Kentucky Cabinet for Health and Family Services
Department for Community Based Services
and
Prevent Child Abuse Kentucky

Child Abuse Recognition Education: Surveys of Physicians and DCBS Staff

Survey Report
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Child Abuse Recognition Education: Surveys of Physicians and DCBS Staff
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Overview: C.A.R.E. Surveys Of Physicians and DCBS Staff

During 2006, the Department for Community Based Services (DCBS) and Prevent Child Abuse Kentucky (PCAK) jointly sponsored two surveys, one of Protection and Permanency workers and the other of physicians licensed in selected medical specialties. Both surveys dealt with two broad issues — the reporting of suspected child abuse and neglect by physicians and the interaction between social workers and reporting physicians. Specific topics covered by the surveys included: physicians' ability to recognize child abuse and neglect; procedures and forms they use to document and report abuse and neglect; barriers to reporting by physicians; and DCBS workers' willingness to share information with physicians about cases under investigation. The surveys were intended to advance the Child Abuse Recognition Education (C.A.R.E.) program, an effort to prevent child abuse and neglect through better recognition of the signs of maltreatment and better collaboration between medical professionals and DCBS.

Survey findings revealed gaps between the perceptions and priorities of the two groups and points on which each group held unfavorable views of the other. These include:

- 90% of physicians were confident they could recognize child physical abuse (physician confidence in their ability to recognize=83% for neglect, 56% for emotional abuse and 69% for sexual abuse). Only 20% of social workers agreed physicians knew the signs and symptoms of physical abuse (worker confidence in physicians' ability to recognize=43% for neglect and 33% for sexual abuse).
- 74% of workers agreed physicians understand DCBS' role in working with families around abuse/neglect, and 80% of workers agreed physicians understand how the decision to investigate is made. Only 48% of physicians said they knew how social services handles reports of abuse or neglect.
- 78% of physicians agreed that abuse or neglect occurs among children in their practices. Only 10% of workers agreed that physicians play an important role in reporting child abuse or neglect, and only 5% of workers considered it very important to include physicians on multidisciplinary teams.
- 88% of physicians wanted to be told what happens to a child after they report abuse or neglect, but only 17% said DCBS kept them informed. 32% of workers said they would inform a physician who is the reporting source that an investigation of child abuse or neglect had been accepted.
- 46% of workers identified the risk of medical malpractice as a barrier to reporting by physicians. Only 10% of physicians identified it as a barrier.
- Only 43% of the physicians said they had had a good experience working with DCBS, and only 24% of them agreed families get the help they need when abuse or neglect is reported.
- Only 41% of workers agreed that physicians respected their views and opinions, and 33% said physicians were hard to work with because they were arrogant.

C.A.R.E. can address these gaps and negative perceptions through its sponsorship of peer-to-peer physician training and its other efforts to broaden understanding, trust and collaboration between physicians and child protection workers. The survey provided at least one additional reason to regard this approach as promising: 82% of the physicians surveyed agreed they would welcome CME/CEU-credited C.A.R.E. trainings.

C.A.R.E. Survey of Physicians
Executive Summary

This survey assessed physicians' views and experiences relevant to the detection, reporting and investigation of child abuse and neglect. It was limited to Kentucky physicians licensed in practice fields likely to bring them into contact with abused or neglected children.

The survey is intended to advance the Child Abuse Recognition Education (C.A.R.E.) program, an effort to prevent child abuse and neglect through better recognition of the signs of maltreatment and better collaboration between medical professionals and DCBS.

Survey items dealt with: physicians' practice settings; protocols and forms they use to record suspected abuse or neglect; their ability to recognize it; their views on interacting with DCBS when they suspect it; and barriers that might make them hesitant to report it. Of the 2,339 survey forms that were sent and deliverable, 807 responses were received for a response rate of 35%.

Analysis of most items was limited to 777 physicians who provided usable data and served children. Summary scores were computed only for 760 physicians who completed both sides of the survey form.

Results Summary

Physician Characteristics:

- Participants reported a median figure of 17 years in medical practice.
- 48% were family practitioners, 37% were pediatricians and 14% were emergency specialists.
- 48% worked in group settings, 20% in solo practices, 18% in hospital emergency departments, 12% in hospital or public health clinics and 9% in academic centers.
- Physicians reported that a median figure of 25% of their patients were under age 18.

Use of Protocols and Forms:

- 36% of physicians reported they had no standard office protocol for reporting child abuse and neglect; 62% reported they used no standardized forms for that purpose.

Recognition and Knowledge:

- 90% of physicians were confident they could recognize physical abuse. Levels of confidence in recognition ability were 83% for neglect, 56% for emotional abuse and 69% for sexual abuse.
- 48% of physicians knew how social services handles reports of child abuse and neglect.

Experiences and Attitudes:

- 88% of physicians wanted to be told what happens to a child after they report abuse or neglect, but only 17% said DCBS kept them informed.
- 43% agreed they had had a good experience working with DCBS.

Special Issues:

- 78% of physicians agreed that child abuse or neglect occurred in their practices.
- 82% agreed they would welcome Child Abuse Recognition Education training.

Regions:

- Differences among current and former DCBS regions were minimal.

Urban/Rural Differences:

- There were no significant differences in physicians' responses that could be linked to the urban-rural makeup of the counties where they practice.

Comments:

- 21% of physicians surveyed entered comments or suggestions and 4% provided contact information. Comment topics included willingness to report cases of abuse or neglect, poor handling by DCBS of such cases and failure by DCBS to make follow-up contact.

Opportunities to Improve

- C.A.R.E. should capitalize on physicians' interest in training around abuse and neglect.
- DCBS should strive to improve relationships with physicians around abuse and neglect. One important step would be keeping physicians informed in ongoing CA/N cases.

Background and Introduction

Purpose and Background

This survey assessed physicians' views and experiences in matters related to the detection, reporting and investigation of child abuse and neglect. The purpose of the study was to gather baseline data for the continued evaluation of the C.A.R.E. program. Survey measures were designed to capture:

- demographic data on county and gender of respondents;
- professional information on physicians' fields of medical licensure, years of experience and practice settings;
- physicians' protocols and use of standardized forms for identifying, reporting and documenting child abuse and neglect;
- physician knowledge of signs and symptoms of abuse;
- perceived strengths and barriers of current collaboration and communication between physicians and DCBS; and
- physician knowledge of the referral process.

The physician survey is intended to advance the objectives of the C.A.R.E. program, a joint initiative of DCBS and Prevent Child Abuse Kentucky.

C.A.R.E. is based on the recognition that members of the medical community are uniquely well positioned to detect nonaccidental injuries in children. Its goal is the prevention of child abuse and neglect through:

- better recognition of the signs and symptoms of child maltreatment by medical providers; and
- better collaboration between medical professionals and DCBS.

Ancillary aims include:

- physician office protocols for assessing and documenting potential child abuse cases;
- heightened awareness by DCBS of the factors and concerns of physicians regarding child abuse/neglect referrals; and
- heightened awareness by physicians of the role, obligations and limitations of DCBS in child abuse/neglect cases.

Toward these ends, C.A.R.E. provides for the development, support and enhancement of a statewide network of medical professionals who participate in peer-to-peer training sessions. A core group of physicians set to work on the training plan in August 2005, pilot sites were chosen in January 2006 and trainings began in May 2006. If successful, C.A.R.E. will significantly expand the number of physicians, nurses and other medical personnel who are skilled at recognizing signs of child abuse and know how to make appropriate referrals.

To broaden the information base for these training efforts, two survey instruments were designed by separate workgroups. One of them was designed for Protection and Permanency field staff. The other survey – the subject of this report – was designed for physicians whose practices were deemed likely to bring them into contact with children who had been abused or

neglected. The survey of physicians licensed in selected specialties was designed to assess; 1) their knowledge of the signs and symptoms of child abuse/neglect; 2) their understanding of the responsibility to report suspected abuse/neglect; and 3) their relationship with DCBS. The survey of DCBS staff assessed their views on: 1) physicians' knowledge of child abuse/neglect; 2) physicians' partnership with DCBS; 3) the sharing of information with physicians in cases of suspected abuse / neglect; 4) the adequacy of medical resources available to help high-risk families; and 5) barriers to reporting by physicians.

The two surveys were also intended to assess urban-rural differences in work by medical professionals and DCBS staff around the reporting and investigation of suspected child abuse and neglect.

Design, Methodology and Measure

Questions for the physician survey were formulated by: a group of private physicians; the DCBS physician, Dr. Allen Brenzel; DCBS staff; and members of the PCAK program staff. The design and content of the instrument were drawn from the C.A.R.E. curriculum and modeled after "Educating Physicians in their Communities – Suspected Child Abuse and Neglect" (EPIC-SCAN), a preliminary study in Pennsylvania from which C.A.R.E. originated.

The survey was limited to Kentucky physicians licensed in practice areas considered likely to bring them into contact with abused or neglected children – family practice, pediatrics, emergency medicine, pediatric emergency medicine, critical care, pediatric critical care and adolescent medicine.

The survey instrument consists of rating scales, checklists and a space for comments. The survey was written at the eighth-grade reading level and required mostly checked responses that could be completed within 10-15 minutes.

With the approval of the Cabinet for Health and Family Services' Internal Review Board (IRB), the survey included an introductory letter that contained all elements of informed consent. This introduction described the survey's purpose, its anonymity and how the results would be used, and it included a contact telephone number for the researcher and the IRB administrator.

The medical professional survey received the endorsement of the Kentucky Pediatric Society and the Kentucky Medical Association. It was announced through a mass e-mailing to all members of each organization and, on May 11, 2006, it was posted via Web-based survey technology on the home pages of the organizations' Web sites. On the same date, the survey of DCBS workers was distributed to workers, also via Web posting.

Few physicians responded to the Web-based survey. It was decided to instead survey them by mail and to limit the survey to physicians in selected specialties.

Mailing lists for physicians were obtained from the Kentucky Board of Medical Licensure and the Kentucky Department for Public Health. To assist in interpreting responses, the surveys were labeled for county based on the recipient's address. Labels also included a code for the recipient's type of medical licensure.

Mailings consisted of a cover letter, the two-page survey form (printed front-and-back on a single page) and a postage-paid return envelope addressed to a post office box in Frankfort. A first mailing was sent to physicians between Oct. 25 and Nov. 15, 2006. A second mailing was sent to physicians between Nov. 16 and Nov. 29, 2006. The second mailing included a new cover letter that asked physicians to participate if they had not already done so and thanked them if they had. Both the original and the follow-up cover letters contained the same elements of informed consent and a survey. A return of the survey was considered consent.

Participants and the Response Rate

Surveys were mailed to physicians licensed by the Kentucky Board of Medical Licensure in the selected practice fields. Of the 2,448 survey forms mailed, 109 were returned as undeliverable by the postal service. Of the 2,339 survey forms sent to valid addresses, 807 responses were received, for an overall response rate of 34.5%.

Fourteen surveys were returned too late to be included in the database. Another 17 surveys were returned essentially incomplete with little or no data. On about half of these incomplete surveys, physicians either wrote that they did not serve children or entered 0% in the item calling for the percentage of their patients who were under age 18. These 17 surveys were deleted from the database, resulting in 777 usable surveys. Another 17 respondents failed to complete the second page of the survey; these surveys were retained, but summary scores for these 17 respondents were not calculated. On all other items, occasional missing data were found on up to 4% of the forms.

Survey Results

Physician Demographics

784 physicians reported their years of experience, which ranged from 0 to 58 years, with a median figure of 17 years. 780 physicians identified their gender, and 489 (63.3%) were male and 284 (36.7%) were female. Physicians reported that a median figure of 25% of their patients were under age 18.

The following table shows, for each of the 16 service regions in place prior to the survey, the number of physicians who returned completed surveys and the percentage of all physicians that they represented.

Service Region	Number	Percent
Barren River	42	5.5
Big Sandy	28	3.7
Bluegrass Rural	61	8.0
Cumberland Valley	32	4.2
Fayette	76	10.0
FIVCO	32	4.2
Gateway	30	3.9

Green River	34	4.5
Kentucky River	19	2.5
KIPDA Jefferson	170	22.4
KIPDA Rural	33	4.3
Lake Cumberland	24	3.2
Lincoln Trail	31	4.1
Northern Kentucky	84	11.1
Pennyrile	36	4.7
Purchase	28	3.7
Total	760	100

On Sept. 16, 2006, the Department for Community Based Services was realigned into nine service regions. The following chart shows the number of survey participants from each of these new service regions and the percentage of all survey respondents that they represented. (Percentages add to more than 100 due to rounding.)

Service Region	Number	Percent
Cumberland	132	17.4
Eastern Mountain	47	6.2
Jefferson	170	22.4
Northeastern	62	8.2
Northern Bluegrass	84	11.1
Salt River Trail	64	8.4
Southern Bluegrass	61	8.0
The Lakes	64	8.4
Two Rivers	76	10.0
Total	760	100.1

The following table shows, for the 777 physicians who returned surveys containing usable data, the number and percentage licensed in each of the seven selected medical specialties.

Field of Licensure	Number of Physicians	Percent
Adolescent Medicine	0	0
Critical Care Medicine	2	0.3
Emergency Medicine	108	13.9
Family Practice	373	48.0
Pediatrics	285	36.7
Pediatric Critical Care Medicine	5	0.6
Pediatric Emergency Medicine	4	0.5
Total	777	100

The survey asked physicians to identify their practice settings. The following table shows the number and percentage of physicians who reported that they practiced in each identified setting.

