Complex Psychosocial Issues

CARE NETWORK CONFERENCE

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The Kempe Center
FOR THE PREVENTION AND TREATMENT OF CHILD ABUSE AND NEGLECT

University of Colorado Anschutz Medical Campus

Children's Hospital Color

CARE Network Goals for Medical Provider

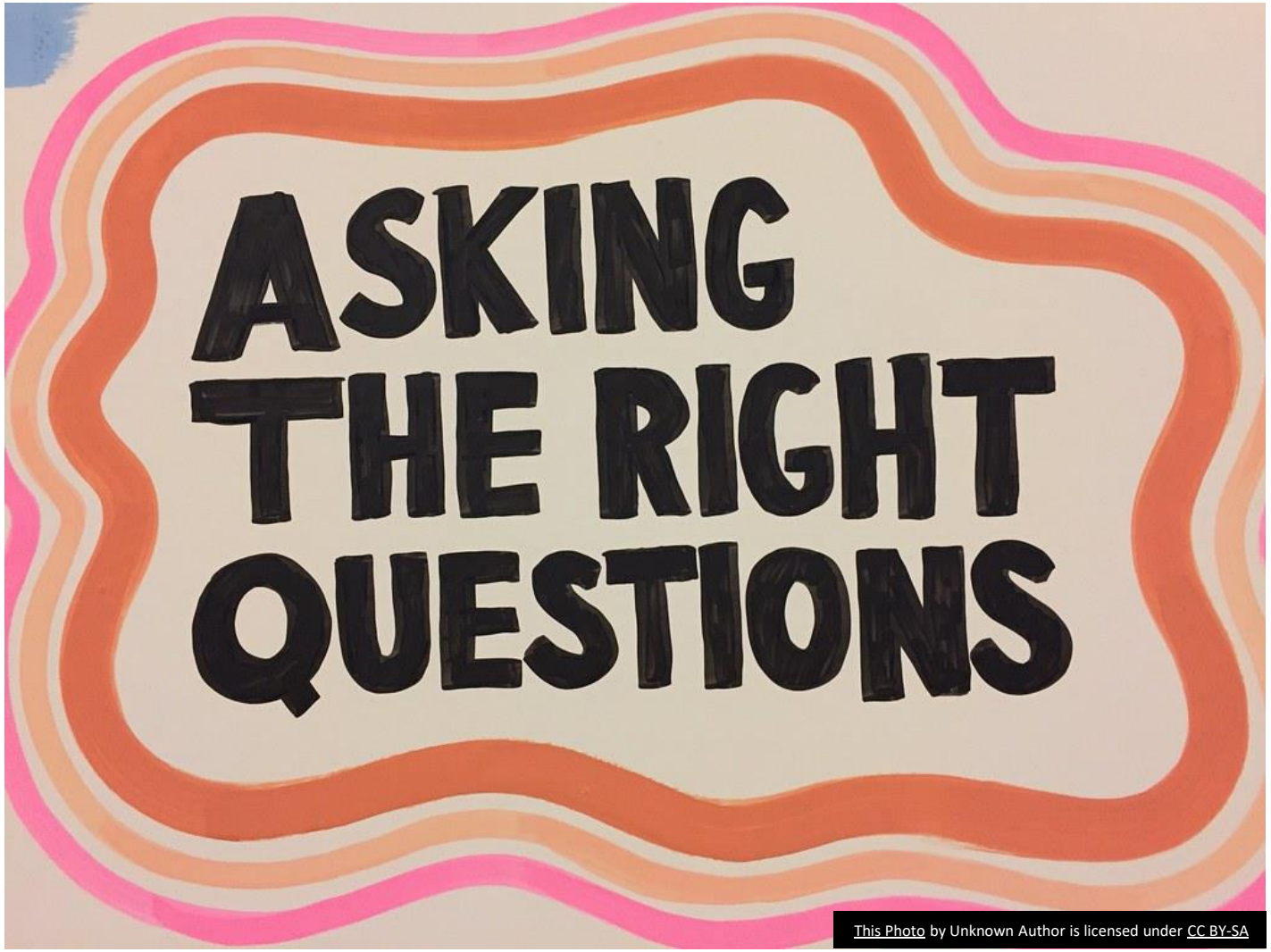
INPUT → OUTPUT

- Medical Evaluation
  - History & info from child
  - Pyschosocial history
  - Developmental assessment
  - Behavioral health screen
  - Physical Exam with findings (photos)
- Collaboration

