Children and Youth Services (CYS) Agency Engagement

On April 17th, individuals leading or working within county Children and Youth Service (CYS) agencies engaged in a virtual guided discussion. The discussion included individuals who previously completed a brief survey (see details of that below). The major themes and discussion points during the April 17th discussion are included below.

**Childline triaging**

- Limitations to what Childline actually collects. Don’t nearly collect enough information as they need to guide the initial conversations and decisions. Can be impacted by both the quality of what is being called into them and they need to ask better questions
- Quality of online reporting every be reviewed as to quality of reports - may not know what all to put into the referrals for ChildLine. Maybe ChildLine should call those made online for additional screening
- A consistent situation that is always problematic are those that involve anything that happens in a vehicle
- Childline registers something a near fatality and yet it isn’t certified by a doctor as such. ChildLine is contradicting the opinion of the doctor. We have issues getting that decertified even though it shouldn’t have been certified in first place
- Sometimes doctor will say child is critical and so reporting (like accidental injuries) because of child’s age. When asked if child is critical doctor will say yes, but doesn’t necessarily say suspected child abuse, so then getting deemed a near fatality but not child abuse related and then county can’t get it decertified. In Lancaster policy of hospitals is that if a child is under 1 with a fracture then called into ChildLine and then coming as a CPS. Calls are made by doctors with more generalized training
- Counties will frequently call back ChildLine to have GPS coded as a CPS. Much easier to go from GPS to CPS versus a CPS to a GPS
- Sometimes a lot of medical jargon gets a CPS by default. Would be better to have more clarification from health care at time it is called in
- Many different medical issues so doctor need to provide better clarity about where concerns are
- There is a fine line in a number for many of the medical issues - failure to thrive, dental can come in as GPS or CPS but not sure the difference is and how Childline designates. Schools call in repeatedly for vision or dental and get some GPS and then sometimes CPS
- Can reassign as needed from GPS to CPS, but we begin with an assignment of GPS and the longer time frame for responding and by time caseworker gets out there the injury may be healing. Great you can reevaluate to CPS but missing the mark because response time of GPS is different
- Would be good for ChildLine workers to have someone in real time to run concerns by. Model what happens at the county level where we send a picture or something from the field and send to medical provider for real time consult
- Childline is just inconsistent. We struggle with having a consistent type of report. Hard to know what to expect. Don’t know what you are getting, depends on the worker, supervisor. It takes a lot of time and effort to argue with them, state your case and we don’t have the time to do that. I just don’t have the manpower and hours in the day to defend with ChildLine and CWIS and so sometimes we just give in. If it shouldn’t have been abuse, then investigate unfound and move on
- Consistently a discussion we have, if having that much then to me it is a training issue
- Curious to know how much of the online reports are fully read, vetted or just sent directly out to county
- About education and staffing at ChildLine
- Agree with inconsistency and time it takes to get these reports more accurate (i.e., it is a scratch it can’t meet bodily injury, siblings fighting, etc). It becomes very argumentative sometimes between county and Childline
If CPS we have to unfound, then sometimes need to make a GPS to validate because could be inappropriate discipline or lack of supervision. That is double the work on the county

Cases come to county as GPS but then later (often much later) it is changed to a near fatality because “it hit the papers”. That “screws up the counties” and retroactive designation is really not helpful to anyone and feels more like liability avoidance

Not accurate data if you are checking a near fatality but they won’t let you decertify it. The data is skewed

Doctors call in things that they are saying is not a near fatality but still being coded as such. Counties then have to deal with upset physicians and parents. And then triggers Act 33, but it wasn’t a near fatality

Head fractures on infants where the child was reported to have been accidentally dropped, go to local hospital and coded as near fatality but then gets to hospital with child abuse doctors who don’t have concerns. To decertify you need to go back to original doctor. Difficult to go back to a doctor, “not a comfortable conversation”. (Could there be some way by which the local hospital makes a call, but the actual certification of near fatality or not is left open until child treated by hospital being transferred to?)

Actual referral source is hospital social worker calling on doctor’s behalf, not actually coming from the doctor. For near fatalities, the doctor should be the one to make the call and be available for follow up

Need better teasing out of this is a child with a serious injury versus the child is in “serious or critical condition”