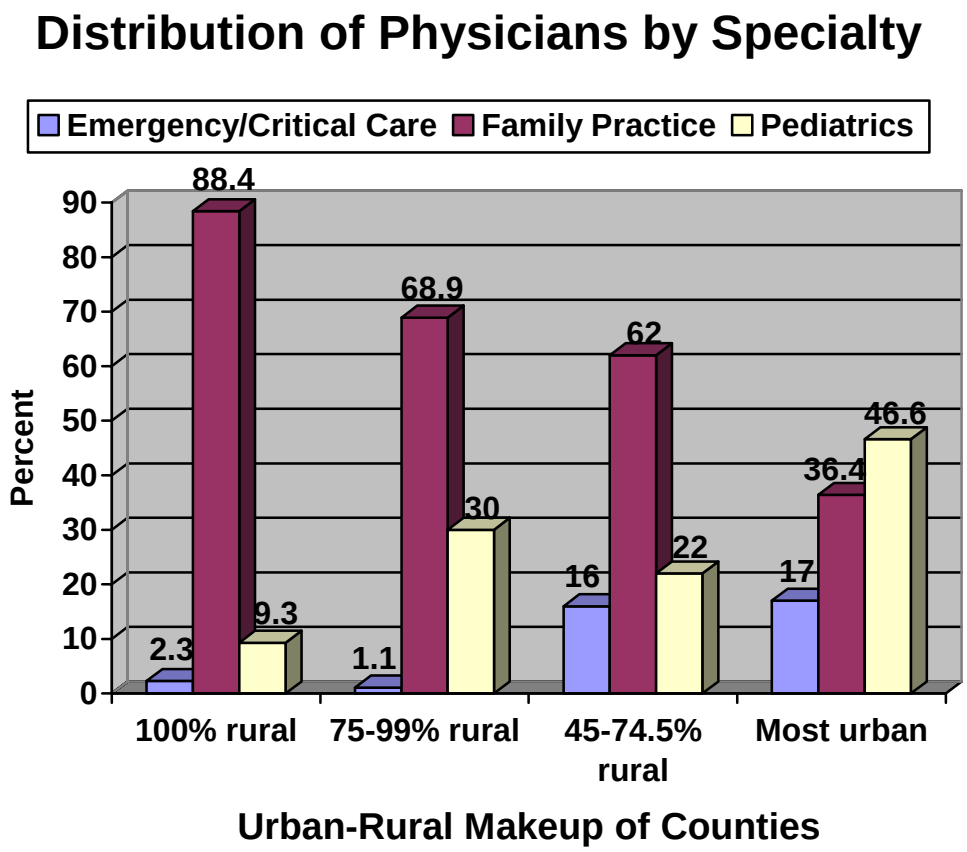
(Because some physicians practice in multiple settings, the total number of physicians exceeds the number of survey participants.)

Setting	Number of Physicians	Percent
Solo medical practice	155	19.9
Group medical practice	375	48.3
Public health clinic	31	4.0
Hospital-based clinic	59	7.6
Hospital emergency room	141	18.1
Academic medical center	72	9.3

The survey forms were coded for the county listed for each physician in medical licensure records. This linkage of each physician with a county made it possible to search for urban-rural differences in physicians' responses. As a first step in this process, all 120 Kentucky counties were divided into four groups, based on U.S. Census Bureau figures on the proportion of each county considered predominantly rural. The following table shows, for each group of counties, the urban-rural composition, the number of counties and the number of physicians surveyed.

Urban-Rural Composition	Number of Counties	Physicians Surveyed	Percent
Most urban counties	24	494	63.6
45-74.5% rural	30	150	19.3
75-99% rural	27	90	11.6
100% rural	39	43	5.5
Total	120	777	100

Among the surveyed physicians, those in the pediatric specialties (pediatrics, pediatric critical care medicine and pediatric emergency medicine) were likely to practice in the most urban counties. Nearly all the surveyed physicians licensed in emergency and critical care medicine practiced in counties that were at least 25% urban. The following chart illustrates the differences in the distribution of medical specialists along urban-rural lines. These differences were highly statistically significant.



Use of CA/N Protocols and Forms

Physicians were asked for information on protocols used in their practices to identify and/or report child abuse and neglect. The following table shows the options they were presented and the number and percentage of physicians who chose each. (Physicians were instructed to indicate all options that applied to their practices, so percentages add to more than 100.)

Protocol Type	Number of Physicians	Percent
No standard office protocol	276	35.5
General unwritten protocol	264	34.0
Rely on my staff to help identify	240	30.9
Protocol in place for reporting	219	28.2
Protocol in place for identifying	137	17.6
Rely on social services to identify	120	15.4

Rely on my staff to report abuse and neglect	102	13.1
Do not know or not sure	18	2.3

Physicians were also asked to identify all standardized forms used in their practices for documenting child abuse or neglect. (Percentages exceed 100.)

Type of Form	Number of Physicians	Percent
No standardized forms	485	62.4
Document each in narrative record	273	35.1
Forms for sexual abuse	88	11.3
Forms for physical abuse	77	9.9
Do not know or not sure	33	4.2
Forms for neglect	32	4.1

Results Summary of Rated Items

20 survey items presented physicians with statements and asked them to rate their degree of agreement or disagreement (options were **strongly disagree, disagree, not sure, agree and strongly agree).** Using factor analysis, these items were grouped into three domains:

- "recognition and knowledge" – eight items that measured physicians' perceptions of their ability to recognize child abuse and neglect;
- "experiences and attitudes" – seven items that dealt with physicians' experiences in reporting child abuse and neglect and their attitudes toward interacting with DCBS in abuse/neglect cases; and
- "special issues" – five items that dealt with a variety of concerns and resources.

For each domain, a total score was calculated for each respondent by adding their responses. These total scores for individuals were used in calculating overall scores for groups of physicians, as described later in this report.

Recognition and Knowledge

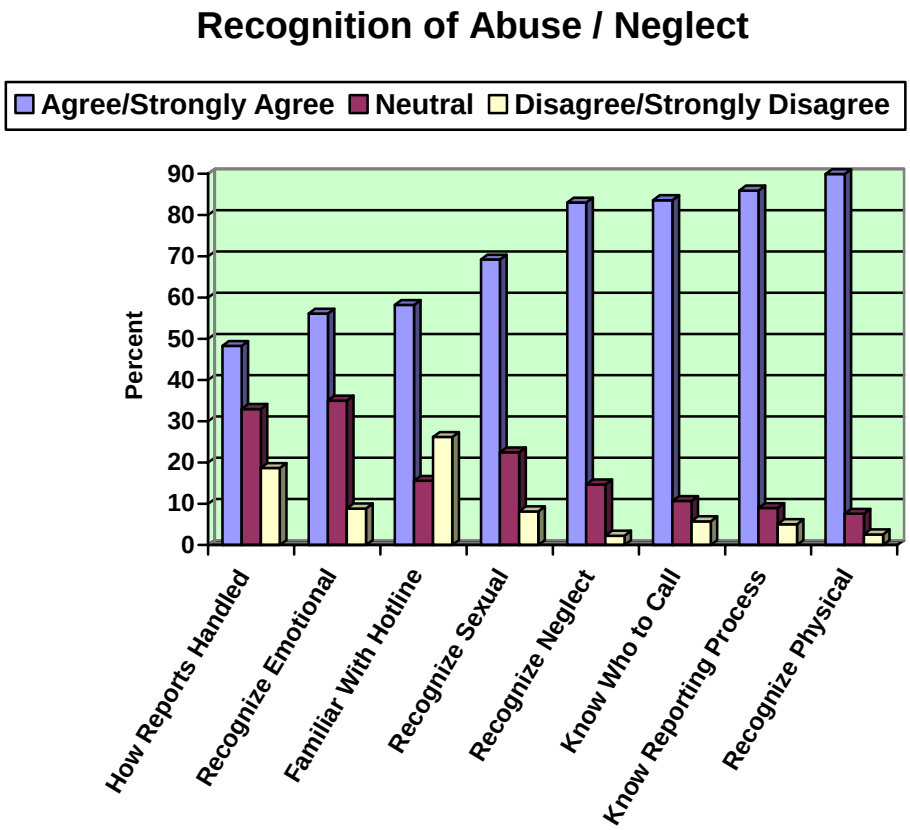
The items and rates of agreement within this domain were:

- **I am comfortable in my ability to recognize child physical abuse.**
  89.9% of physicians agreed or strongly agreed.
- **I know the process of reporting child abuse and neglect.**
  85.9% agreed or strongly agreed.
- **I know who to call locally when I suspect child abuse or neglect.**
  83.6% agreed or strongly agreed.
- **I am comfortable in my ability to recognize child neglect**.
  83% agreed or strongly agreed.
- **I am comfortable I my ability to recognize child sexual abuse.**
  69.2% agreed or strongly agreed.
- **I am familiar with the state's child abuse and neglect reporting hot line.**

58.2% agreed or strongly agreed.

- **I am comfortable in my ability to recognize child emotional abuse.**
  56.1% agreed or strongly agreed.
- **I know how reports of child abuse or neglect are handled by social services.**
  48.3% agreed or strongly agreed.

The following graph displays the survey results on these items, arranged from the weakest to the strongest levels of physicians' confidence in their ability to recognize abuse or their knowledge of reporting processes.



To derive overall scores for recognition and knowledge, each of these seven items was scored on a five-point scale and the scores were summed. The maximum score for the seven items is 35 (strongly agree = 5 times 7 items = 35). Each physician's total score is divided by 35 to get an overall percentage. This percentage ranges from 20% to 100%.

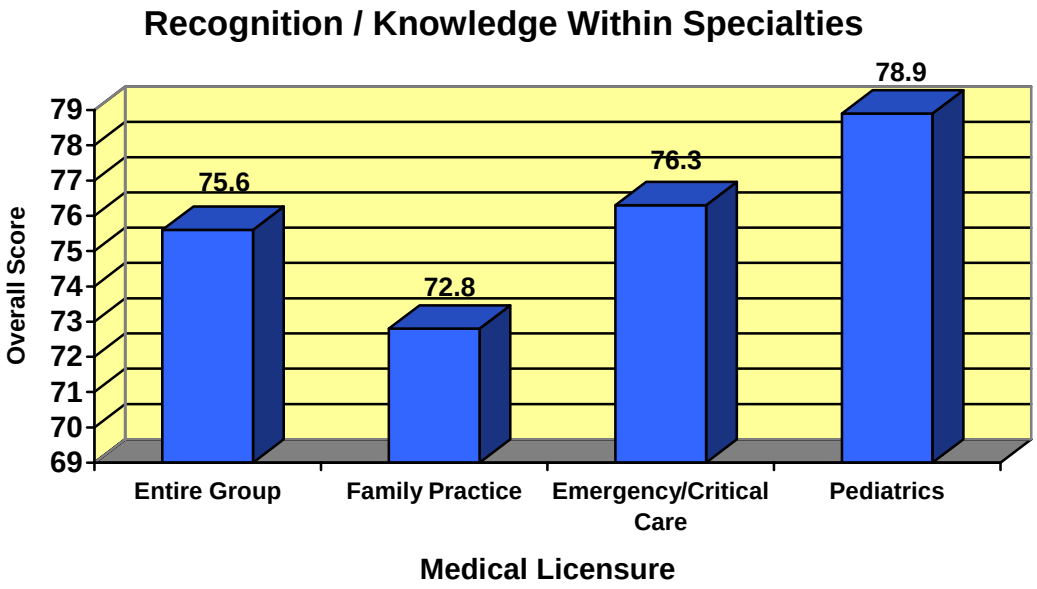
For the 760 physicians for whom summary scores were calculated, the mean overall recognition and knowledge score was 75.6%. There was statistically significant variation in overall scores among the medical specialties surveyed. Physicians licensed in these specialties were combined into the following three groups for analysis:

- 288 physicians licensed in pediatrics, pediatric critical care medicine and pediatric emergency medicine;

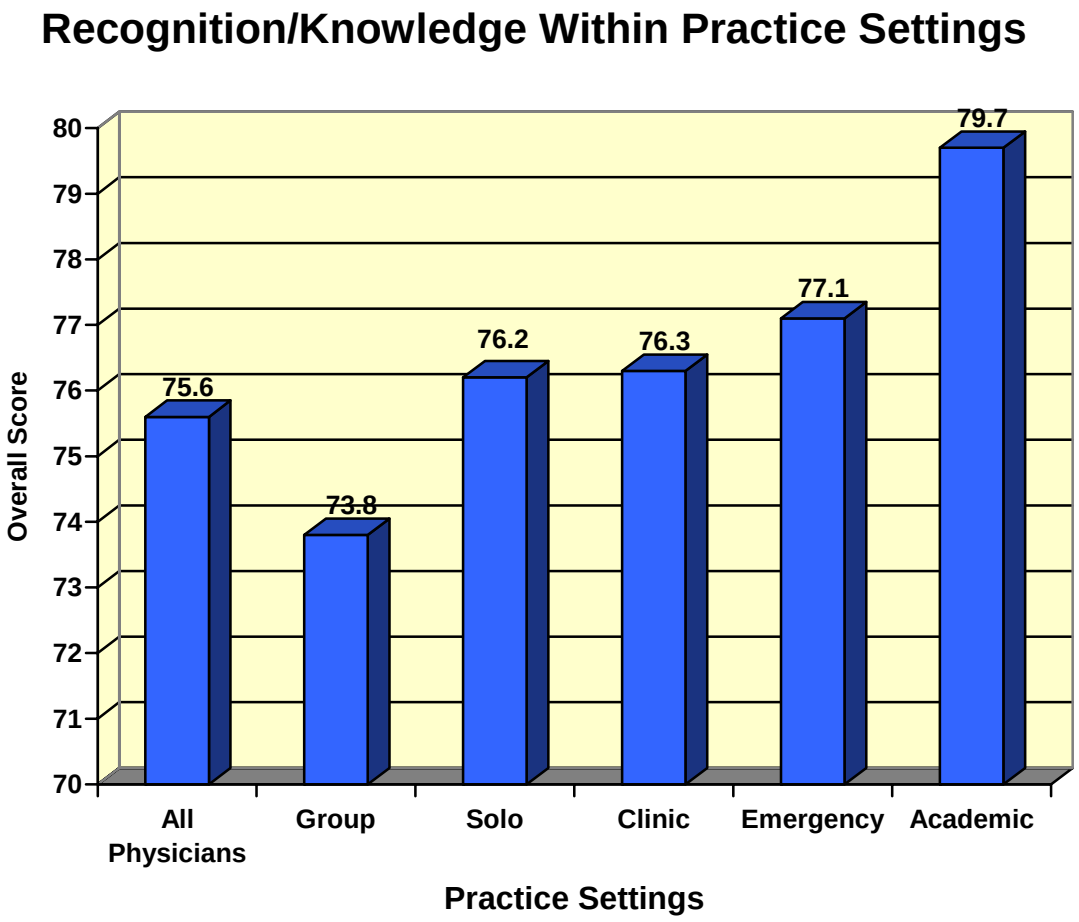
- 108 physicians licensed in emergency medicine and critical care medicine; and
- 364 physicians licensed in family practice.

