VIEWPOINT

Should I Call Child Protection?—Guidelines for Clinicians

Mical Raz, MD, PhD
University of Rochester and University of Rochester Medical Center, Rochester, New York.

Josh Gupta-Kagan, JD
Columbia Law School, New York, New York.

Andrea G. Asnes, MD, MSW
Yale School of Medicine, New Haven, Connecticut.

Child protection investigations are a commonplace occurrence for US children and their families. At current levels of risk, a third of all children and more than half of Black children can expect to experience such an investigation before turning 18 years old.[1] While the risk of child protective services (CPS) investigations varies widely across states, significantly greater risk for Black children is a constant.[2] In addition, large and long-standing disparities in reports to CPS by socioeconomic class, race, and disability status raise significant concerns about equity and justice. Black children are more likely to be investigated and removed from their homes, and, once removed, spend longer time in substitute care; they are less likely to be reunited with their families and experience termination of parental rights at rates higher than White families.[3] Parents with disabilities and parents of children with disabilities are also disproportionately represented among families investigated by CPS. As other studies have identified, physicians and medical professionals contribute to these disparities in reporting.

Pediatric clinicians can narrow the front door to the child protection system by preventing unnecessary reports that can detrimentally impact child and family well-being. While all health care professionals must comply with their states' mandated reporting statutes, clinicians should exercise judgment about when those statutes are triggered and when to call CPS and when to offer supports to families. We offer the following 5 guiding principles to help pediatric clinicians distinguish between those families who need support and resources and those that require a CPS investigation because there is concern of maltreatment.

Five Things Every Pediatric Clinician Should Know About CPS and Equity Before Making a Report

1. More CPS Reports Do Not Keep Children Safer and Come at a Cost

Medical personnel and others report millions of children to CPS each year, a significant investment of taxpayer dollars and manpower. CPS agencies only substantiate a small minority—16.1% in 2022—of reports.[4] In fact, research shows that there is a limit to the effectiveness of reporting and that casting a wider net, meaning higher population rates of reporting, does not result in better identification of children at risk nor in better outcomes for children.[5] The harm of CPS reports is often not recognized, as its impact is primarily downstream. Reporting may result in family mistrust and disengagement and reduce the likelihood that parents will avail themselves of needed health care in the future, perpetuating harm. Furthermore, CPS investigations are intrusive and can result in lost days of work, and parents, especially those parents living in poverty, may lose their source of income while complying with CPS expectations.[6]

2. CPS Reports Usually Do Not Lead to Supports for Struggling Families

CPS reports are not effective tools for providing help to families in need. In reality, a majority of investigations conclude without the provision of new services. Clinicians who make CPS reports out of sincere concern that families lack necessary resources may not realize that these reports will lead to a stressful and expensive investigation, and the family may be no better off at its conclusion. Clinicians worried about families lacking resources should first be knowledgeable of and rely on local resources such as food pantries and housing assistance programs or be prepared to refer to social workers or other professionals who might have this expertise.

3. If You Suspect Physical Abuse but Are Not Sure, CPS Likely Does Not Have the Clinical Expertise to Assess

Pediatric clinicians concerned that a child's injury may be due to physical abuse face real diagnostic dilemmas. But CPS will not likely resolve these dilemmas. CPS relies on the evaluation of medical professionals to assess whether child abuse has occurred. As other scholars have noted, a medical professional who is unsure about the likelihood of maltreatment may refer to CPS, but CPS lacks the expertise to confirm or dispel the concern, leading to a cycle of "mutual deference" when each party—the medical and the legal—believes the other has the ability to provide an accurate assessment.[7] Clinicians concerned about child maltreatment best serve children by consulting a child abuse pediatrician who has expertise in distinguishing those injuries due to abuse and those that are unintentional or explained by a medical cause before calling CPS.[8]

4. Parental Substance Use Alone is Not Child Neglect

Many parents use substances, and substance use alone does not establish child maltreatment. Furthermore, substance use during pregnancy, which is a clinical concern, is best addressed by treatment and support rather than a threat of CPS reporting. There is significant racial disproportionality in testing for substance use during pregnancy, and ample data show that racial and ethnic minority individuals and people on public insurance are more likely to have their urine tested during pregnancy.[9] The Comprehensive Addiction and Recovery Act of 2016 requires a plan of safe care for neonates with substance exposure, but does not require clinicians to report suspected abuse or neglect in these cases. Nonetheless, reports from medical professionals for substance-exposed infants have increased dramatically over the past decade, perpetuating racial inequities, without improving outcomes for infants. Furthermore, many adults worldwide use substances, and which substances are criminalized and in what manner has deeply racialized

Corresponding Author: Mical Raz, MD, PhD, University of Rochester, 362B Rush Rhees Library, PO Box 270070, Rochester, NY 14627 (micalraz@rochester.edu).

