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Child Abuse Assessment and Reporting by Social Workers: An Action Research Project

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This is to certify that the doctoral study by

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2023

Abstract

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MSW, University of Central Florida, 2005

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Project Submitted in Partial Fulfillment

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Abstract

Social workers in pediatric medical settings often fail to assess for abuse and neglect or do not report their concerns when abuse and neglect are suspected. Social workers are mandated reporters, and children are left in dangerous situations when they neglect to intervene. The purpose of this study was to gain a better understanding of what prevents social workers from following through on these responsibilities. The research questions focused on barriers that social workers face, such as lacking the necessary training or experience or lacking adequate support from other social workers or medical professionals. Research participants were also asked what strategies can be implemented to overcome these barriers. Social learning theory, social exchange theory, and operant conditioning were used to inform this study. Interviews were conducted with six social workers with experience in pediatric medical settings. Data were transcribed and coded through thematic analysis. Participants identified education deficits and interactions with other members of the medical team as the primary barriers to assessing and reporting abuse and neglect. Education and training for social workers along with better communication and collaboration with the medical team were identified as possible solutions. Results of this study highlight the importance of social workers abiding by the National Association of Social Workers Code of Ethics and the need for changes to occur in education, relationships with other professionals, and practices employed by pediatric medical social workers in order to effect positive social change. Positive social change on behalf of children and families can occur when social workers adequately assess for abuse and neglect and report their concerns.

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Dedication

This project is dedicated to Russ and Donna Wagner. More than two decades ago, I was a shy young adult with very little vision for what I wanted my future to be. You took me into your home and provided love, support, and guidance. You encouraged me to work hard and taught me the value of receiving a formal education. Your unwavering commitment to helping me succeed academically ignited a spark in me that I hadn't previously known existed. You had such a profound impact on my life, and I would not be where I am today without you. Thank you for everything.

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I want to thank Dr. Chase for her guidance and support over the last several years. I would not have made it through this program without her continuous oversight and feedback. I would also like to thank my fellow classmate Anetrice Rogers, who helped to keep me focused and motivated.

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Section 1: Foundation of the Study and Literature Review

Incidents of child maltreatment through abuse or neglect affect a large population of Florida's children. The U.S. Census Bureau (2023) estimates that nearly 20% of Florida's population in 2022 was comprised of those under the age of 18. In December 2017, more than 24,000 calls were accepted by the Florida Abuse Hotline and nearly 70% of those met the requirements for an investigation (Florida Department of Children and Families [DCF], 2018). During 2022, 472 child deaths were reported to the Florida Abuse Hotline (Florida DCF, 2023). Eighty-one percent of these deaths occurred in children aged 3 and younger. Of these deaths, 97 were sleep related, 93 were drownings, and 52 remained under investigation (Florida DCF, 2023). Fifty-nine of these deaths were labeled as "other," which primarily consisted of drug toxicity as the cause of death. Many of the sleep-related deaths occurred while an infant was cosleeping with a caregiver (Florida DCF, 2023).

Abuse and neglect occur in many forms, such as domestic violence, physical and sexual abuse, emotional neglect, and educational neglect (James, 2018). Many victims of child abuse and neglect present with their injuries and other signs or symptoms of neglect to their pediatricians, emergency departments, or other acute care medical settings (Burrell et al., 2016; Eniola & Evarts, 2017; Leetch et al., 2015; Leetch & Woolridge, 2013; Lynne et al., 2015; Roberts et al., 2022; Schilling & Christian, 2014). Physicians and medical social workers are in optimal positions to assess for child abuse and neglect in these settings. However, even with physicians and social workers being deemed as

mandated reporters, many cases of abuse and neglect go unreported (Feng et al., 2012; Lynne et al., 2015; Pietrantonio et al., 2013; Tiyyagura et al., 2015; Tufford et al., 2015).