Physicians in pediatric specialties gave the highest ratings to their recognition of child abuse and neglect and their related knowledge, followed by the emergency and critical care specialists and the family practitioners.

The following chart shows the self-ratings of these three groups.



There was also statistically significant variation in the ratings that physicians who practice in different professional settings gave to their ability to recognize abuse and neglect and their related knowledge. Physicians practicing in hospital emergency rooms gave themselves the highest mean ratings of recognition and knowledge, followed by those in academic medical centers, clinic-based physicians (those in hospital-based and public health clinics), physicians in solo practices and those in group practices.



The survey of physicians was conducted soon after 16 pre-existing DCBS service regions had been reorganized into nine regions. There was modest statistical significance among both the former and current service regions in physicians' self-ratings of recognition and knowledge. Among physicians in the former regions, those in Bluegrass-Fayette had the highest mean score on recognition and knowledge, 79.1%, and those living in the Purchase Region had the lowest, 71.8%. Among the current regions, the highest mean score, 77.3%, was in the Cumberland Region and the lowest, 72.5%, was in the Northern Bluegrass Region.

There was no statistically significant variation in physicians' overall scores on recognition and knowledge based on the rural-urban makeup of the counties where their practices are located.

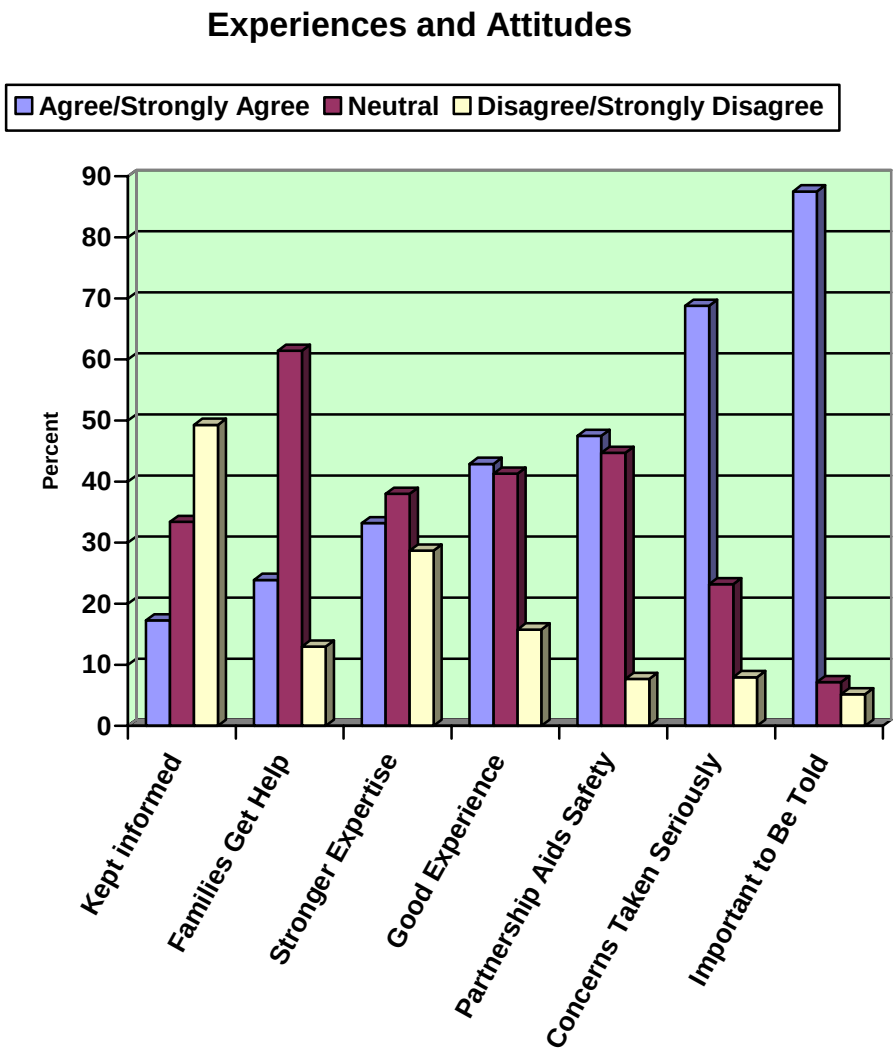
Experiences and Attitudes

Items and rates of agreement in this domain were:

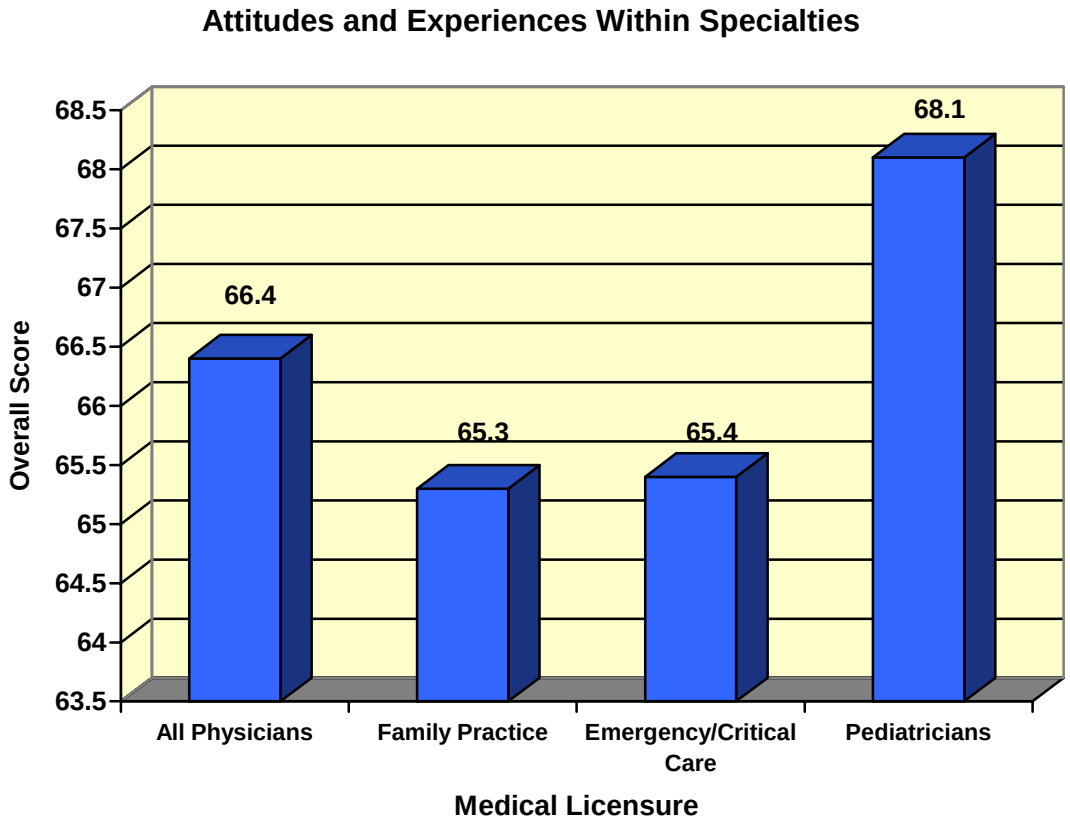
- **It is important to be told what happens to the child after I report child abuse or neglect.**
  87.5% of physicians agreed or strongly agreed.

- **When I call to report suspected child abuse or neglect, my concerns are taken seriously.**
  68.8% agreed or strongly agreed.
- **The partnership between my practice and the local DCBS office helps ensure safety for neglected or abused children.**
  47.5% agreed or strongly agreed.
- **I have had a good experience working with DCBS.**
  42.9% agreed or strongly agreed.
- **State social workers have stronger expertise than I in identifying child abuse and neglect.**
  33.2% agreed or strongly agreed.
- **Families get the help they need when abuse or neglect is reported.**
  23.9% agreed or strongly agreed.
- **I am kept informed by the Department for Community Based Services (DCBS) on the progress of child maltreatment cases.**
  17.3% agreed or strongly agreed.

The following graph displays the survey results on these items, arranged from the weakest to the strongest levels of physicians' positive ratings of their experiences or attitudes.



To a high degree of statistical significance, physicians licensed in different medical specialties differed in their overall scores on these attitude and experience items. Physicians in the pediatric specialties produced more positive ratings on these items than did those licensed in emergency and critical care specialties or in family practice. The following chart illustrates these results:



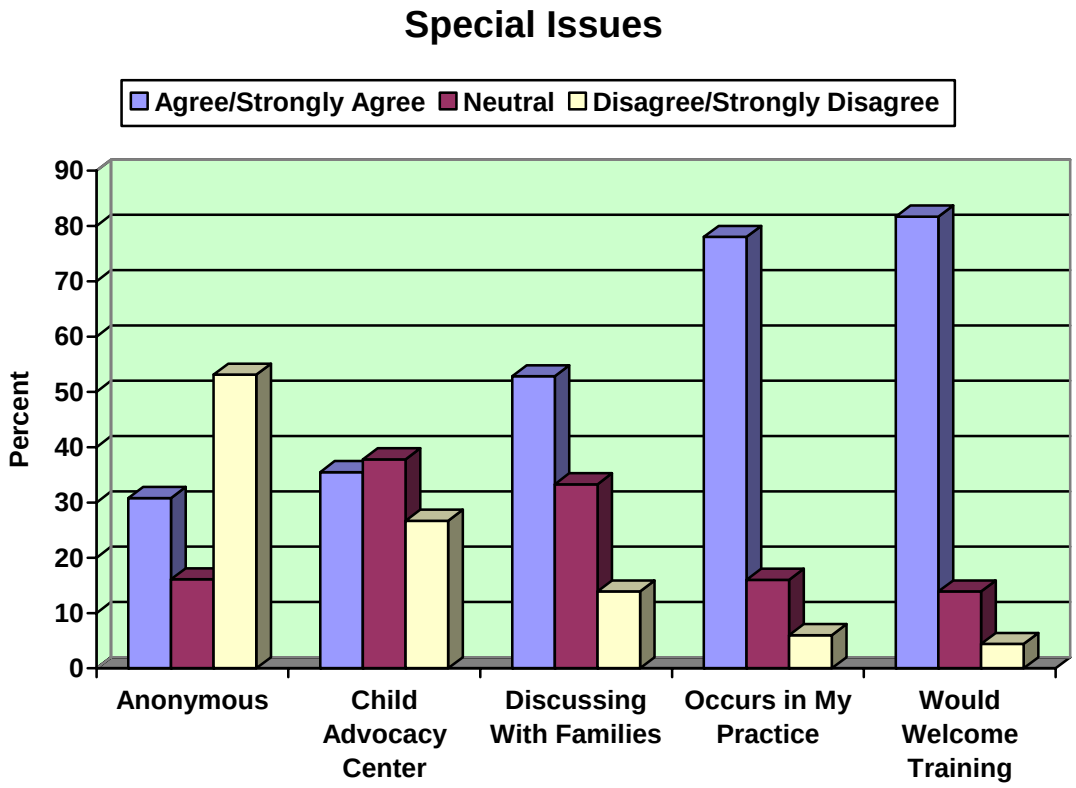
There were no statistically significant differences along urban-rural lines, among practice settings or among regions in physicians' attitude and experience measures.

Special Issues

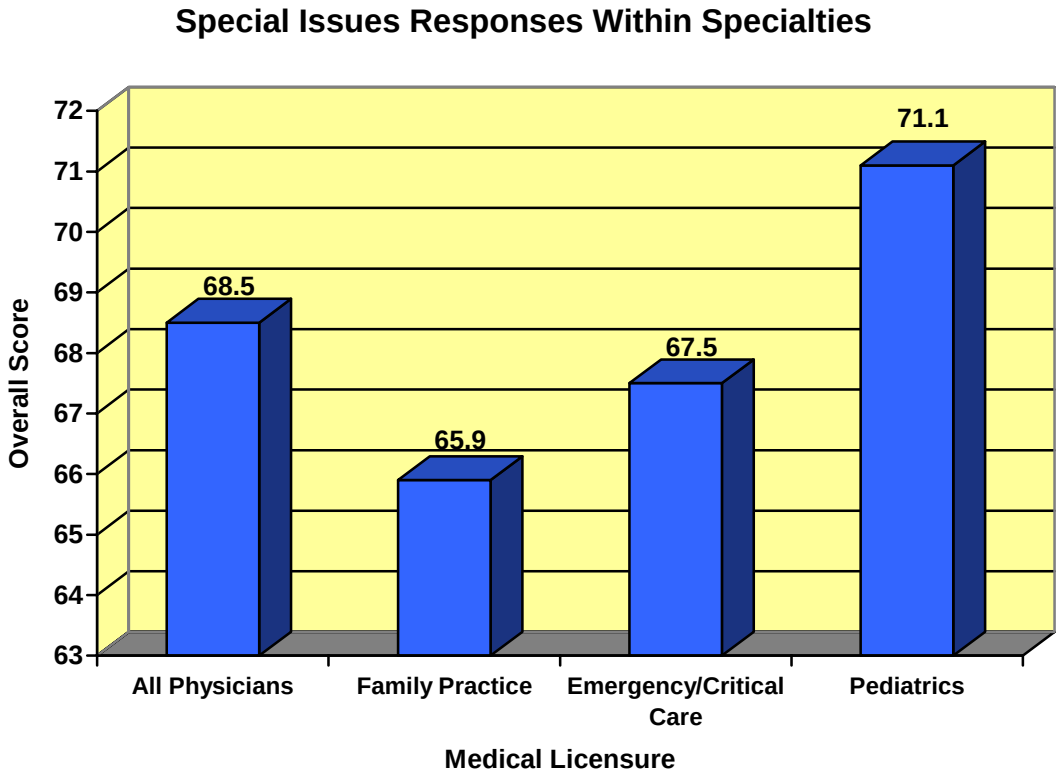
Five survey items dealt with a variety of concerns and resources that factor analysis showed to be statistically related, even though they shared no common theme. Physicians were asked their degree of agreement or disagreement with the following statements:

- **I would welcome CME/CEU credited Child Abuse Recognition Education (CARE) trainings.**
  81.7 percent agreed or strongly agreed.
- **Child abuse or neglect occurs among children in my practice.**
  78% agreed or strongly agreed.
- **Discussing with families my plans to file a report helps maintain my MD-patient relationship.**
  52.8% agreed or strongly agreed.
- **I am familiar with the services provided by the local Child Advocacy Center.**
  35.5% agreed or strongly agreed.
- **I prefer to be anonymous when reporting child abuse or neglect.**
  30.8% agreed or strongly agreed.