**Standardized policy/directives about the when and why of a medical evaluation**

- Impacted by availability of having a doctor to do it versus making a parent go to an urgent care and then have to pay for it or take to ER and also have to pay the cost
- More “black and white” guidance on when a medical evaluation is needed would help
- Need available provider and funding
- Philadelphia has nurses onsite and we have two children’s hospitals with protection clinics so can always make those referrals and call for consultation
- Westmoreland lucky to have a Child’s Place and Children’s Hospital - bringing on a nurse (will be an employee at UPMC with funding from needs based) developed out of a “relationships” emerging from the children’s advocacy center. Urban/rural mix counties send every case to Children’s Hospital, but families may not be able to get there due to transportation
- CAC prioritizes sex abuse, but children’s hospital can see physical abuse, if need at a clinic at CAC will see them there but priorities/appointments for sex abuse
- Doctor in Delaware County but has own practice affected availability. A solution could be having a nurse onsite and have go out on case and “see child” and can help understand “no that is normal childhood injury”. Nurses can do range of cases
- Lehigh County co-located so have access to doctors on GPS or CPS cases. Try to schedule for medical after forensic interview, family “may refuse it” but offered to them
- Workers struggle when it is “not as obvious”. Strangulation one of the most difficult to investigate because no visible injury. Those and others where injury may not be “obvious” try to reinforce with caseworkers that it is important to have child “medically cleared”. Caseworkers may downplay bruises
Strengthening collaboration between disciplines

- Challenges where CAC won’t support need for forensic interview unless law enforcement says it can be done. If interview doesn’t happen, likely medical won’t either
- Great deference to district attorney’s office
- Need statutory statement in the CPSL
- Child welfare is at the bottom “catching it all” and even as central as CYS is to the team still no: viewed as “equal party”. Child welfare can coordinate and facilitate and even when doing good things still not “viewed positively”
- It is always about the “integrity of law enforcement’s investigation”. They want to “get their person and we interfere with that”. Forget we have to make an independent determination. It is not child first
- View is that there are two investigations and one is more “valuable” and that is not the child welfare one
- Dauphin County worked with the child protection team at Hershey so can get reviews with them even if child doesn’t get to a CAC or forensic interview. Other doctors (outside Hershey CPT) are “wildcards”
- When get to administrative hearing and appeals no matter how “good our case,” we lose
- On law enforcement side, charges not always brought or dropped. If DA is trying to keep a “rate of convictions” won’t see certain cases brought. (Consider study of charges filed when child involved vs. conviction)
- In Philadelphia see a bit more “struggle” when dealing with homicide, if case picked up by Special Victims more collaborative (and timely)

Mandatory reporting of suspected child abuse

- CPSL law changed, mandated reporter training changed and so now have so many who are “fearful” if they don’t make report
- Mandated reporters “don’t process” with a professional (not likely at ChildLine) so no “1st level filtration”
- Training for mandated reporters needs revamped. “Shouldn’t walk away afraid of not reporting” - needs to be reevaluated and trained on other options. Example kids with lice every September we get the calls. Schools should know about resources beyond child welfare
- We need to “refocus on child abuse” because now just “calling in everything”. It has become “something it really wasn’t supposed to be”
- Agree we are engaged in an “over surveillance of our families” and these calls need redirected. Other partners need “to step up” and child welfare needs to be directed to “child abuse and neglect”. Made need more training for mandated reporters to “understand this is to be specific to child abuse and neglect”
- Schools get so “furious with us” because they think we need “to fix” everything if it involves a child. We are taking a “lot of flack”
- Wish we had a “prevention piece”
- We have prevention options but takes “manpower”
- Recall when GPS cases came directly to county and abuse went to ChildLine but now all goes to ChildLine and mandated reporting training “goes over all the other stuff” so calls being made
- Increasingly have people making calls saying I don’t think this is “child abuse but concerned”
**Preventing morbidity, mortality in children 0-2**

- Having nurse work in conjunction (onsite) with child welfare will be a “game changer” especially since direct connection to children’s hospitals
- Don’t have numbers to support a nurse
- Missing piece (re: “affected by” infants by prenatal substance exposure) is early intervention - referrals not happening from hospital - that is a gap
- Things like Shaken Baby, safe sleeping are “very generic” and also overlooks when child is not going home with parent (i.e., going home with kin, 65-year-old grandma)
- Early intervention “is a mess” infant may go into placement in another county and then when returned home there is a “gap” when “goes back to mom”
- Need more services “mandated” and more “automatic” when you have an infant that has been substance exposed
- Definitely more seeing more violence against young children
- Clarity needed on plans of safe care - hospitals should be doing plans of safe care someone other than child welfare
- In our county none of our hospitals do plans of safe care so won’t have one unless child welfare agency receives a referral
- We find “struggle” more when not part of Healthy Beginnings or Nurse Family Partnership (sc done prenatally)
- Need more educating with pediatricians for infants (with prenatal substance exposure) when challenges arise at 3-4 months. May do OK for first few months (child and family) but then fall “off radar”
- Get nothing from private OBs because only Healthy Beginning moms need referral

**Final thoughts/asks**

- We “missed the mark on monitoring” impact about 2012-14 legal changes. Urge you not to do the same with the design/implementation of any new strategic plan