The rest of Section 1 consists of identifying the practice problem—in this case, why pediatric medical social workers do not identify or report concerns for abuse and neglect; the research questions; the design of the study; and how research participants will be identified. The ways in which the results of the research apply to the field of social work will be explored, and the theoretical framework used to inform the research will be explained. Finally, this section will conclude with the literature review.

Section 2 includes the research design, the methodology used for collecting data, and information about the research participants. This section will also review how the data were collected and analyzed. It will conclude with ethical procedures that were implemented to protect the research participants and the data collected. Section 3 is comprised of the techniques implemented to analyze the data and the findings that emerged during interviews with research participants.

In Section 4, the final section of this paper, I will explore the application to professional practice and implications for social change. This will include how the results of the study relate to the National Association of Social Workers (NASW) Code of Ethics and recommendations for applying the results to social workers currently employed in pediatric medical settings as well as my own practice. Finally, the potential impact this study can have on positive social change will be addressed.

Problem Statement

Suspicions of child abuse and neglect frequently go undetected and unreported in healthcare settings. At one Florida children's hospital, there is often conflict between social workers and other members of the healthcare team, specifically physicians, regarding the assessment and reporting of abuse and neglect. In addition, some social workers lack the necessary training to adequately identify and report signs of abuse or neglect. Physicians and other members of the healthcare team have challenged social workers on their assessment of the situation and their belief that a report should be made to the state child abuse hotline. Furthermore, some social workers have disclosed that they have not reported their concerns of abuse or neglect due to conflicts with physicians who did not agree with their assessment or belief that a report should be made.

Numerous studies have been conducted that support the lack of assessment and reporting that occurs at this children's hospital. Although these studies have provided a variety of reasons for this, one thing is clear: Many providers in the medical field fail to protect one of the most vulnerable populations. Even when physicians and nurses witness and acknowledge signs of physical abuse, some of them never report their concerns (Cleek et al., 2019). For example, Tiyyagura et al. (2015) found that some physicians and nurses do not report their concerns because they want to believe the child's caregiver or because they have an established relationship with the caregiver. Conversely, findings by Christian (2015) demonstrated that medical staff do not feel comfortable questioning caregivers, or they choose to believe that the child sustained injuries accidentally. An earlier study conducted by Sege et al. (2011) with 110 pediatricians concluded that while

physical abuse accounted for 81% of injuries in their patients, physicians only reported 21% of these patients to authorities. A study conducted by Roberts et al. (2022) indicated that some physicians do not believe it is their responsibility to report concerns of abuse and neglect and that social workers should do the majority of the reporting.

While there is an adequate amount of research related to child abuse reporting in healthcare settings, there is limited research that focuses specifically on medical social workers. However, a study conducted by Wood et al. (2012) at Children's Hospital of Philadelphia (CHOP) revealed that not only were hospital social workers consulted infrequently, but they also reported concerns for abuse and neglect infrequently in situations when they were consulted to complete an assessment. In contrast, other studies completed with social workers who do not work in a medical setting revealed that they do not identify signs of abuse and neglect and still underreport their concerns when child maltreatment is identified. For example, Tufford et al. (2015) conducted a study with a combination of novice social workers, experienced social workers, and social work students in which various case studies were presented. They noted that very few of the study participants were able to appropriately identify signs of child maltreatment, and when they did make the identification, a report to authorities was not made because the social workers felt they did not know how to broach the subject with the child's caregivers. Furthermore, in a study conducted by Fleming et al. (2015), it was noted that some social workers did not report concerns for child abuse and neglect due to concerns about the impact that reporting would have on their reputations. A more recent study by

Tufford et al. (2021) confirmed that social workers continued to provide the same rationale for why they did not report signs of abuse and neglect.