- Written report
- Opinion about whether injuries or condition is related to maltreatment
- Identify medical issues
- Identify behavioral health issues
- Identify family needs
- Treatment recommendations
- Warm hand-off to referrals when possible
- Communication with non-medical professionals
  - Written, phone, in person
- Testimony

Recognition → Treatment → Coordination → Improved Outcomes

Taking a Social History is part



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And part

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Honoring the Roll We Play

Pay attention to patients' emotional well-being

Listen deeply and respond to patients' concerns and questions

Have a sustained practice of checking-in and providing reassurance

Seek and use authentic feedback from patients

Promote relationship with patients

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What is in a Social History?

- Planned/unplanned pregnancy?
- How would you describe child? (personality, development)
- What's your favorite thing about child? What's most difficult?
- Who lives in the home?
- Who is primary caretaker for child(ren)?
- Family history of mental health issues?
- Substance use in the home? (including THC)

Social History cont'd

- Current relationship: how long together? How did you meet? How would you describe? How do you handle conflict?
- Prior concerns of abuse or neglect?
- Previous CPS involvement either as children or parents?
- Prior law enforcement involvement?
- What supports do you have?
- What is going well in your family?

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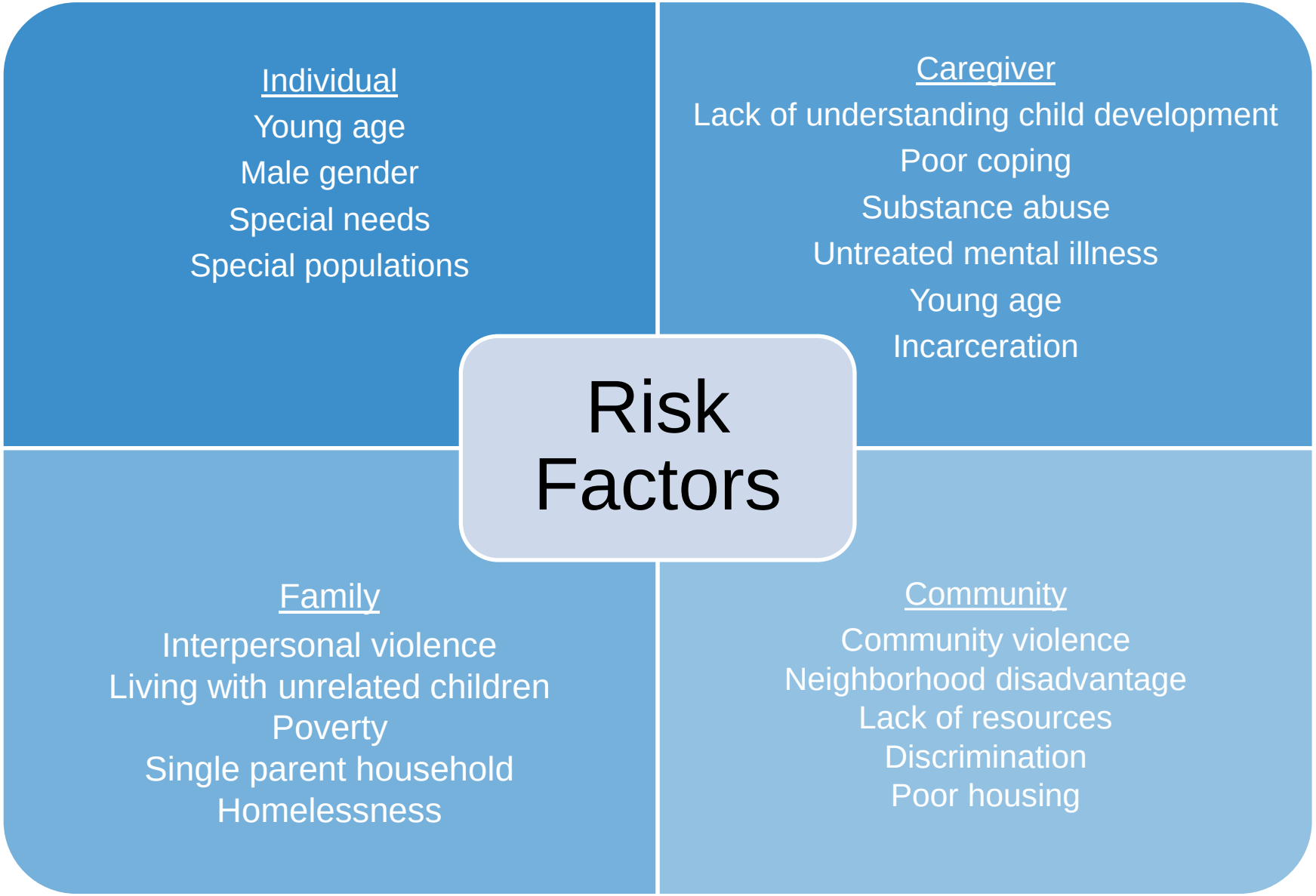
Risk and Protective Factors



