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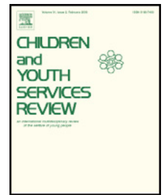

Characteristics of cases submitted to a statewide system of child abuse experts

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ABSTRACT

Background: The Texas Department of Family and Protective Services (DFPS) created a statewide network of child abuse pediatricians working at 6 academic centers in 2006.
Methods: Case data for the period 9/1/2012–8/31/2014 were reviewed for child demographics, risk factors, physician determinations, injury descriptors, and information made available to the physician.
Results: 8061 of 410,315 DFPS cases (2%) were referred during the period. Network utilization rates ranged from 7.5% in counties served by San Antonio to 1.4% in Austin-served counties. Cases from outlying counties were less likely to involve older children. African American children were over-represented in referrals, and Caucasian and Asian children were underrepresented. Prevalent risk factors included prior DFPS history, single parent-household, mental illness, substance abuse, and domestic violence. Network providers found no or only nonspecific evidence for maltreatment in 45% of cases. Determinations were hindered by poor quality photographs in 188 cases and inadequate skeletal surveys in 121. Insufficient information precluded case completion for 65 cases of children <2 years.
Conclusions: Our data indicate that child abuse centers in Texas are underutilized, and there are practice differences with respect to medical referrals across different regions. Our findings concerning ethnic differences and risk factors are consistent with national trends. The problems of inadequate photographs and case information may improve with better training of workers; the issue of poor quality skeletal surveys requires further study. Standard DFPS criteria for referrals to child abuse pediatricians should mitigate some of the problems identified by this study.

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1. Introduction

Texas Children's Protective Services (CPS) handles a heavy burden of child maltreatment cases each year, with 168,164 completed cases in FY 2014, representing 2.3% of the child population (Texas Department of Family & Protective Services, 2016). The state also has a relatively high number of child maltreatment deaths, with 3.08 cases per 100,000 children in 2012, as compared to the U.S. average of 2.20 (U. S. Department of Health & Human Services, 2012). The problem of Texas' high child maltreatment death rate as compared to other states has persisted over time, and has been linked to relatively larger burdens of poverty and teen motherhood, as well as a low priority given to prevention programs (Burstain, 2009). Similar to nationally reported data, Texas CPS showed significant declines in most types of maltreatment from 1992 to 2012 despite a steadily growing child population, but rates have remained nearly unchanged since then (Fig. 1, TDFPS, 1992–2014; US DHHS, 2012).

The parent organization of Texas CPS, the Department of Family and Protective Services (DFPS), implemented the state's first statewide network of child abuse pediatricians in 2006. The "Forensic Assessment Center Network" (FACN) is comprised of 10 child abuse pediatricians (CAPs) and 4 specialized nurse practitioners working at 6 academic medical centers (FACN hubs) in Houston, San Antonio, Galveston, Dallas, Austin, and Lubbock. Cases must have active DFPS involvement in order to be entered into the FACN system. The FACN handles all forms of child maltreatment, though sexual abuse cases are underrepresented because of a separate state means of funding these investigations at some centers. Monthly quality assurance reviews of randomly selected cases help ensure consistent practices across the system. FACN hubs serve their local populations as well as rural counties so that each of Texas' 254 counties has an assigned FACN center. The system is an available resource not only to CPS workers, but also to DFPS workers who handle cases involving children in daycare settings (Childcare Licensing, or CCL). For a majority of CPS and CCL workers, the FACN is their only expert medical resource, but workers in the Fort Worth area, Corpus Christi, El Paso, and Houston have an additional academic child abuse

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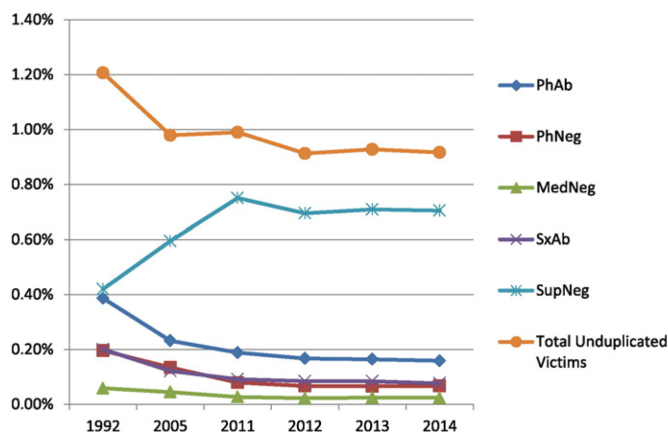

Fig. 1. Numbers of Texas CPS child maltreatment cases proportional to state child population.

center that operates outside of the FACN. The FACN began collecting statewide data in 2008, and since 2012 has been using a consistent data system to document all of its cases.