Purpose Statement

This study addressed the social work practice problem that child abuse and neglect are often not detected and not reported in pediatric medical settings. Research questions included the following: What barriers do medical social workers experience when needing to assess and report concerns for abuse/neglect? Do medical social workers lack the necessary training/experience to identify and report abuse/neglect? Do medical social workers lack the support needed from the healthcare team to report concerns for abuse/neglect? What measures can be put in place to help medical social workers identify signs of abuse and neglect and to report their concerns? Definitions of child abuse and neglect are included in the study, along with examples of abuse and neglect. Additionally, the concept of "reasonable suspicion" will be discussed.

The NASW (2021) code of ethics states that social workers have a duty to protect vulnerable populations from harm. This study is relevant and valuable because there is a gap in protection as evidenced by the above-referenced studies. Due to the fact that the majority of research regarding assessing and reporting child abuse and neglect in medical settings has been conducted with physicians and other healthcare providers, this study will give new insight into medical social workers and the barriers they face when assessing for child maltreatment and when deciding whether or not a report needs to be made to the state abuse hotline.

Nature of the Doctoral Project

For this study, a cross-sectional descriptive study design was utilized (Rindfleisch et al., 2008; Salkind, 2012). Cross-sectional studies allow the researcher to observe a population at a specific point in time (Singh Setia, 2016). These studies are also used to delineate and comprehend the correlation between several variables at a specific point in time. Cross-sectional studies enable the researcher to observe and compare the various traits of research participants and how these traits affect the dependent variables (Bowden, 2011). In the current study, the implementation of a cross-sectional research design allowed me to observe medical social workers at a specific time and to explore how the various characteristics of each social worker impacted their ability and willingness to identify and report signs of child abuse and neglect.

The data for this study were obtained via individual interviews with medical social workers recruited from various pediatric medical settings. Research participants were recruited from various Facebook groups created for social workers. Interviews are a common method of obtaining data in qualitative research. They allow researchers to closely explore and investigate various issues on a personal level, fostering a safe environment for research participants to openly share their experiences (DiCicco-Bloom & Crabtree, 2006). Utilization of individual interviews for this study allowed me to partake in discussions with other medical social workers to gain a deeper insight into why child abuse and neglect are not identified and reported. After the interviews were completed, data were coded by assigning various topics and listing common themes under each topic.

Significance of the Study

There are several contributions that this study brings to the field of social work. First, the results of the study identify barriers experienced by social workers when assessing and reporting child maltreatment in medical settings. Second, the knowledge gained from this study can be used to facilitate the development of new training programs for medical social workers. Finally, the study's findings can be incorporated into the academic setting and field placements to enhance the knowledge base and understanding of future social workers. This study will contribute to the growth of the field of social work in the area of child protection in changing current practices and policies around child abuse assessment and reporting. The implications for social change are far reaching and can lead to the effective evaluation of child maltreatment and subsequent intervention for numerous children and their families nationwide.

Theoretical/Conceptual Framework

Social learning, operant conditioning, and social exchange theory were used in this study. These theories focus on how an individual's thoughts, behaviors, and actions are influenced by others. These theories informed this study by demonstrating that social workers are often not taught how to correctly assess for signs of child maltreatment or may succumb to peer pressure to not report their concerns based on their interactions with other medical professionals.

Social learning theory (Bandura, 1971) indicates that an individual's actions and behavior are modeled after the actions and behaviors of others or due to reinforcement from others. Brauer and Tittle (2012) and McLeod (2016) supported the idea that

responses that are received from other individuals are an important element of social learning theory. These responses, both positive and negative, promote changes in the behaviors of others. In relation to social workers in medical settings who take on the role of assessing and reporting child maltreatment, the theory indicates that the responses of other members of the healthcare team may influence how social workers respond in these situations.

In operant conditioning (Skinner, 1963), reward and punishment affect an individual's behavior and responses. These rewards and punishments then alter the behavior of the individual on the receiving end of these responses. In operant conditioning theory, punishment serves to diminish or completely eliminate a behavior (McLeod, 2015). For social workers in a healthcare setting, experiencing negative reinforcement or punishment from other healthcare workers can result in the minimization or termination of discussing and reporting their concerns.