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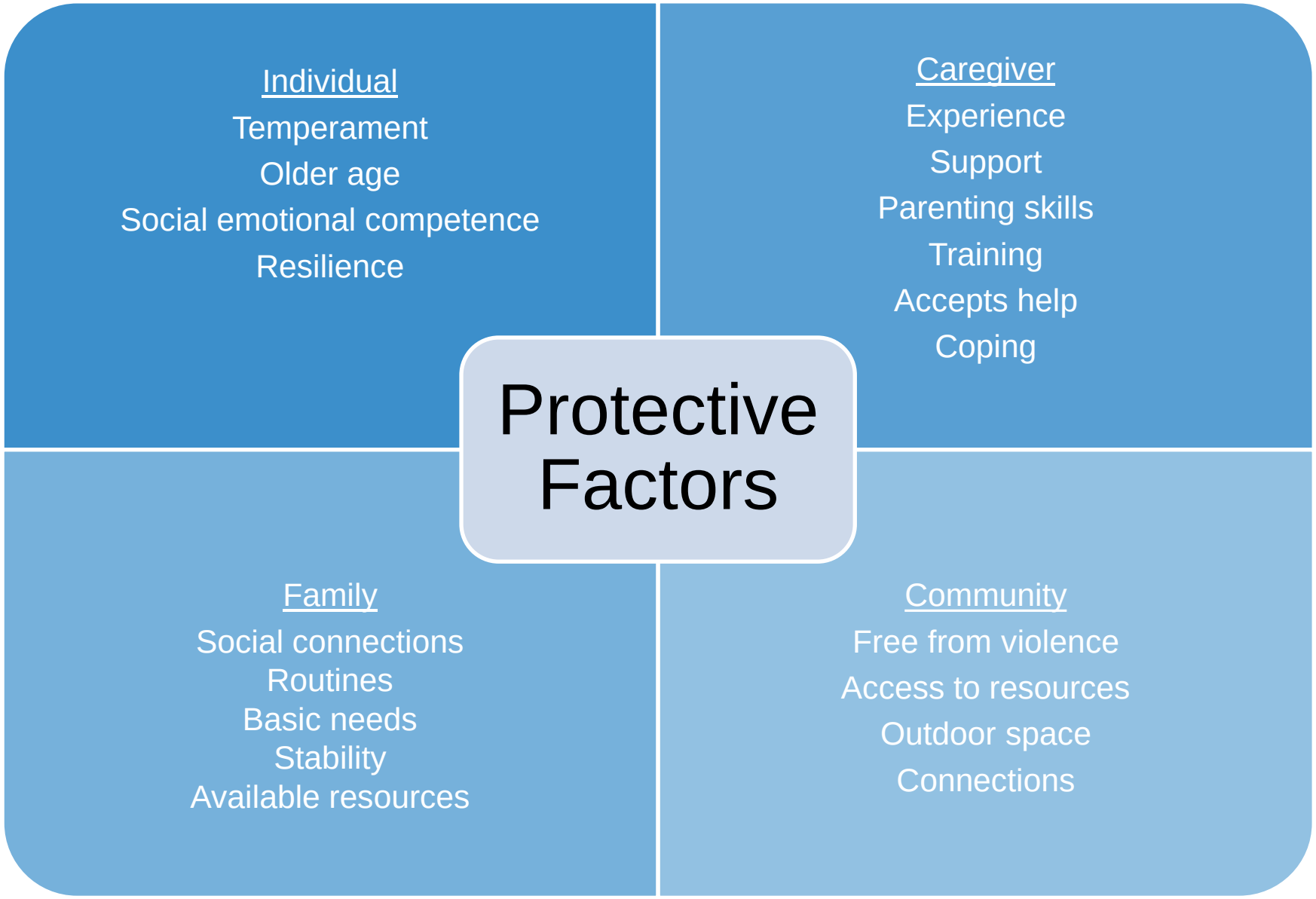