© 2024 American Medical Association. All rights reserved.

Downloaded from jamanetwork.com by Gayle Nash on 09/28/2024

roots. Punitive approaches to substance use, divorced from actual harm to children, perpetuate racist and ableist stereotypes.[10] Pediatric clinicians should understand that they are obligated to explore and develop plans of safe care for newborns, not to report all substance use during pregnancy.

5. Structural or Cultural Barriers to Medical Adherence Should be Understood and Addressed Before Medical Neglect is Reported to CPS

Pediatric clinicians are often frustrated by parents who miss appointments or fail to give prescribed medications. These parental actions can be harmful to children and clinicians rightly feel called to act. Rarely, however, is CPS a solution to this challenge. Often parents face structural barriers to adherence that include lack of funds to pay for medication or transportation or childcare needs that interfere with medical appointments. Additionally, Black and other racial and ethnic minoritized individuals hold a historically accurate mistrust of the health care system that may interfere with compliance. Pediatric clinicians should strive to identify barriers to engagement with care and address them before making a CPS report. Provision of a medical taxi or use of telehealth for a parent unable to attend appointments due to other responsibilities may solve the issue of noncompliance. Taking time to understand a family's experience with the health care system may identify a resolvable barrier to successful engagement with needed medical care and help to establish trust.

Conclusions

While some children require an immediate CPS report to protect their safety, most children reported to CPS would be better served by an alternative mechanism to ensure that they receive the services and supports they need to thrive. An understanding of what CPS can and cannot do, and what legal statutes require, can improve clinicians' decision-making process when referring to CPS.

ARTICLE INFORMATION

Published Online: September 16, 2024. doi:10.1001/jamapediatrics.2024.3624

Conflict of Interest Disclosures: Dr Asnes reported being the principal investigator on grants that support child abuse programs from the State of Connecticut to Yale School of Medicine and providing expert testimony in court on suspected child abuse cases for which the Yale Department of Pediatrics has been compensated. No other disclosures were reported.

REFERENCES

1. Kim H, Wildeman C, Jonson-Reid M, Drake B. Lifetime prevalence of investigating child maltreatment among US children. *Am J Public Health*. 2017;107(2):274-280. doi:10.2105/AJPH.2016.303545

2. Yi Y, Edwards F, Emanuel N, et al. State-level variation in the cumulative prevalence of child welfare system contact, 2015-2019. *Child Youth Serv Rev*. 2023;147:106832. doi:10.1016/j.childyouth.2023.106832

3. Dettlaff AJ, Boyd R. Racial disproportionality and disparities in the child welfare system: why do they exist, and what can be done to address them? *Ann Am Acad Pol Soc Sci*. 2020;692(1):253-274. doi:10.1177/0002716220980329

4. US Department of Health & Human Services Children's Bureau. Child maltreatment. 2022. Accessed August 14, 2024. https://www.acf.hhs.gov/cb/data-research/child-maltreatment

5. Ho GW, Gross DA, Bettencourt A. Universal mandatory reporting policies and the odds of identifying child physical abuse. *Am J Public Health*. 2017;107(5):709-716. doi:10.2105/AJPH.2017.303667

6. Fong K. *Investigating Families: Motherhood in the Shadow of Child Protective Services*. University Press; 2023.

7. Presler C. Mutual deference between hospitals and courts: how mandated reporting from medical providers harms families. *Columbia Journal of Race and Law*. 2021;11(3):733-766. doi:10.52214/cjrl.v11i3.8750

8. Raz M, Gupta-Kagan J, Asnes AG. Using child abuse specialists to reduce unnecessary child protective services reports and investigations. *JAMA Pediatr*. 2023;177(12):1249-1250. doi:10.1001/jamapediatrics.2023.3676

9. Jarlenski M, Shroff J, Terplan M, Roberts SCM, Brown-Podgorski B, Krans EE. Association of race with urine toxicology testing among pregnant patients during labor and delivery. *JAMA Health Forum*. 2023;4(4):e230441-e230441. doi:10.1001/jamahealthforum.2023.0441

10. Meinhofer A, Witman A, Maclean JC, Bao Y. Prenatal substance use policies and newborn health. *Health Econ*. 2022;31(7):1452-1467. doi:10.1002/hec.4518

© 2024 American Medical Association. All rights reserved.

Downloaded from jamanetwork.com by Gayle Nash on 09/28/2024