Proponents of social exchange theory (Emerson, 1976) assert that rewards and social acceptance influence an individual's behavior. This theory (Lewis, 1957) suggests that conflicts between groups of people create social change and new norms. Ancarani et al. (2018) also suggested that social exchange theory has an impact on the relationship between supervisors and supervisees—in this situation, social workers and their superiors.

These theories were chosen specifically for their application to social science and to better understand people's behaviors. The goal of this study was to understand what prevents social workers from assessing for abuse and neglect or from reporting their

concerns. When applied to this study, these concepts will assist in confirming the responses participants provided during the interview process.

Literature Review

The professional and academic literature contained in the literature review was obtained via search engines provided through Walden University's library system. The search method utilized allowed me to access numerous resources, including books and articles in various journals focusing on social work and child welfare. This also allowed me to verify that all journal articles used were peer reviewed. For statistical information, national websites such as that of the U.S. Department of Human Services and state websites such as the Florida DCF were utilized. Several key words and combinations of key words were used in the search, including "child abuse and neglect," "child maltreatment," "pediatric emergency room," "pediatric hospital," "healthcare," "nurses not reporting," "physicians not reporting," "social workers not reporting," and "barriers to reporting."

History of Child Welfare in the United States

There are a limited number of documented examples of attempts to protect children from maltreatment in this country starting in the 1600s (Myers, 2008). These primitive efforts to provide assistance to children and families were rooted in the English Poor Laws, and interventions were conducted by the New York Charity Organization Society (COS; Jimenez, 2006). Unfortunately, these early interventions often served as a form of punishment and separated families, rather than provide them with support and services needed for them to become more self-sufficient and able to provide physically,

emotionally, and financially for their children (Abel, 1998; Dulmus & Sowers, 2012; Jimenez, 2006).

The U.S. government began to take a more active role in protecting children during the 1900s. During William Taft's presidency, the Children's Bureau was developed in 1912 (Children's Bureau, 2016; Myers, 2008). The Children's Bureau took a primary interest in infant and maternal health as well as conditions and laws concerning child labor (Children's Bureau, 2016).

In the 1960s, national attention was given to child welfare with the publication of *The Battered Child Syndrome* in 1962. Authored by pediatricians, *The Battered Child Syndrome* helped to drastically increase awareness and knowledge regarding child maltreatment in the United States (Myers, 2008). Revisions were also made to the Social Security Act during this time, placing greater emphasis on the safety and wellbeing of children. Furthermore, nationwide reporting laws were implemented by 1967 and child protective services were available in all 50 states (Myers, 2008).

The U.S. government furthered its investment in protecting children with the establishment of new laws. The Child Abuse Prevention and Treatment Act (CAPTA), signed into law in 1974, was a leading piece of legislation regarding the wellbeing of children in the United States (U. S. Department of Health and Human Services [DHHS], 2003). Created by DHHS, the purpose of CAPTA was to address several issues impacting children. These issues included access to resources, domestic violence, advocacy, adoption, protection, and research (U.S. DHHS, 2003).

National Child Abuse Statistics

Mandatory child abuse reporting laws exist in all 50 states as well as the District of Columbia (Child Welfare Information Gateway, 2016). According to the U.S. DHHS (2020), most child abuse reports are investigated by authorities. The total number of reports increased from 3,717,000 in 2014 to 4,327,000 in 2018 (U.S. DHHS, 2020). According to the U.S. DHHS (2021), among cases where abuse and neglect were confirmed, 18% were for physical abuse and 75% were cases of neglect. Children who are determined to be at low to moderate risk of being abused or neglected and whose parents or guardians agree to voluntarily engage with social services do not receive an investigation. These children and families receive other offered services to help meet their needs and keep the family intact (U.S. DHHS, 2020).