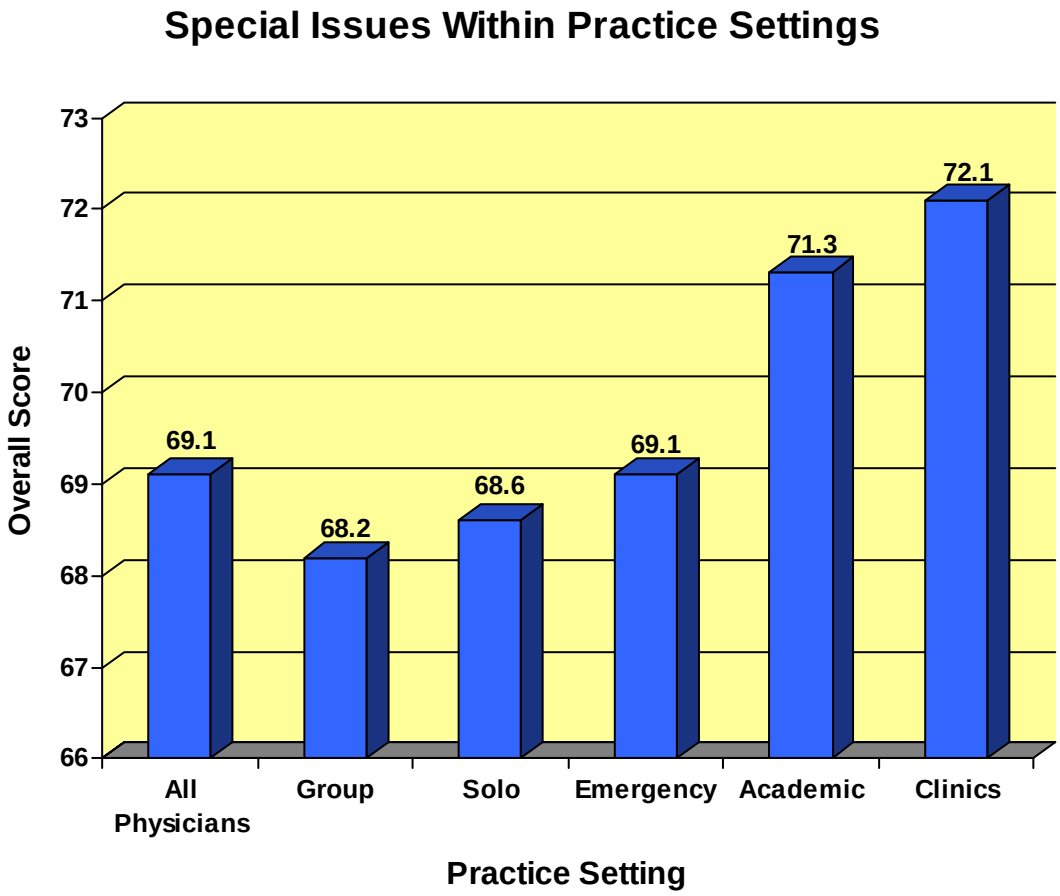
The following graph displays the survey results on these items, arranged from the weakest to the strongest levels of physicians' positive responses.



To a high degree of statistical significance, physicians' responses to the five items classed as special issues varied according to their fields of medical licensure. Physicians in the pediatric specialties gave the most positive responses, followed by those licensed in emergency or critical care and the family practitioners. The following graph shows these results:



Physicians in differing practice settings also differed significantly in their responses to the five survey items classed as special issues. Those in public or hospital-based clinic settings were the most likely to agree or strongly agree with the statements in these items, followed by those in academic medical centers, hospital emergency departments, group medical practices and solo practices. The following graph illustrates these results:



Responses on items classed as special issues varied among the 16 old and nine new DCBS regions at levels that barely achieved statistical significance. Among the former regions, Lake Cumberland produced the highest mean score on the special-issues items, 72.2%. Physicians living in the former Purchase Region had the lowest mean score, 64.7%. Among the current regions, Two Rivers yielded the highest mean score, 70.6%, and The Lakes produced the lowest, 66.1%.

There was no statistically significant variation along urban-rural lines in physicians' overall scores on the special-issues domain or on one item of key interest – their willingness to welcome CME/CEU credited C.A.R.E. trainings. (To continue their licenses, medical professionals must complete Continuing Medical Education courses or Continuing Education Units.)

Barriers to Reporting

The survey asked physicians to fill in check-boxes to indicate whether any of 12 factors might make them hesitant to report child abuse or neglect to social services. The most commonly identified factor was **uncertainty that reporting will help the child**, with 25.9% of physicians

indicating that was a barrier. The other listed factors and the percentages of physicians who considered them barriers were:

- **Fear that reporting will make it worse for the child**
  22.4%
- **Loss of relationship with the family**
  22.1%
- **Inconsistent response to previous reports**
  20.5%
- **Do not know the social workers**
  11.7%
- **Risk of medical malpractice**
  10.1%
- **Previous bad experiences**
  9.6%
- **HIPAA rules or perception of HIPAA barriers**
  8.7%
- **Limited knowledge of child abuse and neglect**
  7.9%
- **Do not know how to report**
  6.2%
- **Changes of social workers**
  5%
- **Conflict with social service workers**
  4.5%

Comments and Willingness to Volunteer

The final section of the survey invited physicians to:

- offer suggestions or other comments.
- include their contact information if they wished to take part in child fatality reviews or team reviews or receive more training.

Of the 777 respondents who provided usable data, 165 physicians (21.2%) entered suggestions or comments and 34 (4.4%) included their contact information.

106 of the 165 comments and suggestions (64.2%) were positive or neutral in tone. 59 comments (35.8%) described experiences that physicians found disappointing or DCBS practices they regarded as flawed. Recurrent themes in the comments and suggestions included:

- **Respondents consistently report suspicions of child abuse or neglect**
  Comments by 34 physicians, 10.6% of the survey group
- **Cases of suspected abuse or neglect were poorly handled by DCBS**
  32 comments, 19.4% of group
- **DCBS made no follow-up contact with the reporting physician**
  21 comments, 12.7% of group
- **Physicians and/or DCBS workers need training relevant to the reporting of abuse and neglect**

12 comments, 7.3% of group

- **Respondents cite reasons for hesitancy in reporting**
  10 comments, 6.1% of group
- **Concerns about lawsuits and time spent in court**
  6 comments, 3.6% of group
- **Concerns about ways to report, including the abuse/neglect hotline**
  6 comments, 3.6% of group

Comments of these types included the following:

Consistently report

- I always report when I suspect abuse or neglect. The most frustrating issue is the non-existent communication/feedback on what happens after I report.
- I will report all suspected cases of abuse but I am frequently disappointed by how cases are handled and how many children remain in unsafe homes.
- I never feel hesitant to report suspected abuse to our local social services offices. I do not feel it is likely that sexually, emotionally and possibly physically abused children enter and leave our office every day without us knowing the types of lives they lead: therefore I cannot ever say I am comfortable identifying neglected or abused children.

Poor handling by DCBS

- Our local social services dept. general does nothing when abuse and neglect is reported. We have significant problems in our county and social services consistently refuses to investigate.
- Social response varies greatly with worker and county. Some are fine; some are useless.
- I have seen social workers who were overly aggressive and did more harm than good.
- Child abuse is taken seriously, medical neglect is not.
- Child on child cases are being disregarded.
- (Workers are) often resistant to come in to evaluate patient in evening hours.
- CPS (child protective services) is unaccountable to ANYONE. Once CPS gets the case, everything is legal and polarized. The family does not get any parenting aids. The physician is completely out of the loop except to submit testimony!
- Our local social services dept. general does nothing when abuse and neglect is reported. We have significant problems in our county and social services consistently refuses to investigate.
- Some social workers are willing to conceal some facts that may in part exonerate families in some instances of presumed physical abuse resulting in fractures.
- Overhaul social services and judicial system – children and elderly people are suffering.
- Our office has reported several cases – one, multiple times and nothing seems to get done. We never have received updates all the status reports. The counselors are unresponsive to written and verbal reports, and seem uninterested and indifferent. One case was actually reported to me by another physician because he didn't know who to contact. There was actual written documentation of unusual parental behavior & a bruise on the child that didn't fit the mother's account; however, the caseworkers didn't think

there was enough evidence to pursue the case. My impression was that any case, especially those reported by physicians, were required to be investigated.

Lack of follow-up contact

- There is no feedback at all from our local DCBS.
- I am routinely told that DCBS does not give information about ongoing investigations when I try to call and follow up. I also have heard several cases when investigators have not bothered to look at photos taken by my office prior to ruling unsubstantiated.
- Local social services never follow-up with me. I'm not sure they even request my detailed evaluation.
- All referrals from physicians should (be) accept(ed) with follow-up.

Reasons for hesitancy in reporting

- Fear that I might be wrong and this could be damaging to the family and/or child as well as to my relationship with family.
- It is definitely more awkward in a rural setting, when I, the reporting MD live in the same town. But it's my job to help people, even if I put myself at risk.
- There is some fear of personal retaliation in a small community – we have personally experienced this.

Legal and court-related concerns

- My employer discourages active involvement in medical care encounters that have definite legal ramifications so usually kids suspected of having been abused are sent to E.R. for evaluation and entry into social service system.
- Have been sued once for reporting suspected child abuse.
- It is extremely important to keep us from wasting our time at the courthouse. I closed my office for 2 (half?) days and 1 full day for a case in an adjacent county, only to be told each time it had to be postponed!
- When is the state going to start paying physicians for their time they have to spend in court? We only get paid for the exam. I guess physicians just have to suck it up. You're sending the message that kids don't matter.

Need for training

- I am always interested in education on child sexual abuse.
- Social workers, medical personnel, police and justice department in this state are in serious need of information concerning the recognition and handling of abuse.

Means of reporting

- I find it a difficult process to report cases. Multiple times I have been bounced from local to state level agencies.

- There has traditionally been a confusing patchwork of authorities to take reports. Everybody seems to want to "Pass the Buck," especially if the abuse happens outside our county.
- I know that all suspected cases must be reported, but am never sure just who to report to (police, state hotline, local social service). This problem is especially difficult to solve after 5:00 p.m. and on weekends.
- Hot line should not immediately screen out physician calls-very discouraging-I ask for supervisor.
- It currently takes a long time to get through to anyone on the CPS hotline.
- Not aware of hotline. Have called children's services.

Appendix: Survey Measure

Physician Child Abuse and Neglect Reporting

1. I have _____ (number) years of experience as a physician.

2. Gender: M F

3. About _____ % of my patients are children under age 18.

4. Identify the county or counties where your practice/clinic(s) is/are physically located:

   _____ _____ _____

5. Check the setting/s in which you practice (check all that apply):
   _____ Solo medical practice
   _____ Group medical practice
   _____ Public health clinic
   _____ Hospital-based clinic
   _____ Hospital emergency room
   _____ Academic medical center

6. Please identify the protocol/s used for identifying and/or reporting child abuse and neglect in your practice (check all that apply):

_____ No standard office protocol	_____ Rely on social services to identify
_____ Protocol in place for identifying	_____ Rely on my staff to help identify
_____ Protocol in place for reporting	_____ Rely on my staff to report abuse and neglect
_____ General unwritten protocol	_____ Do not know or not sure

7. Please identify any standardized forms used in your practice for documenting child abuse or neglect (check all that apply):
   _____ No standardized forms
   _____ Forms for physical abuse
   _____ Forms for sexual abuse
   _____ Forms for neglect
   _____ Document each in narrative record
   _____ Do not know or not sure

8. ***Please place an "X" in the box that best describes your response to the following statements:***

	Strongly Disagree	**Disagree**	**Not Sure**	**Agree**	**Strongly Agree**
a) I am comfortable in my ability to recognize child **physical** abuse.					
b) I am comfortable in my ability to recognize child **sexual** abuse.					
c) I am comfortable in my ability to recognize child **neglect**.					
d) I am comfortable in my ability to recognize child **emotional** abuse.					
e) Child abuse or neglect **occurs among children** in my practice.					
f) I know the **process of reporting** child abuse and neglect.					
g) I am familiar with the state's child abuse and neglect **reporting hotline**.					

(Turn Page Over)

	Strongly Disagree	Disagree	Not Sure	Agree	Strongly Agree
h) I know **how reports** of child abuse or neglect **are handled** by social services.					
i) State social workers have **stronger expertise** than I in identifying child abuse and neglect.					
j) I know **who to call locally** when I suspect child abuse or neglect.					
k) I prefer to be **anonymous** when reporting child abuse or neglect.					
l) When I call to report suspected child abuse or neglect, my **concerns are taken seriously**.					
m) I am **kept informed** by the Department for Community Based Services (DCBS) on the progress of child maltreatment cases.					
n) It is important **to be told** what happens to the child **after** I report child abuse or neglect.					
o) I have had **a good experience** working with DCBS.					
p) **Families get the help** they need when abuse or neglect is reported.					
q) The partnership between my practice and the local DCBS office **helps ensure safety** for neglected or abused children.					
r) **Discussing with families** my plans to file a report helps maintain my MD-patient relationship.					
s) I am familiar with the services provided by the local **Child Advocacy Center**.					
t) I **would welcome CME/CEU credited** Child Abuse Recognition Education (CARE) trainings.					

9. Identify the factors that may make you hesitant to report child abuse or neglect to social services (check all that apply):

☐ Risk of medical malpractice	☐ Loss of relationship with the family
☐ Conflict with social service workers	☐ Uncertainty that reporting will help the child
☐ Changes of social workers	☐ Fear that reporting will make it worse for the child
☐ Do not know the social workers	☐ Inconsistent response to previous reports
☐ Limited knowledge of child abuse and neglect	☐ HIPAA rules or perception of HIPAA barriers
☐ Do not know how to report	☐ Previous bad experiences

Suggestions or other comments:

_____

_____

_____

If you would like to be more involved with child fatality reviews, receive more training or participate in a team review, please add your name and contact information or card. Thank you!