Beyond Adversity

Good and bad experiences shape our brains

- Esp during periods of rapid brain growth

Good experiences improve our health and promote health development

Good experiences help us heal

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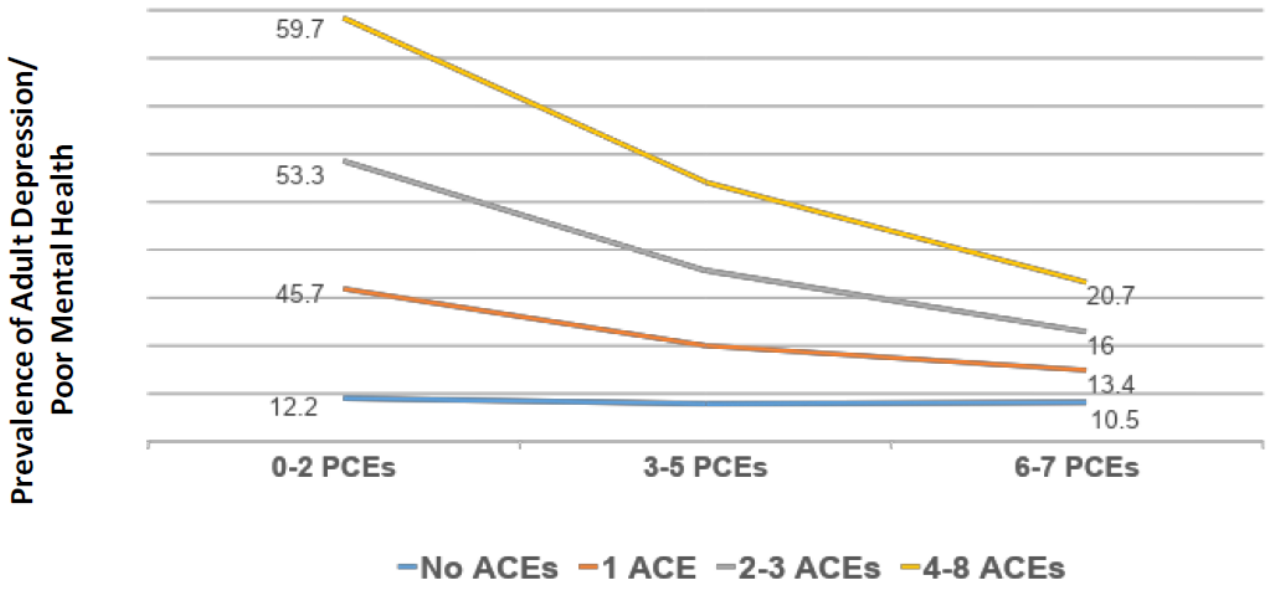
Beyond Adversity

Positive Childhood Experiences (PCEs) Can Mitigate Effects of ACEs



Bethell C, Jones J, Gombojav N, Linkenbach J, Sege R. Positive Childhood Experiences and Adult Mental and Relational Health in a Statewide Sample: Associations Across Adverse Childhood Experiences Levels. *JAMA Pediatrics*. 2019;173(11):e193007. doi:10.1001/jamapediatrics.2019.3007

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HOPE

Postiveexperience.org

HOPE Building Blocks

- The Building Blocks of HOPE:
  - Have meaning at the family and community level
  - Should be advanced at the service delivery level
  - Can be and must be supported by public policy

HOPE -- A paradigm shift

Focus on child and caregiver in context of family & community

Focus on early experiences and relationships of child

Science-based, strength-based and family-centric

Foundational to equity, resiliency, recovery and protection

Recognizes cultural variability in parenting, but sees emotional health as universal

Is not one program, but an “all-in approach” across all place-based, community efforts

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Case Scenario #1

5-mo male with a broken leg

Father holding baby, rolled over to get out of bed and heard pop

“Grabbed his knees to check his hips and knew R knee wasn’t right so hauled ass to the local ER”

X-rays showed L femur fracture

Mother present in ED for consult, but father answers all the questions and won’t separate from mother

Father reports he has 2 other children in 2 different states but he’s “not allowed to see them”

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Now What?

- What's your initial gut about what's happening?
- What else do you want to know?
- How would you address concerns with POC?
- How would you document?