In 2018, maltreatment reports were submitted by a variety of sources. The vast majority of reports were initiated by professionals, with employees from schools and educational settings accounting for 20.5% of all reports, followed by 18.7% from law enforcement and other legal entities, and 10.7% of reports initiated by social services professionals (U.S. DHHS, 2020). Additional reports were made by parents and relatives (6.2% each), neighbors and friends accounted for 3.8%, and an additional 16.1% of reports were made by unidentified sources (U.S DHHS, 2020).

Victim Characteristics

The younger a child is, the more susceptible the child is to being a victim of abuse or neglect. Children under the age of 3 years account for nearly 30% of maltreatment cases in the United States, with approximately 15% of these children being under 1 year

of age (U.S. DHHS, 2020). Boys and girls experience abuse and neglect at nearly the same rates, with boys accounting for 48.5% of victims and girls accounting for 51.2% (U.S. DHHS, 2020). The sex of the victim was unknown in .3% of reported cases (U.S. DHHS, 2020). Approximately 44% of these children are White, followed by Hispanic children (22.6 %) and African American children (20.6%; U.S DHHS, 2020).

Risk Factors for Abuse and Neglect

Prematurity and Child Abuse

Several researchers have focused on the link between premature birth and physical abuse. Primitive research conducted by Frodi et al. (1978) exposed parents to the faces and cries of infants born prematurely and measured their responses. The researchers then compared the parents' reactions to being exposed to the faces and cries of full-term infants. The reactions of the parents were measured by their physiological responses and self-report of how they felt after being exposed to both scenarios (Frodi et al., 1978). When participants were exposed to the sound of premature infants crying, they experienced a stronger autonomic arousal response and felt more aversion towards the babies when compared to their responses to the cries from infants born at term. When the faces of preterm infants were combined with their cries, responses from the participants were further enhanced. Frodi et al. proposed that the reactions demonstrated by study participants are associated with an increased risk of abuse in preterm infants.

A more recent study was completed in England in which researchers studied incidents of child abuse and neglect that had been reported over a 19-year period (Spencer et al., 2006). They examined more than 158,000 documented cases of abuse and

neglect and found that infants born at least 4 weeks premature were significantly more likely to experience abuse and neglect. Furthermore, Spencer et al. (2006) discovered that infants who were born at least 6 weeks premature had a higher probability of being sexually abused. A more recent study conducted on child maltreatment among military families found that out of 59 confirmed cases of abuse or neglect in children under the age of 2, the victim was born premature in 7% of cases (Sullivan et al., 2022).

Disabilities and Child Abuse

Some studies have shown that disabled children have an increased likelihood of experiencing various types of maltreatment. Govindshenoy and Spencer (2006) examined four studies that assessed for the correlation between disabled children and occurrences of abuse. Results of their examination support that disabled children have a higher likelihood of being abused than children without disabilities. Govindshenoy and Spencer discovered that the type of disability was associated with different forms of abuse. For example, children with cognitive or emotional disabilities, such as conduct disorder and learning disabilities, are at greater risk of being exposed to all types of abuse while children who require special education assistance for their disabilities are specifically at greater risk of being sexually abused (Govindshenoy & Spencer, 2006). Additionally, Sullivan et al. (2022) noted that 3% of children who were abused in their study were born with some type of birth defect.

Utilizing logistic regression analysis to study abuse and neglect among children with intellectual disabilities, Brendli et al. (2021) found that these children were nearly 3 times more likely to be victims than children without an intellectual disability. Helton et

al. (2018) purported that children with learning disabilities are more susceptible to sexual abuse than their peers. Their research concluded that children with learning disabilities are 2.5 times more likely to report that they have been sexually abused when compared with children who do not have a learning disability.