Summary and Conclusions

This survey showed that physicians in the selected specialties are generally confident in their ability to recognize child abuse and neglect. Most indicated they also would welcome training aimed at improving their recognition skills. Most physicians in the survey said that when they report child abuse or neglect, their concerns are taken seriously. Most wanted DCBS to keep them informed of what happens to a child after that point, but few said DCBS did so. Fewer than half indicated they knew how reports of abuse or neglect were handled, and fewer still reported a good experience working with DCBS.

Most physicians were unsure whether families get the help they need after abuse or neglect is reported, and 22% of those surveyed indicated they feared reporting would make things worse for the child. Asked to identify barriers to reporting, 22% of physicians also cited the loss of relationship with families, and 21% cited an inconsistent response to previous reports. Only 10% of physicians rated the risk of medical malpractice as a barrier to reporting. (In contrast, 46 percent of DCBS workers who completed a separate C.A.R.E. survey identified the malpractice risk as a barrier to reporting by physicians.)

Analysis of the data showed that, among the medical specialties surveyed, pediatricians had the strongest combination of ability to recognize child abuse and knowledge relevant to the subject. Pediatricians also had the most positive scores on survey items dealing with their experiences, attitudes and other issues relevant to the reporting of child abuse and neglect. Physicians working in academic medical centers were likelier than those in other practice settings to express confidence in their ability to recognize child abuse and neglect and in their knowledge relevant to that subject.

The survey points to possible steps toward improvement, including:

- **Peer-to-peer training** sponsored by C.A.R.E. that capitalizes on some physicians' expertise in recognizing and reporting abuse and neglect and other physicians' desire to learn more.
- Efforts by DCBS workers and supervisors to **strengthen** their **partnership with physicians** around abuse and neglect prevention. These efforts should include: making sure that physicians know how to report; ensuring prompt action is taken when they do; and keeping them informed of the handling of cases they report.

C.A.R.E. Survey of DCBS Staff
Executive Summary

This survey assessed the views held by Protection and Permanency field staff members on physicians' role in detecting, reporting and investigating child abuse and neglect. It also assessed workers' understanding of physician barriers to reporting and their relationship with local physicians.

It is intended to advance the Child Abuse Recognition Education (C.A.R.E.) program, an effort to prevent child abuse and neglect through better recognition of the signs of child maltreatment by medical providers and better collaboration between medical professionals and the Department for Community Based Services (DCBS).

Survey items dealt with: physician knowledge of child abuse/neglect; the role of physicians in child abuse/neglect; the relationship between DCBS and physicians; information sharing between DCBS and physicians; and barriers to physician reporting. Of the 1,815 front-line social workers and supervisors targeted by the survey, 570 responses were received, for a response rate of 31%. Analysis of survey sections that deal with interaction with physicians was limited to the 516 workers in positions likely to bring them into contact with physicians around abuse/neglect issues.

Results Summary

Worker Characteristics:

- 560 workers reported their years of experience, and the average figure was 9.0 years.
- Most were investigative workers (26%), ongoing workers (26%) or supervisors (24%).

Access to Medical Specialists:

- 83% of workers had access to specialists who could evaluate sexual abuse. Rates were 63% for evaluation of physical abuse, 50% for neglect.

Physician Knowledge of Child Abuse/Neglect:

- 74% of workers agreed physicians understand the role of DCBS in working with children and families around abuse/neglect. 80% agreed physicians understand how the decision is made to investigate. 48% agreed physicians know the signs and symptoms of abuse or neglect.

Perceptions of Physicians' Partnership with DCBS:

- Only 10% of workers agree that physicians play a central role in reporting child abuse and neglect, yet 64% disagree that physicians underreport neglect.
- 52% rated communication with reporting physicians as excellent and 65% said physicians who report want to be kept informed on cases.

Sharing of Information with Physicians:

- Workers are less likely to inform physicians at the initiation of a case than they are at its conclusion or in its latter stages.

Resources:

- 66% of workers agreed they had adequate medical resources for high-risk families.

Barriers to Physician Reporting:

- Court appearance was the most commonly identified barrier.

Regional Differences:

- Differences among current and former DCBS regions were minimal.

Urban-rural Differences:

- Workers in more urban settings and those in predominantly rural settings had significantly different perceptions of physicians' knowledge of matters related to the detection and reporting of child abuse and neglect.

Comments:

- 21% of respondents wrote comments. Subjects included training and knowledge issues, court-related barriers, other barriers physicians could correct, information-sharing and teamwork.

Conclusions and Opportunities to Improve

- There is a need to improve relations between workers and physicians around abuse and neglect.
- Workers need broader access to specialists who can evaluate all types of abuse and neglect.

Background and Introduction

Purpose and Background

This survey assessed the views held by Protection and Permanency field staff members on physicians' role in detecting, reporting and investigating child abuse and neglect. It also assessed workers' understanding of physician barriers to reporting and workers' relationship with local physicians. It is intended to advance the objectives of Child Abuse Recognition Education (C.A.R.E.), a joint initiative of the Department for Community Based Services (DCBS) and Prevent Child Abuse Kentucky (PCAK).

C.A.R.E. is based on the recognition that members of the medical community are uniquely well situated to detect non-accidental injuries in children. Its goal is the prevention of child abuse and neglect through:

- better recognition of the signs and symptoms of child maltreatment by medical providers; and
- better collaboration between medical professionals and DCBS.

Ancillary aims include:

- physician office protocols for assessing and documenting potential child abuse cases;
- heightened awareness by DCBS of the factors and concerns of physicians regarding child abuse/neglect referrals; and
- heightened awareness by physicians of the role, obligations and limitations of DCBS in child abuse/neglect cases.

Toward these ends, C.A.R.E. provides for the development, support and enhancement of a statewide network of medical professionals who participate in peer-to-peer training sessions. A

core group of physicians set to work on the training plan in August 2005, pilot sites were chosen in January 2006 and trainings began in May 2006. If successful, C.A.R.E. will significantly expand the number of physicians, nurses and other medical personnel who are skilled at recognizing signs of child abuse and know how to make appropriate referrals.

To broaden the information base for these training efforts, two survey instruments were designed by separate workgroups. One of them – the subject of this report – was designed for Protection and Permanency field staff. The other was intended for physicians whose practices were deemed likely to bring them into contact with children who had been abused or neglected. The survey of physicians licensed in selected specialties was designed to assess:

- their knowledge of the signs and symptoms of child abuse/neglect;
- their understanding of the responsibility to report suspected abuse/neglect; and
- their relationship with DCBS.

The survey of DCBS staff assessed their views on:

- physicians' knowledge of child abuse/neglect;
- physicians' partnership with DCBS;
- the sharing of information with physicians in cases of suspected abuse/neglect;
- the adequacy of medical resources available to help high-risk families; and
- barriers to reporting by physicians.

The two surveys were also intended to assess urban-rural differences in collaborative work by medical professionals and DCBS staff around the reporting and investigation of suspected child abuse and neglect.

Design, Methodology and Measure

A workgroup of DCBS management and Protection and Permanency field staff members met in March 2006 to formulate questions and discuss logistics for the staff survey.

The survey instrument consists of rating scales, checklists and space for comments. The survey was written at the 12th-grade reading level and required mostly checked responses that could be completed within 10-15 minutes.

With the approval of the Cabinet for Health and Family Services' Internal Review Board (IRB), the survey included an introductory paragraph that contained all elements of informed consent. This introduction described the survey's purpose, anonymity and how the results would be used, and it included a contact telephone number for the researcher and the IRB administrator.

The survey was distributed to workers via Web-based Zoomerang technology. On May 11, 2006, DCBS Protection and Permanency field staff received an e-mail announcement from the DCBS commissioner's office notifying them that the survey had been posted on the cabinet's intranet website. On the same date, the physician survey was posted via Zoomerang on the Web sites of the Kentucky Medical Association and the Kentucky Pediatrics Society.

On May 15, 2006, slight revisions were made in one rating question on each survey instrument. The survey administrator decided the incorrect wording was either unnoticed or viewed by respondents as an error, and that it did not affect their responses.

Participants and the Response Rate

Of 1,815 front-line social workers and supervisors targeted by the staff survey, 570 responses were received, for a response rate of 31.4 %. Participants included 562 workers and supervisors in regional offices, one central office employee and seven employees who did not identify their place of work. Responses by DCBS personnel who did not fit the target group were eliminated from the data set.

The following table shows, for each of the 16 service regions in place at the time of the survey, plus the central office, the number of workers who responded and the percentage of all qualifying respondents that they represented. (Percentages do not sum to 100 because of rounding.)

Service Region	Number	Percent
Region Code Missing	7	1.2
Barren River	20	3.5
Big Sandy	34	6.0
Bluegrass Rural	24	4.2
Central Office	1	0.2
Cumberland Valley	50	8.8
Fayette	17	3.0
FIVCO	20	3.5
Gateway	20	3.5
Green River	40	7.0
Kentucky River	47	8.2
KIPDA Jefferson	84	14.7
KIPDA Rural	22	3.9
Lake Cumberland	56	9.8
Lincoln Trail	36	6.3
Northern Kentucky	38	6.7
Pennyrile	35	6.1
Purchase	19	3.3
Total	570	99.9

Worker Characteristics

Workers were asked to record their years of experience. For the 560 workers who did so, the range was from 0 to 35 years, the mean was 9.0 years and the median was 4 years. They were also asked whether they had participated in the Public Child Welfare Certification Program (PCWCP), which prepares highly qualified Bachelor of Social Work students at 10 universities in Kentucky for service as state child welfare workers. Of the 550 workers who responded to this item, 78 (14%) indicated they had participated in the PCWCP and 472 (86%) indicated they had not.

Workers were also asked to classify their position in one of six categories. If they chose the category labeled "other," they were asked to specify their job title. There were 565 respondents to this item, and the following chart shows the number and percent who listed themselves in each job category.

Job Position	Number	Percent
Investigative Worker	149	26.4
Ongoing Worker	146	25.8
Supervisor	133	23.5
Administrator	22	3.9
Specialist	36	6.4
Other	80	14.2

Self-described positions in the "other" category included family support specialist, generic, office support assistant, recruitment and certification (R&C) worker and social services aide.

The survey asked workers to identify the county where they worked. This linkage of each survey with a county made it possible to search for urban-rural differences in workers' responses. As a first step in this process, all 120 Kentucky counties were divided into four groups, based on U.S. Census Bureau figures on the proportion of each county's population that is considered predominantly rural. The following table shows, for each group of counties, the urban-rural composition, the number of counties and the number of DCBS workers surveyed.

Urban-Rural Composition	Number of Counties	Workers Surveyed	Percent
Most urban counties	24	248	44.5
45-74.5% rural	30	135	24.2
75-99% rural	27	99	17.8
100% rural	39	75	13.5
Total	120	557	100

Survey Results

Several sections of the survey focused on DCBS workers' interactions with physicians. Analysis of responses to these sections was limited to the 516 workers in positions considered likely to bring them into contact with physicians around abuse / neglect issues (generic worker, investigative worker, ongoing worker, R&C worker, specialist and supervisor).

Access to Medical Specialists

The survey asked workers to indicate whether they had access to medical specialists for assessments of sexual abuse, physical abuse and neglect.

- 82.9% reported access to medical specialists for assessment of **sexual abuse**,
- 63.2% for **physical abuse**; and
- 50% for **neglect**.

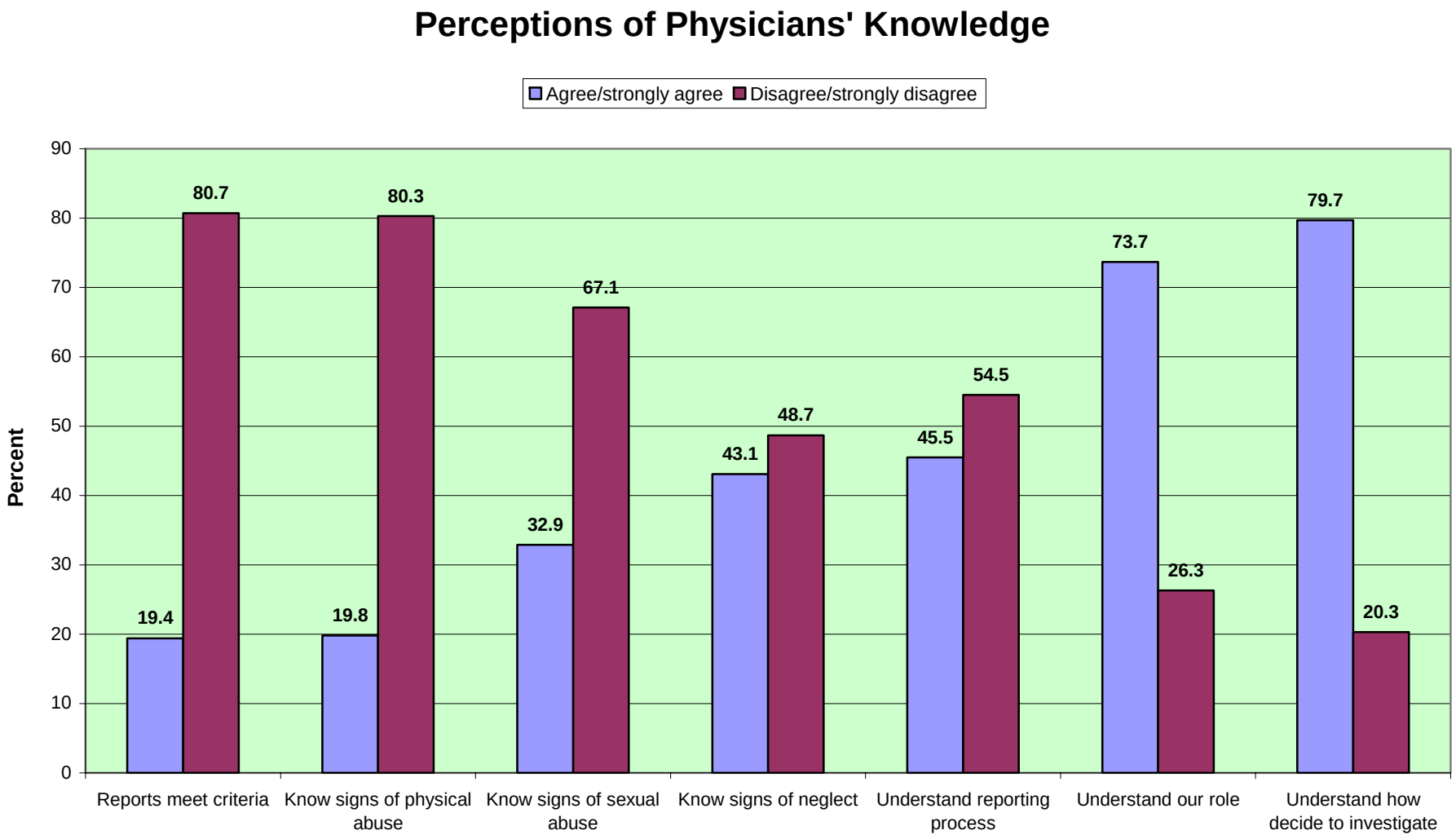
Physicians' Knowledge of Child Abuse/Neglect