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Case Scenario #2

6-mo baby

Admitted for 2nd time for failure to thrive

Baby is only breastfed and when mother returns to work, she won't allow anyone to feed during the day

Mom appears almost "too attached" to patient

Mom always presents alone and never talks about any supports

When really pressed, Mother identifies someone who is "like an aunt"

Now What?

- What's your initial gut about the situation?
- What additional information do you want to know?
- How do you approach with mother?

Case Scenario #3

2-mo with history of “rolling off the couch”

Found to have bruising to face, arm and leg

Skeletal shows rib fractures

Both POC present in the ED

During social history father escalates and screams “Why the fuck are you asking these questions? I already told you what happened. Why aren’t you taking care of my baby?”

Now What?

- What's your reaction to what just happened?
- How do you respond to father?
- How do you document?

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Case Scenario #4

Mother present for medical care with her 5-year-old child

Mother wants child evaluated for a parasitic infection of the abdomen that she thinks is causing poor appetite in the child

Child has poor expressive speech and appears unkempt

Mother displays erratic behavior in the ED – pacing, smacking her lips, speaking rapidly, and scratching at her arms and neck

Now What?

- What do you think is happening?
- Is there anything else you want to know?
- How would you address concerns?
- How would you document?

RESOURCES FOR FAMILIES

- Colorado Community Response - Voluntary program that providing prevention services to families who have been referred to the child welfare system, but ultimately not required to engage in services. Requires a referral from county child welfare staff.
- Family Resource Centers -- Community based centers to help build family strength and improve self reliance. A complete list of programs by county can be found at coloradoofficeofearlychilhood.force.com
- SafeCare Colorado – Voluntary, in home parent support program, children ages five and under. 18-20 weekly sessions to complete (about 4-6 months). Learn more at SafeCare.CO4Kids.org
- Parents as Teachers -- Parent education and family support program from pregnancy until kindergarten. Pairs trained Parent Educators with families to ensure school readiness and healthy child development, once or twice per month in home or at family place of choosing.
- Nurse Family Partnership -- Free, voluntary, in home visiting program that pairs first-time low-income mothers with highly trained nurses, pregnancy to age 2 years old.

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RESOURCES FOR FAMILIES

- Healthy Steps for Young Children -- Free, voluntary program that helps parents understand what to expect from growing children and provide solutions for challenges. Specialists meet with families in the pediatrician's office and at home for up to 3 years.
- The Colorado Early Childhood Mental Health Specialists Program -- Free and confidential resource that supports children's social and emotional development age 0-8 yr. Occurs on-site at the child's childcare program or another convenient location.
- Nurturing Healthy Sexual Development -- 2- to 3-hour introductory workshop developed to help foster relationships that support the healthy growth and development of children. Addresses normal sexual behavior, common myths, responding to sexual behavior and questions
- Risk and Protective Factors
  https://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html.
- Family Support Programs
  http://coloradoofficeofearlychildhood.force.com/oec/OEC_Families?p=family&s=Family-Support-Programs&lang=en.

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Strong Partnerships

Goals

Collaborative approach to early identification and intervention

Mutual respect

Shared responsibility in the prevention of child abuse/neglect

Information sharing for optimal decision making

Challenges

Confidentiality concerns

Cumbersome medical record systems

Access to care

Time constraints

Silos

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Social Service Safety Screening

Opportunity to partner with medical providers

Young parents

Vulnerable infant

Substance use

Mental illness

Lack of knowledge of child development

Low income

Adverse life experiences

Current or historical trauma

Distorted beliefs about parenting

Too many people living in a household

Low education

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Casework Perceptions

Myths and Misconceptions	Reality
Medical providers can definitively confirm or refute abuse	The medical opinion is just one piece of the puzzle
If the medical provider can't prove it, no one can	CW burden of proof does not require a definitive opinion
Many cases are INCONCLUSIVE	We make the best decisions with the best data that we have

Documentation

HELPFUL

- Thorough
- Unique history
- Detailed behavioral history
- In-depth recommendations including time that treatment might take

NOT HELPFUL

- Basic information that DHS may already have
- “Check-boxes”
- Vague recommendations

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Thought Provoking Questions

What characteristics support a strong working inter-professional relationships?

Are there recommendations you can make in your reports, leveraging community resources to promote “building blocks” of HOPE?

- Relationships
- Environments
- Social-emotional development

THANK YOU!

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