- Perception of expected outcomes of a report to CPS: clinicians who did not report explained that they anticipated negative consequences to the child or family due to the report.

Jones et al. 2008
Barriers: the Anecdotal Evidence

- Parents continued to bring child for care, appeared concerned.
- Another, clear possible medical explanation existed.
- Nothing in the social history was especially worrisome.
- It is hard to think about infants and children being abused.
- Family was well presented/appropriate.
- “I asked a few questions.”
- No concern was raised by other medical professionals who evaluated the child.
Illustrative Case

- 20-month-old previously well child with liver laceration, right-sided adrenal hemorrhage, shock, and multiple bruises and lacerations.

- Full work-up for occult injury revealed evidence of blunt force abdominal trauma and multiple skin injuries including bruises, abrasions and superficial lacerations over her chest, abdomen, back, sides and thighs as well as multiple deep, healing ulcerations on her anterior neck and an avulsed left thumbnail.
Illustrative Case

- Mother was asked about skin lesions and explained that they were due to eczema.
- No explanation for multiple internal injuries, fractured rib, and avulsed thumbnail was offered.
- Child abuse diagnosed, child placed for safety.
Illustrative Case

- Seen in ED at 18 months of age with what was facial bruising.
- Mother reports to medical staff that this finding is secondary to eczema.
- Child abuse, along with eczema, is noted in the differential diagnosis.
- An additional notation described mother as “appropriate” and child is given final diagnosis of eczema.
- Discharged home with mother.
- 4 months later with severe, inflicted, blunt abdominal trauma.
Barriers: Lessons Learned

• Barriers are real and they can influence level of suspicion and decision making in the setting of possible abuse.

• Be especially careful when evaluating suspected abuse in the setting of a longitudinal relationship with a family, and when you find yourself thinking about that last case you reported and how badly it went.

• When abuse is on your differential, remove it only when diagnostic testing rules it out.

• Remember the mandated reporting laws.
Changes in Child Welfare Practice

• Overview of the landscape of child welfare nationally and locally
• Structured Decision Making and DRS
• Emphasis on Communities of Care/Current Vision for Partnering
• Information needed to effectively partner?
National Transformations in the Field

- SAFETY
- OOH
- PROCESS
- MANAGEMENT

- WELL-BEING
- IN-HOME
- OUTCOMES
- LEADERSHIP
Population Projections

- Commissioner’s targets
  - Fewer than 20% of the children in congregate settings
  - More than 30% of the children placed with relatives/kin
  - Fewer than 150 children placed out of state
  - Fewer than 60 children 12 and under in congregate settings
  - Zero children ages 6 and under in congregate settings
## “Rightsizing” Progress

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<thead>
<tr>
<th>Commissioner’s Targets</th>
<th>9/1/2012 Update</th>
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<tbody>
<tr>
<td>Fewer than 20% of the children in congregate settings</td>
<td>23.7% (down from 29.8%)</td>
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<tr>
<td>More than 30% of the children placed with relatives/kin</td>
<td>24.8% (up from 19%)</td>
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<td>Fewer than 150 children placed out of state</td>
<td>105 (down from 364)</td>
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<td>Fewer than 60 children 12 and under in congregate settings</td>
<td>68 (down from 201)</td>
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<tr>
<td>Zero children ages 6 and under in congregate settings</td>
<td>6 (down from 38)</td>
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Children in Placement: The number of CIP decreased from 4784 in January 2011 to 4154 in September 2012. There are 630 fewer children in care than at the beginning of 2011.
SDM and DRS

- Guides the decision making process
- Structured Decision Making- helped to differentiate between safety and risk
- Provided consistency in decision making across the state
- Lower risk families are now served by community
- Families served by the dept have safety and high risk
Differential Response System

**INTAKE**

- In cases of serious child maltreatment:

  A comprehensive investigative response that may include close collaboration with law enforcement that may result in a clear message that violence against children is a crime and will be punished.

**FAMILY ASSESSMENT**

- In cases of less serious child maltreatment:

  A comprehensive family assessment and coordinated service delivery will result in better engagement and involvement of families and consequently in better protection for children.
Differential Response System

CARELINE
DCF Referral

Family Assessment
Lower Risk Cases (72-hour responses)
15 Rule Outs Determine Appropriateness
Face-to-Face Contact within 5 days
Protective Factors Assessed
Service Plans & Family Team Meetings
45-Day Completion

MAIN FOCUS
Services Recommended
Services Not Needed
Transfer for Continued Services determined by Partnership through use of Risk Assessment

Can Switch Between Tracks

Intake
Response Times (Same Day/24/72)
Investigation
Mandated Collateral Contacts
Case Decision & Central Registry
45-Day Completion