Seven items on the survey called on workers to rate physicians' knowledge of matters essential to proper reporting of abuse or neglect. Workers were asked whether they strongly agreed, agreed, disagreed or strongly disagreed with each of the following statements (items are ordered by extent of agreement):

- **Physicians understand how the decision is made to investigate or not.**
  79.7 % of workers in the selected job categories agreed or strongly agreed.
- **Physicians understand our role (what we can and cannot do) in working with children and families around abuse/neglect.**
  73.7 % agreed or strongly agreed.
- **Physicians understand the process of reporting.**
  45.5 % agreed or strongly agreed.
- **Physicians are knowledgeable of the signs & symptoms of neglect.**
  43.1 % agreed or strongly agreed.
- **Physicians are knowledgeable of the signs & symptoms of sexual abuse**.
  32.9 % agreed or strongly agreed.
- **Physicians are knowledgeable of the signs & symptoms of physical abuse.**
  19.8 % agreed or strongly agreed.
- **Abuse / neglect reports from physicians meet criteria for investigation.**
  19.4 % agreed or strongly agreed.

A composite analysis of the results on these seven items shows that, compared to workers who are unlikely to have contact with physicians, those who are more likely to have such contact had a significantly higher perception of physicians' knowledge.

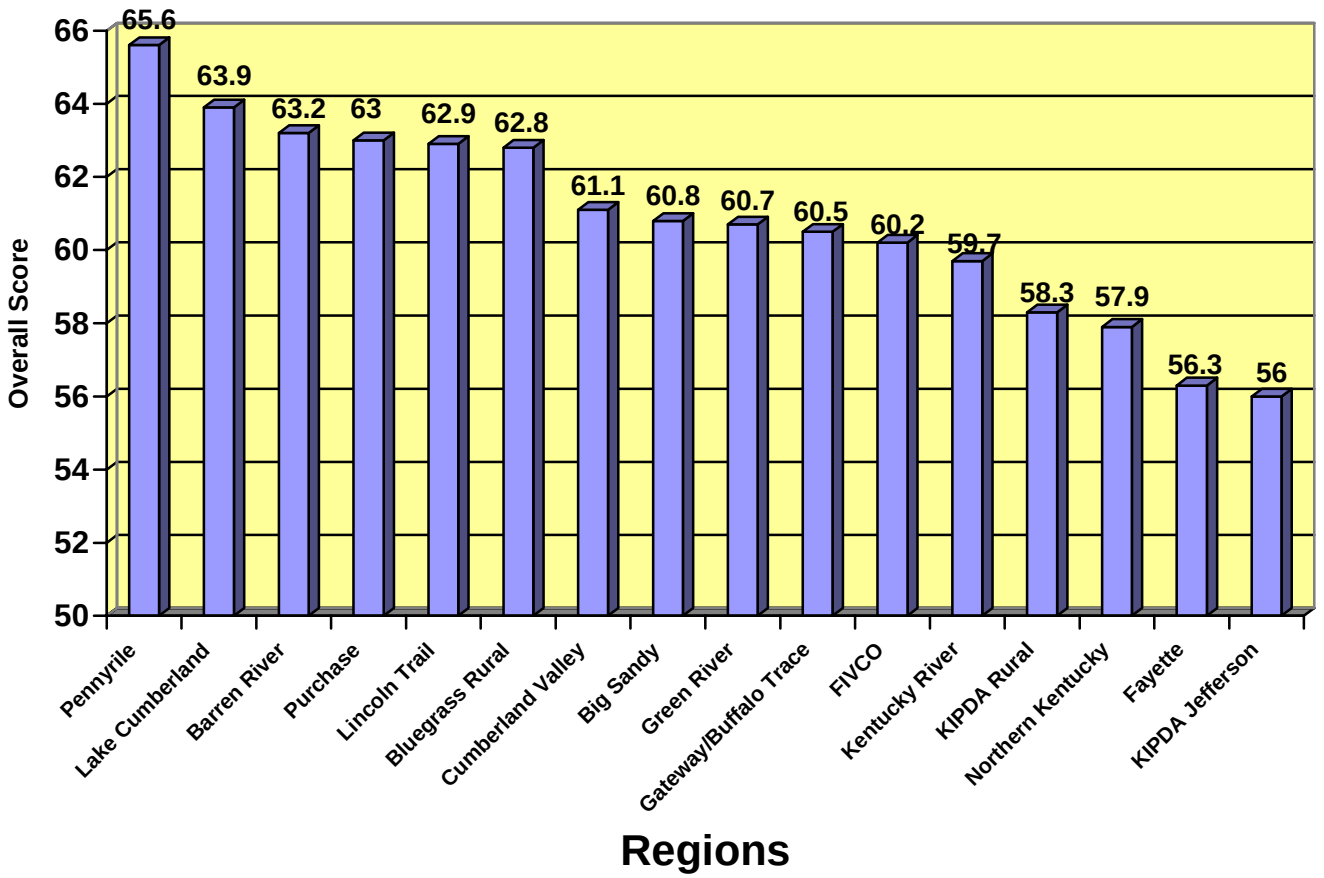
The following graph displays the survey results on these items, arranged from the weakest to the strongest levels of physicians' knowledge, as rated by DCBS workers in the selected job categories:


Perceptions of Physicians' Knowledge
Agree/strongly agree
Disagree/strongly disagree
Percent
90
80
70
60
50
40
30
20
10
0
19.4
80.7
19.8
80.3
32.9
67.1
43.1
48.7
45.5
54.5
73.7
26.3
79.7
20.3
Reports meet criteria
Know signs of physical abuse
Know signs of sexual abuse
Know signs of neglect
Understand reporting process
Understand our role
Understand how decide to investigate

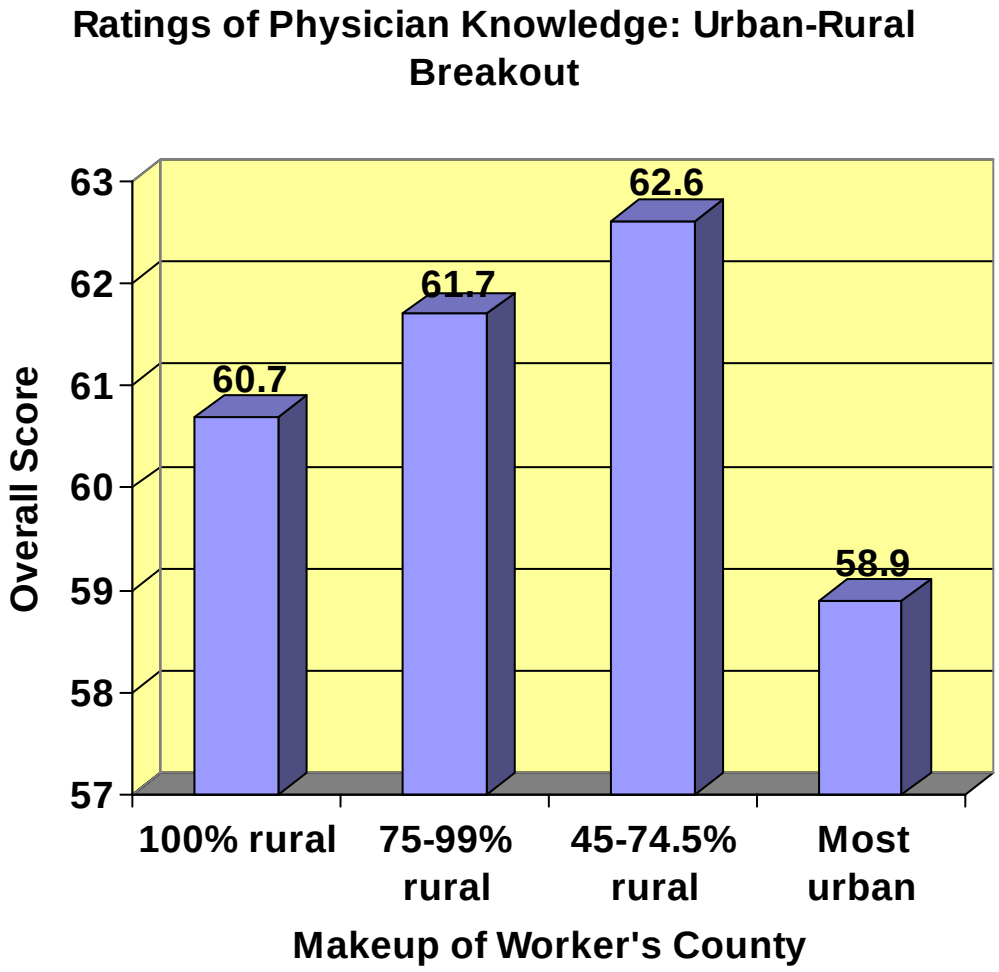
To derive overall scores for workers' perceptions of physicians' knowledge, each of the seven relevant survey items was scored on a four-point scale and the scores were summed. The maximum score for the seven items is 28 (strongly agree = 4 times 7 items = 28). Each worker's total score is divided by 28 to get an overall percentage. This percentage ranges from 25% to 100%.

The mean overall score was 61.9%. Among the service regions in place when the survey took place, there was statistically significant variation in workers' perceptions of physicians' knowledge. Mean scores ranged from 56% in Jefferson County to 65.6% in the Pennyrile Region. The following chart shows the full range of scores for physician knowledge among the regions.

Worker Ratings of Physician Knowledge



Workers' perceptions of physicians' knowledge varied significantly along urban-rural lines. The following chart illustrates these differences.



There was no significant difference between the ratings of physician knowledge by PCWCP graduates and ratings by other DCBS workers.

Perceptions of Physicians' Partnership with DCBS

The survey included 11 questions concerning physicians' performance as partners with DCBS in the detection and investigation of suspected child abuse and neglect. Two other questions dealt with physicians' role in reporting domestic violence or elder abuse. Workers were asked whether they strongly agreed, agreed, disagreed or strongly disagreed that:

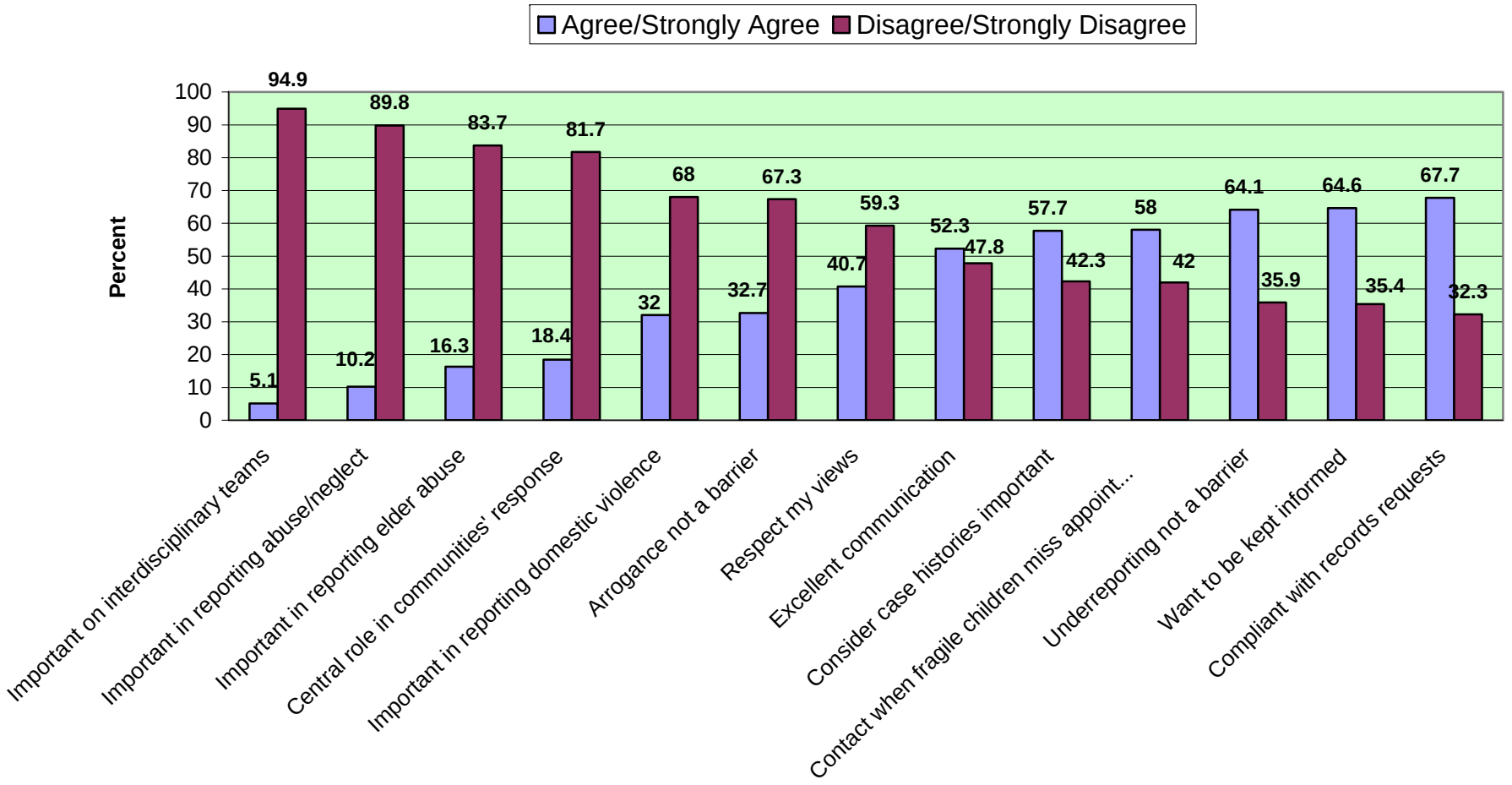
- **There is significant hesitation on the part of physician offices to comply with requests for medical records.**
  67.7 % disagreed or strongly disagreed, indicating generally positive views of physicians' performance in this area.
- **Physicians who report are always interested in being kept informed on the progress of the case.**
  64.6 % agreed or strongly agreed.
- **Neglect is underreported by physicians.**
  64.1 % of workers in the selected categories disagreed or strongly disagreed—an indication that most workers take a positive view of physicians' performance in reporting neglect.
- **Physicians contact us when medically fragile children miss appointments.**
  58 % agreed or strongly agreed.
- **Physicians consider case records and family histories as risk factors for child abuse/neglect.**
  54.9 % agreed or strongly agreed.
- **Communication between my office and reporting physicians is excellent.**
  52.3 % agreed or strongly agreed.
- **My views and opinions are respected by the physicians I work with.**
  40.7 % agreed or strongly agreed.
- **Physicians are difficult to work with because they are arrogant.**
  32.7 % disagreed or strongly disagreed, indicating that they took a positive view of physicians on this indicator.
- **Physicians play an important role in reporting domestic violence.**
  32 % agreed or strongly agreed.
- **Physicians play a central role in communities' response to child abuse/neglect.**
  18.4 % agreed or strongly agreed.
- **Physicians play an important role in reporting elder abuse cases.**
  16.3 % agreed or strongly agreed.
- **Physicians play an important role in reporting child abuse / neglect cases.**
  10.2 % agreed or strongly agreed.
- **It is very important for local physicians to be involved in multidisciplinary teams.**
  5.1 % agreed or strongly agreed.