Texas is one of only a handful of U.S. states to have a state-funded network of child abuse pediatricians that serves the entire state population, and very little data from such systems has been published to date. A report by Kivlahan et al. described Missouri's network of trained health care providers who serve child victims of sexual assault using a uniform protocol and reporting system. The network was associated with higher case substantiation rates, even in cases where there was no physical evidence (Kivlahan, Kruse, & Furnell, 1992). Moore and colleagues described North Carolina's Child Medical Evaluation Program, providing valuable information about the group's operations, as well as data on overall case numbers and maltreatment diagnoses, but no additional case demographics (Moore, Hudson, & Loda, 1986). The fiscal management for New Jersey's state network of regional child abuse diagnostic and treatment centers has been described in helpful detail (Kairys, Ricci, & Finkel, 2006). Florida statutes include detailed criteria for suspected child maltreatment cases that warrant referral to a network of specialized pediatricians, but centralized data collection is limited and there have been no reports on the system in the medical literature. California has a less formal network of specialized providers who conduct peer review across institutions, but also does not have a mechanism to analyze aggregate data.

To date, Texas DFPS has not established guidelines for caseworkers regarding when they should refer cases to the FACN, apart from a limited provision for children diagnosed with sexually transmitted diseases. Some children come directly to the FACN via hub hospitals and clinics, but the remainder of FACN referrals are made at the discretion of DFPS workers and their supervisors. Children seen at FACN hubs are assessed according to standard child maltreatment protocols, including published guidelines for appropriate imaging in cases of suspected physical abuse (American College of Radiology, 1997). Unfortunately, Texas' vast distances make direct examination by an FACN provider impractical for many children living in rural areas. For cases that involve review of records, photographs, and/or radiographs by the FACN provider, but no examination of the child, the ability of the provider to make a determination may be compromised by insufficient quality of these sources of information. We were therefore interested in determining the factors that influence workers to refer cases to the FACN, and the ability of FACN providers to make determinations in cases that involve only reviews of records and other materials. This report examines the characteristics of cases referred to the FACN system (demographics, injury descriptors, and risk factors for maltreatment), FACN provider determinations, and the quality of information of cases in the FACN; an ongoing companion study will survey CPS workers and supervisors regarding the factors that influence their decisions to consult with medical child maltreatment experts.

2. Methods

The FACN data collection system is web-based and password-protected. DFPS workers and FACN providers all have the ability to create cases in the system, and each case supports uploaded documents and photographs. Uploaded materials may include investigator narratives, medical records, and/or photographs of the child or scene investigation. Because digital radiographs involve various viewing programs, caseworkers must mail these materials to FACN centers for cases from non-FACN medical facilities that involve radiographs. Caseworkers and providers receive automatic email notifications whenever new information is posted to one of their assigned cases. Providers can either upload final affidavits to cases, or create formal letters in the system. FACN cases are categorized as either involving solely record reviews (case consultations) or direct patient care. Data on case category, case agency (CPS or CCL) and child demographics are forced fields. Optional fields are available to all users to document maltreatment risk factors, when known, such as substance abuse, mental health disorders, poverty, etc. FACN providers also have optional fields to detail the sources of information made available to them for case consultations, including whether photographs were good quality or poor, and whether skeletal X-rays included only limited views vs. complete bone surveys that meet current national guidelines. The system forces FACN providers to provide a minimum of one case descriptor (e.g. bruising, intracranial injury, and sexually transmitted infection) for each case. FACN providers must also choose at least one case determination, categorized as follows: at risk for maltreatment; insufficient information available, therefore unable to determine whether child was abused or neglected; no evidence of maltreatment, or an explanation other than abuse or neglect is likely; nonspecific (may result from abuse or neglect, but accidental/natural explanations are also possible); concerning for maltreatment; and/or substantial evidence of maltreatment. Cases deemed to represent concerning or substantial evidence for maltreatment are further delineated by maltreatment type (physical abuse, sexual abuse, emotional abuse, physical neglect, supervisory neglect, medical neglect, and/or medical abuse).

We queried all FACN cases from the period 9/1/2012–8/31/2014 for child demographics, risk factors, physician determinations, and injury descriptors. We also examined data concerning the quality of information made available to the physician, i.e. whether adequate medical records, photographs, and/or radiographs were included with the case when applicable. Because sexual abuse cases are represented unevenly across different FACN centers according to their other outside funding sources, we included only sexual abuse cases in this study that also involved additional types of maltreatment. Cases were queried without child, caseworker, or physician identifiers.

3. Results

3.1. Demographic characteristics

8061 CPS cases were referred to the FACN during the study period, as compared to a total of 410,315 cases assigned for CPS investigation, for a referral rate of 2%. An additional 275 FACN cases (3% of all FACN cases) involved Child Care Licensing alone or in addition to CPS, for a total of 8321 FACN cases for the study period. Because CCL cases comprised only a small proportion of all FACN cases during the study period, subset analyses were conducted on CPS data alone.

CPS cases were assigned to the counties in which suspected maltreatment occurred, and were from 174 of the state's 254 counties. 5617 cases (70%) were from hub counties. There was significant variation between FACN sites, however, with the highest utilization rates in counties served by San Antonio (7.5% of CPS cases assigned for

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