MAIN FOCUS
Substantiation or Unsubstantiation
Transfer for Ongoing Services mandated by DCF through use of a Risk Assessment

Based on Safety Assessment
Can Switch Between Tracks
Connecticut’s Framework

**MISSION**: Healthy, Safe, Smart & Strong

**Six Cross-Cutting Themes**
1. Family-centered practice
2. Trauma-informed practice
3. Neuroscience of early childhood and adolescence
4. Service and support for families at the community level
5. Improved leadership, management, supervision and accountability
6. DCF as a learning organization

**Six Principles of Partnership**
1. Everyone desires respect
2. Everyone needs to be heard
3. Everyone has strengths
4. Judgments can wait
5. Partners share power
6. Partnership is a process
Effective Partnering

• What information do you need from us?

• What information/training should DCF staff have?
Logistics of Reporting
Bruising of Pinna in 3-year-old

AAP visual diagnosis of child abuse 3rd edition
Slap Mark in 4-Month-Old

AAP visual diagnosis of child abuse 3rd edition
How to Report

• Must report to Careline by phone within 12 hours: 860.842.2288

• Must mail written report within 24 hours:

How to Report Continued

• Always call the DCF Careline about new concerns, NOT the ongoing worker

• Let staff begin the written/oral report, THEN pull you to finish form and phone report – this takes only a few minutes of your time

• Don’t call it in and then tell the Careline that you are not worried

• If you need immediate response tell them so and ask for callback with ETA
Triage

- Refer to Pediatric ED if immediate concerns for safety (may send in ambulance)
- If no immediate safety concerns (e.g. non-acute sexual abuse, no ongoing contact) may refer to child abuse program non-urgently
- YOU MUST REPORT TO DCF EVEN IF REFERRING ON
- Call child abuse MD in your region for phone support if you have questions about triage
  - SCAN at CT Children’s: 860.837.5890
  - DART at Yale: 203.688.2468
Talking with Family about Report

• Assure safety of child first (e.g. if sending on to ED, may wait until child in ED to discuss)

• When telling family of report, keep focus on the child and keep language objective

• Tell them that child needs further evaluation and multiple possibilities will be evaluated simultaneously

• Assure them that you will keep in touch with them as evaluation progresses
“Jane has a broken leg we don’t know how she got that. She needs further evaluation for possible trauma or bone disease right away. The law is that I have to report any unexplained injuries in children to child protective services, and I just made that report. Someone from DCF will come to assess Jane’s safety. The medical team will remain focused on giving Jane the right diagnosis and treatment, and we will communicate with you throughout the evaluation process. Do you have any questions about that?”
Talking with Investigators

- In the initial reporting period you may communicate your concerns to investigators without a release (but get them when able)
- For follow-up communication, need releases
- Investigators may record anything you say
- Keep information simple/ use lay language
- Don’t speculate
Investigators Will Want to Know:

• How old is this bruise/fracture?
• How could this injury be caused?
• Is this child abuse?
• Could this have been an accident?
• Have you had any prior concerns?
Common Areas of Confusion for Mandated Reporters

- Sexual contact in minors who say they assented
- Intimate partner violence (IPV)
Reporting Sexual Contact

- **<13 yrs:** report all contact

- **13-15 yrs:**
  - may legally consent with a person within 3 years of age
  - Greater than 3 yrs age difference but older person <21 is legally statutory rape, reporting to DCF is at your discretion, family may report to police
  - Report to DCF if older individual is 21 or older

- **>16:** may consent to sexual contact

CT General Statutes 46b-120, 53a-71(a)(1)
Letter from AAG Blumenthal to DCF Commissioner Ragaglia 9.30.02
Reporting Sexual Contact

• Always report at any age if:

  – there was coercion
  
  – there is cognitive limitation
  
  – there was contact with a caregiver/person entrusted or a relative
  
  – you judge that consent was not/cannot be given
Are You Mandated to Report IPV?

- Any injury resulting from a gun or firearm must be reported to the police (CT General Statute 19-490f)
- If there is reasonable suspicion of abuse or neglect then a report to DCF is warranted; this depends on your assessment of harm or risk of harm
DCF’s Position on Reporting IPV

• Operational Definitions
  
  – Physical or Emotional Neglect
    • “exposure to family violence which adversely impacts the child physically or emotionally”
    • “inability to provide or maintain a safe living environment”
  
  – Emotional Abuse
    • “terrorizing the child by exposing the child to violent, brutal or intimidating acts or statements including exposure to family violence”
Reporting IPV: Consider Safety

• If you are going to report, mother should know so that she can make an appropriate safety plan for herself and children

• Encourage mother to call DCF from your office herself to reduce risk of separation of mother from children
Contact information

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