These results suggest that workers who are likely to have regular contact with physicians tend not to regard them as major contributors to the reporting of child abuse and neglect. Yet workers also tend to disagree that physicians underreport neglect. Workers are likely to rate positively their relations with physicians in ongoing cases, as shown by the ratings of physicians'

willingness to comply with requests for records and physicians' desire to be kept informed of the progress of a case.

The following graph displays survey results on these items, arranged from weakest to strongest performance by physicians, as rated by workers in the selected job categories:

Worker Views of Physicians' Performance as Partners



To derive overall scores for workers' perceptions of physicians' partnership with DCBS, each of the 13 relevant survey items was scored on a four-point scale and the scores were summed. The maximum score for the seven items is 52 (strongly agree = 4 times 13 items = 52). Each worker's total score is divided by 52 to get an overall percentage. This percentage ranges from 25% to 100%.

The mean overall score was 57.8%. There were no statistically significant differences among the regions, among counties of varying urban-rural makeup or between PCWCP graduates and non-graduates in workers' overall perceptions of physicians' partnership with DCBS.

Sharing of Information with Physicians

The survey posed 11 questions that were intended to gauge workers' willingness to provide physicians with information in cases of suspected child abuse or neglect. Workers were asked whether they strongly agreed, agreed, disagreed or strongly disagreed with these statements:

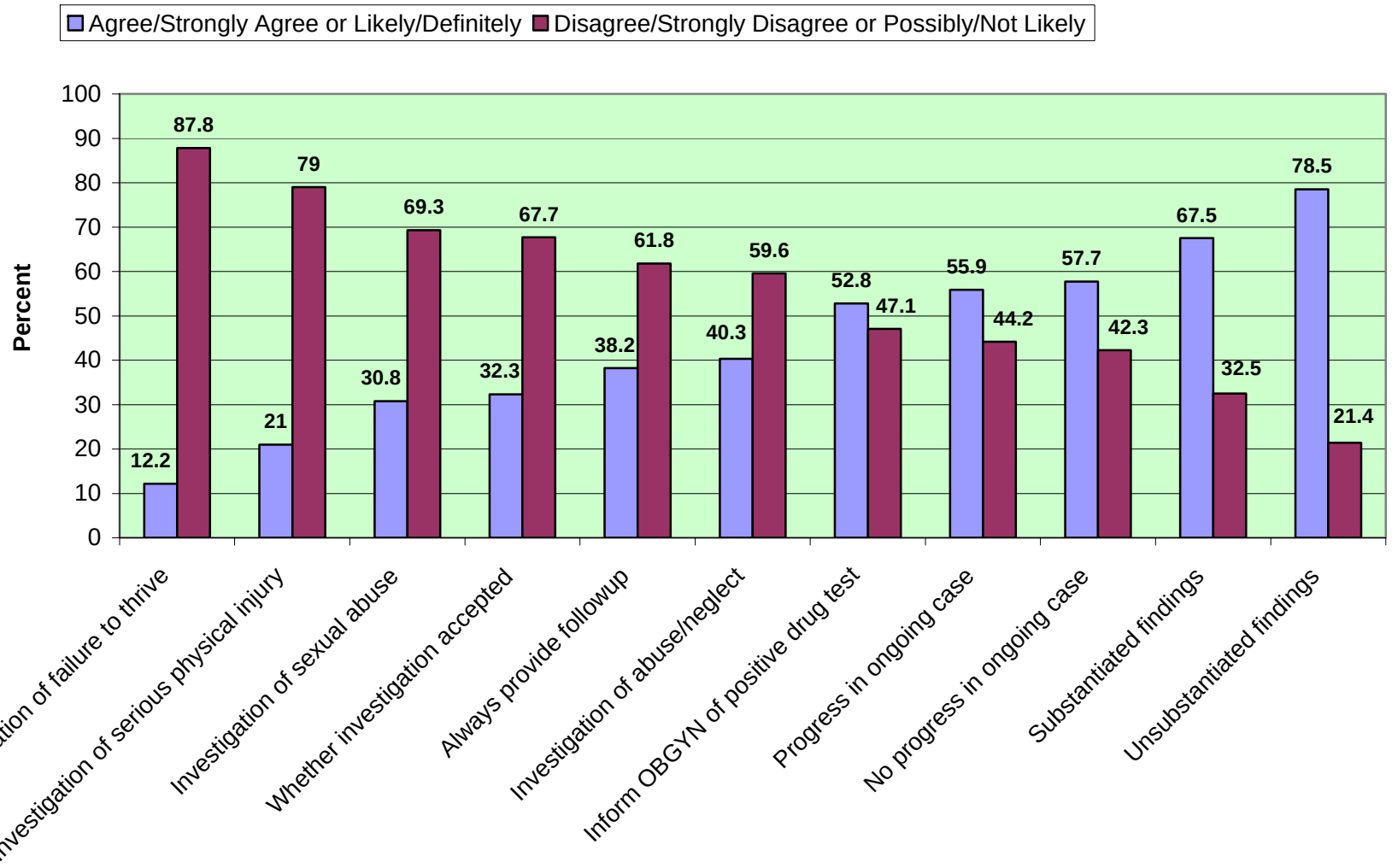
- **I always inform a pregnant client's OBGYN if she tests positive for drugs during her pregnancy.**
  52.8 % in the selected job categories agreed or strongly agreed.
- **I always call the referral source to provide follow up.**
  38.2 % agreed or strongly agreed.

Workers were also asked to indicate, on a four-point scale from "definitely inform" to "not likely to inform," how likely they were to:

- **inform a child's physician of unsubstantiated findings in an investigation.**
  78.5 % would definitely inform or were likely to do so
- **inform a child's physician of substantiated findings in an investigation.**
  67.5 % definitely/likely
- **keep a child's physician informed if there is no progress in an ongoing case.**
  57.7 % definitely/likely
- **keep a child's physician informed about the progress in an ongoing case.**
  55.9 % definitely/likely
- **alert a child's physician about an investigation of abuse/neglect.**
  40.3 % definitely/likely
- **inform a physician who is the reporting source that an investigation has or has not been accepted.**
  32.3 % definitely/likely
- **alert a child's physician about an investigation of sexual abuse.**
  30.8 % definitely/likely
- **alert a child's physician about an investigation of serious physical injury.**
  21 % definitely/likely
- **alert a child's physician about an investigation of failure to thrive.**
  12.2 % definitely/likely

Responses to these questions suggest that workers are less likely to inform physicians at the initiation of a case than they are at its conclusion or in its latter stages. The following graph displays survey results on these items, as arranged from weakest to strongest likelihood that workers in the selected job categories would inform physicians:

Workers' Willingness to Share Information



To derive overall scores for workers' willingness to share information with physicians, each of the 11 relevant survey items was scored on a four-point scale and the scores were summed. The maximum score for the seven items is 44 (strongly agree = 4 times 11 items = 44). Each worker's total score is divided by 44 to get an overall percentage. This percentage ranges from 25% to 100%.

The mean overall score was 59.3%. There was no statistically significant variation among the regions, among counties of differing urban-rural makeup or between PCWP graduates and non-graduates in workers' overall willingness to share information with physicians.

Resources

Two other survey items dealt with medical resources and a means of smoothing a path for their delivery in cases of child abuse or neglect. Workers were asked whether they strongly agreed, agreed, disagreed or strongly disagreed with these statements:

- **We have adequate medical resources to meet the needs of high-risk families.**
  66.4 % of workers in the selected job categories agreed or strongly agreed.
- **We need to have a designated person in my office to serve as a liaison between physicians & DCBS.**
  36.5 % agreed or strongly agreed.

Barriers to Physician Reporting

The survey asked workers to fill in check-boxes to indicate whether they considered any of seven factors to be barriers to physician reporting of child abuse and neglect. **Court appearance** was the most commonly identified factor, with 84.7 % of workers in the selected job categories indicating it was a barrier. The other listed factors and the percentages of workers in the selected categories who regarded them as barriers were as follows:

- **Relationship with (patient) family**
  51.2 %
- **Limited knowledge of the law**
  47.1 %
- **Medical malpractice**
  46.1 %
- **Reluctance to work with DCBS**
  45.9 %
- **Limited knowledge of abuse/neglect**
  44.8 %
- **Limited willingness to report CA/N**
  36.2 %

There were no significant differences in workers' overall perceptions of barriers among counties of varying urban-rural makeup.

Comments

The survey's final item invited comments, and 119 front-line workers and supervisors — 20.9 % of the 570-member survey group — wrote comments on the form. Six comments were positive in tone, 48 were negative and 64 were neutral. For analysis, the comments were grouped into five categories:

- **training and knowledge issues**
  comments by 32 workers, 5.6 % of the survey group
- **court-related barriers**
  19 workers, 3.3 % of survey group
- **other barriers that physicians could correct**
  18 workers, 3.2 % of survey group
- **information-sharing and teamwork**
  45 workers, 7.9% of survey group)
- **general comments**
  51 workers, 8.9% of survey group

Some workers' comments fit multiple categories. There was no marked variation among worker types or regions in the levels of expressed concern with any of these issues.

Here are some excerpts from the comments, arranged by category (minor editing changes have been made):

Training and knowledge issues

- Some medical professionals in our area try to conduct sexual abuse exams without having the medical training and do not refer the child to the sexual abuse centers for an exam.
- I believe physicians need training regarding court testimony. . . . I would like to see more medically fragile training also.
- It would be very nice to have some sort of mandatory training for all the physicians and us so we could understand what would help us in getting medical records more smoothly and being able to talk to them and they could understand the law.
- More training should be required on recognizing high-risk signs and recognizing abuse and neglect for physicians who are working with children (pediatricians and OB/GYNs). It seems that in this area physicians are better trained and quicker to report signs of abuse to elderly than to children. Offering a training to physicians where child protective services and law enforcement share how they handle cases of suspected abuse or neglect and what meets criteria may assist physicians in understanding what things should be reported.
- Doctors see so much, maybe a little of the sensitivity to signs of "mild" abuse and particularly "mild" neglect is gone, and may not prompt reporting to authorities. A bruise or broken bone which "could be" from accidental causes is sometimes not reported, even though it may well be from nonaccidental (causes). Possible neglect signs such as chronic poor hygiene, dental decay, failure to comply with medical care or to give prescribed medication etc. appear sometimes to not rise to the level of warranting a report to CPS by MD as neglect, but may at times be seen as stemming from cultural, poverty, etc. issues and tolerated. Doctors will however faithfully report if a child's life seems to be endangered due to medical neglect or malnutrition of infants, a severe injury

(that) does not fit account, sexual abuse. There are many doctors however who fully understand that any suspicion of abuse or neglect should be called into CPS and do comply with this law.

- I think it would better enhance a DCBS and physician working relationship if physicians were educated regarding DCBS policies and limitations regarding reports of sexual, physical, medical neglect, emotional injury and shaken baby reports. This office depends on their professional diagnosis of a situation in these cases and often the physicians act like they do not know what we are asking and in their contact notes the issues discussed are not even documented, just an ambiguous statement of there were no apparent signs of abuse/neglect. I understand malpractice but we depend on them and their professional opinion in high risk cases and need their professional documentation to support or findings as a lot of times their findings are what we rely on as they are medical professionals.
- I believe most physicians are willing to report but are not as well versed on what meets criteria and what we can and cannot do. Physicians could do a better job of recognizing patterns that indicate abuse and neglect. Sometimes they only report when the worst scenario plays out but should have reported sooner based on the cumulative patterns.
- It is my experience that more often than not, physicians report incidents that do not meet criteria. They make referrals if the parent has a distant history, or when there is no real indication of abuse/neglect. I had one doctor ask for a mother to be checked up on because she was single! As an agency, we frequently get slammed for not taking referrals that don't meet criteria, so physicians need to know what meets criteria and what doesn't and what we as an agency are legally able to do.
- In rural South Central Kentucky, we do not have the special medical personnel to address a lot of the issues that are reported. If this specialized medical attention is needed, we have to look to areas such as Louisville or Lexington. Many of our clients do not have the means to get to these necessary appointments.
- Most reports that come into the office are when a mother brings a child in because she is in a custody battle and is suspicious of sexual abuse. Child does not report abuse and no finding of abuse on the exam but doctor reports it anyway just to make sure. Physicians under-report elder abuse and domestic violence.
- The limited amount of physicians that I work with are very knowledgeable. However, due to the extreme nature of some of my cases, and due to the documented history of doctor visits, it is clear to me, that some of the physicians are not getting the connection.
- I think that it would be beneficial if all physicians (went) to a child abuse and neglect course that was longer than 3 hours. They need to know signs of abuse no matter if they are physical or emotional … signs.
- (T)here is no one available in our county/region that is adequately trained for child sexual abuse. We have to take all of those children 75 miles to Louisville.
- I think physicians have the knowledge of abuse/neglect but I really don't think they understand DCBS' role and I don't think many of them take the time to really get an accurate history of what may or may not be going on when it comes to abuse and neglect.
- I think it's vital that our medical professionals are educated on the signs of abuse and neglect, along with reassuring them that they are protected, as the referral source.

Court-related barriers

- The medical community sometimes takes a "don't get involved" attitude with these issues, and rarely will they take a strong stance in court... An MD is a highly respected individual and if they would take a solid position in court it would assist our cases tremendously.
- We have a very difficult time getting physicians to put results in writing due to having to testify in court. This is especially true with psychiatrists and psychologists. Sometimes without medical diagnosis, we are unable to prove cases in court.
- Many times physicians don't want to get pulled into court and understandably so. However, their testimony is vital for DCBS to get a court finding of abuse/neglect.
- My experience is that doctors hate coming to court and will do everything in their power to avoid coming to court.
- I feel that one of the greatest barriers is (that) some doctors do not want to specify what their findings are on certain assessments because of either court or the liability factor. As social workers, we are oftentimes held accountable for what doctors did or did not find. This is also true when working with the mental health providers. I feel that doctors need to be more proactive and stand behind their diagnosis, after all they are the experts in this area.
- Since I have been employed, I have never witnessed a physician testify in a guardianship hearing, or any other hearing for that matter. They always state that they are too busy to appear in court and appear to be more concerned with losing money than providing their expert knowledge on cases.
- Most physicians do not want to get involved due to wasting time in court appearances. Even in the event that they are subpoenaed they will not come to court, most just send a letter. On occasion the county attorney will allow them to submit some type of dictated report because they will not appear (they lose hundreds of dollars an hour attending court). In addition, a lot of physicians are afraid of lawsuits or hurting their practice if they are known to make reports to the agency.
- One of the concerns is that physicians will typically include nearly verbatim language in (their) findings that was given by the parent as the presenting problem. This has created problems when the physician is contacted for the court deposition and then will not testify to what was clearly written as a finding/diagnosis of "abused child" and then says that was based on what the parent in attendance at the office visit reported. If physicians are unwilling to testify to what is written in a patient's medical report as his findings/diagnosis, then that should not be the finding/diagnosis.
- I believe one of the biggest barriers for physicians is the fear of having to testify. For example, recently for an adjudication hearing we had several community partners subpoenaed and the partners had been to court FOUR times before the case was actually heard, and then the judge didn't take any testimony because the parents stipulated. So think about the amount of time we took away from those professionals and that is a barrier for medical providers to become involved. Laws need to change regarding whose testimony can be provided during these juvenile hearings.

Other barriers that physicians could correct

- Some physicians are understanding and cooperative, while others tend to let their office managers make the decision pertaining to record requests. Some feel they are doing us a favor when they assist with neglected and abused children . . . .
- If there is a difference of an opinion, many doctors are not open for suggestion from DCBS workers as they feel we are less educated.
- Rarely are doctors available to discuss issues and most are discussed with staff at the office.
- In my experience, physicians are rarely the reporting source. I have very little dealings with the physicians themselves, it's usually a nurse or someone in the office.
- A major factor that has had an impact on investigations I have worked involving doctors is they are more concerned about the family keeping them as their physician versus they safety of the child.
- Medical persons want to tell social workers how to work the case — usually wanting no contact or removals.
- If you are not a nurse or other "medical professional" you are viewed as a moron. Medical personnel want information and assistance from us but will not or at least (are) extremely reluctant to reciprocate.
- Various doctors report often but many times they fail to hear any objections to their point of view. The high number of limited (low function) adults who must have a variety of services are often presented by doctors as adults who "don't need their children." This is not a point that DCBS addresses as policy states we have to try to keep families together. A more supportive role of doctor to DCBS will be helpful many times as the clients will possible feel support as opposed to the feel of judgment.
- I have found that, since we are usually dealing with support staff (i.e. nurses, clerical, etc), they have a very limited knowledge of mandatory reporting laws, what information they can and cannot release to DCBS, and just what CPS actually does in the community in general. I do not believe that it is the physicians but more importantly, it is the support staff that causes barriers during investigations. I have waited several weeks to obtain medical records because the support staff is not sure what they can and cannot release to us. They do not understand that they must release information to us during an investigation, even though the HIPAA laws that they give to every patient clearly state that they must release information to us during an investigation. In larger medical offices, there should be a liaison at each office to deal directly with DCBS. Even if that was not the liaison's primary position, it would (be) beneficial for one person to have a few hours of extra training regarding DCBS. This way, that person would have more knowledge of how DCBS actually works. In general, it is far more difficult for me to work with the medical community on an investigation rather than for example, a therapist's office or the police department.

Information-sharing and teamwork

- Oftentimes the nature of the report is a determining factor as to whether the physician is informed regarding reports. When the report comes from the physician reporting back is done.

- Majority of the time we take parent's word of who their physician is as there are too many cases to be worked to inform or request information from them all.
- I think it would also help if the workers and physicians could meet once a year to put a name with a face and build a working relationship.
- For years we have worked with the family and their therapists towards issues regarding mental health/substance abuse. It just hasn't become common practice for us to work with physicians regarding abuse and neglect. It seems to be common sense that we would but we, as an agency, and all medical providers need to work towards developing this team approach.
- We cannot just go inform a child's doctor of an investigation we are doing. If the doctor is the reporting source, we can tell the doctor if the information meets criteria or not. I have found that a lot of doctors inform their receptionists or nurses to call in the information. A lot of questions go unanswered during the intake process when that happens.
- Physicians could be a powerful assistance to our mission, but many are reluctant to get involved. Some who do want to tell us how to do our job. Many do not want to release information to us and we have to send the KRS so they know they can. Honestly I would like to be able to tell family physicians about reported abuse so they can keep an eye on the child during routine visits but I am concerned about HIPAA and violating confidentiality.
- We find that HIPAA causes barriers between workers and physicians.
- Our policies are barriers in communicating with the medical field regarding ongoing and substantiated abuse/neglect, unless we have parental consent.
- I believe that doctors do belong in the multidiscipline meetings and any other meeting that will assist (with) learning the reporting procedures.
- Doctors fear violating privilege, yet we are also bound by confidentiality & cannot share all investigative info if not relevant to child's health.
- Hospitals usually report but local doctors seldom report child abuse/neglect.
- Sometimes physicians report cases of neglect and then will not follow up and allow this agency to have medical records (such as drug screens), which in turns allows a child to remain in an unsafe home because this agency has no proof to protect the child.
- If a doctor is alert and involved at the outset, I'm very likely going to furnish any and all data that he/she may request to treat and protect the child.
- I feel at times there is confusion on both sides on what can and cannot be discussed due to HIPAA.
- The greatest problem that I've faced has been medical providers' misunderstanding of HIPAA and the fact that CA/N investigations do not have to have a release of info. I personally carry a copy of the HIPAA (federal) law with me just to show it to them. That still doesn't always work.
- I called physicians on a lot of my cases, but it has become a barrier to get information, delayed my investigations, and provided a lot of frustration, so now I hesitate to call any more. I rely on other collaterals to provide me information.
- (Physicians) get angry when the parents tell them that DPP told them they reported although I tell the doctor to expect this because most reports from the medical field are medical neglect and it does not take a rocket scientist to figure out where the report originated.

- Collaboration could enhance child safety and minimize repeat maltreatment.

General comments

- In our small county, we have an excellent pool of physicians who are very knowledgeable about child abuse and neglect, who are approachable, easy to work with and who are resources on whom we can depend to assist us in our efforts to protect children and vulnerable adults.
- Overall, the medical staff is willing to work and is willing to cooperate with investigations.
- Some physicians I have worked with in the past have been exceptional to work with – (but) those have been few and far between.
- Most of the doctors I have worked with will provide information when requested. There are some ER doctors that will not call CHFS when needed.
- We have very good working relationships with medical providers in this county. They are used as collaterals with all children who are not school age and asked if they have concerns. They are very forthcoming and dialogue is very open during investigations. With ongoing cases dialogue is based upon the needs of the child.
- Some of our physicians are great to work with – others "do not want to get involved" – others seem to care less!

Appendix: Survey Measure

DCBS Staff Survey

Working with medical professionals and physicians on reporting child abuse / neglect

1. County: _____
2. Region:_____
3. Years of Experience: _____
4. PCWCP: (*please circle)* yes no

5. Position:
   - □ Investigative Worker
   - □ Ongoing Worker
   - □ Supervisor
   - □ Administrator
   - □ Specialist □ Other

6. Do you have access to a medical specialist for assessments of: (check all that apply)
   - □ Sexual Abuse
   - □ Physical Abuse
   - □ Neglect

How strongly do you agree or disagree with the following statements? (place an X next to your response)

7. Physician knowledge of child abuse / neglect	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
a) Abuse / neglect reports from physicians meet criteria for investigation				
b) Physicians are knowledgeable of the signs & symptoms of sexual abuse				
c) Physicians are knowledgeable of the signs & symptoms of physical abuse				
d) Physicians are knowledgeable of the signs & symptoms of neglect				
e). I always call the referral source to provide follow up				
f) Physicians understand the process of reporting.				
g) Physicians understand our role (what we can and cannot do) in working with children and families around abuse / neglect				
h) Physicians understand how the decision is made to investigate or not				
i) Neglect is underreported by physicians				

8. The role of Physicians in child abuse / neglect	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
a) Physicians play an important role in reporting child abuse / neglect cases				
b) Physicians play a central role in the communities response to child abuse / neglect				
c) Physicians play an important role in reporting domestic violence				
d) Physicians play an important role in reporting elder abuse cases				
e) It is very important for local physicians to be involved in multidisciplinary teams				

9. Relationship with Physicians	**Strongly Agree**	**Agree**	**Disagree**	**Strongly Disagree**
a) There is significant hesitation on the part of physician offices to comply with requests for medical records				
b) Physicians who report are always interested in being kept informed on the progress of the case				
c) Physicians consider case records and family histories as risk factors for child abuse / neglect				
d) Physicians contact us when medically fragile children miss appointments				
e) Physicians are difficult to work with because they are arrogant				
f) Communication between my office and reporting physicians is excellent				
g) My views and opinions are respected by the physicians I work with				
h) We have adequate medical resources to meet the needs of high-risk families				
i) I always inform a pregnant client's OBGYN if she tests positive for drugs during her pregnancy				
j) We need to have a designated person in my office to serve as a liaison between physicians & DCBS				

10. In working with children, families and physicians around issues of abuse, the sharing of information is sometimes a tricky question. Although every case is unique, please answer the following questions based on what would be your most likely approach to practice.

	(4) Definitely Inform	**(3)**	**(2)**	**(1) Not likely to Inform**
a) How likely are you to inform a physician who is the reporting source that an investigation has or has not been accepted?				
b) How likely are you to keep a child's physician informed about regarding progress in an ongoing case?				
c) How likely are you to keep a child's physician informed if there is no progress in an ongoing case?				
d) How likely are you to alert a child's physician about an investigation of serious physical injury?				
e) How likely are you to alert a child's physician about an investigation of sexual abuse?				
f) How likely are you to alert a child's physician about an investigation of				

failure to thrive?				
g) How likely are you to alert a child's physician about an investigation of abuse / neglect?				
h) How likely are you to inform a child's physician of substantiated findings in an investigation?				
i) How likely are you to inform a child's physician of unsubstantiated findings in an investigation?				

11. Which of the following factors are barriers to physician reporting? (check all that apply)

Medical Malpractice

Court Appearance

Reluctance to work with DCBS

Limited knowledge of abuse/neglect

Relationship with (patient) family

Limited knowledge of the law

Limited willingness to report CA/N

Comments:

Summary and Conclusions

Workers expressed generally positive views of physicians on several headings, including:

- Physicians' understanding of the role DCBS plays in suspected abuse/neglect cases and of how the decision is made to investigate or not;
- Physicians' compliance with requests for medical records;
- The interest that reporting physicians show in being kept informed of the progress of a case;
- The likelihood that physicians will report suspected neglect;
- Physicians' consideration of case records and family histories as risk factors for abuse/neglect; and
- The quality of communication between reporting physicians and DCBS staff.

The survey also showed that most DCBS front-line workers disagree that physicians know the signs and symptoms of child abuse. Most workers consider physicians unimportant as reporting sources in child abuse/neglect cases, and they attach low importance to having local physicians as members of multidisciplinary teams.

Workers were more likely to report access to specialists for the evaluation of sexual abuse than for physical abuse or neglect. However, some workers commented on the lack of local medical expertise for the evaluation of sexual abuse.

Workers were more likely to keep a child's physician informed at the conclusion of an investigation or in its latter stages than they were to alert the physician to the existence of an investigation.

Two-thirds of workers agreed that they had access to adequate medical resources to meet the needs of high-risk families. Physicians' reluctance to appear in court was the most often-cited barrier to physician reporting of suspected abuse or neglect.

The survey points to a number of possible steps toward improvement, including:

- Building workers' confidence that physicians recognize signs of child abuse/neglect. Peer-to-peer training of physicians through C.A.R.E. should be a key part of this effort.
- Elevating workers' estimate of physicians as important reporting sources and important members of multidisciplinary teams. Toward these ends, DCBS should work to improve teamwork with physicians around abuse/neglect issues.
- Improving workers' willingness to share information with physicians when it is appropriate to do so.
- Broadening workers' access to specialists who can evaluate all types of abuse and neglect.
- Working to overcome barriers to physician reporting of suspected child abuse/neglect.