Socioeconomic Status and Child Abuse

Although there is limited research in this area, some studies have shown a correlation between socioeconomic status and child maltreatment. Bugental and Happaney (2004) conducted a study with Hispanic families in which educational and socioeconomic status were examined as a predictor of abuse. This study found that mothers who experience depression or feelings of powerlessness in the home are associated with higher rates of inability to provide safe environments for their children as well as higher rates of more punitive and severe parenting skills (Bugental & Happaney, 2004). Other researchers have come to similar conclusions over the last several decades. Govindshenoy and Spencer (2006), Frodi et. al. (1978), and Spencer et. al. (2006) all discovered an association between low socioeconomic status and child maltreatment. As Maguire-Jack and Sattler (2023) stated, "neglect and poverty are often difficult to disentangle" (p. 4825).

More recent research suggests that the link between poverty and neglect and abuse remains. Helton et al. (2019) analyzed data from the Fragile Families and Child Wellbeing Study and discovered that food insecurity was present in 16% of families who participated in the study. The authors noted that these families experienced an increase in physical and psychological aggression from parents toward their children. A 2020 study

conducted in central California (Navarro, 2021) where seasonal work is a prevalent form of employment found that children whose families experienced 6 or more months of poverty had a higher risk of experiencing abuse and neglect. However, Navarro (2021) noted that when families were expecting to experience periods of unemployment, a child's chance of experiencing abuse and neglect decreased.

Defining Terminology and Recognizing Child Maltreatment

The Florida DCF (2018) provides several definitions related to child abuse and neglect. A *child* is a person under the age of 18 who has not been emancipated and is not married. *Abuse towards children* consists of intentional threats and acts that produce mental, sexual, or physical harm that causes or is likely to cause harm to the physical, mental, or emotional well-being of the child.

Neglect occurs when a child is intentionally deprived of or is allowed to be deprived of their basic needs, such as food, shelter, medical treatment, and clothing (Florida DCF, 2018). Neglect also occurs when a child is residing in a hazardous living environment that has already resulted in harm or has the potential to harm the physical, mental, or emotional wellbeing of the child. Finally, *mandated reporters* in the state of Florida extend beyond those who are in the profession of caring for children. In Florida, mandated reporters include anyone, regardless of profession or training, who has reason to believe a child is being abused or neglected (Florida DCF, 2018).

Pediatricians are often some of the first individuals to come in contact with a child who has been abused or neglected and are in an opportune position to identify the signs and symptoms of maltreatment (Kodner & Wetherton, 2013). However, many

physicians do not adequately identify these signs and symptoms (Petska & Sheets, 2014). Sanders et al. (2015) supported these sentiments, reporting that many children present to their pediatrician with signs of child maltreatment that go unrecognized at least once before a severe or life-threatening injury occurs. Petska and Sheets (2014) defined a *sentinel injury* as "a visible, minor injury in a precruising infant that is poorly explained and therefore concerning for physical abuse" (p. 923). Sentinel incidents are common in infants who are abused and infrequent in infants who are not abused. Research conducted by Sheets et al. (2013) supported this statement. These researchers conducted a retrospective study of 401 abused infants under the age of 12 months and found that 27.5% had a sentinel injury. This was compared with zero sentinel injuries in 101 infants who were not abused (Sheets et al., 2013).

Occult injuries are injuries that are not easily identified by caregivers because they are not usually visible and include injuries to bones and organs (Petska & Sheets, 2014; Sheets et al., 2013). These injuries result in rib fractures, skull fractures, retinal hemorrhages, and organ damage (Petska & Sheets, 2014). Kodner and Wetherton (2013) noted that occult injuries result in tenderness in the areas where the injuries have occurred, which can be discovered on a physical exam by a physician or other healthcare professionals.

Hornor (2014) sumised that neglect is the most frequent and deadliest form of maltreatment yet is frequently overlooked in healthcare settings. Neglect can take many forms, such as medical and dental neglect, lack of supervision, educational neglect, neglect related to lack of adequate nutrition or obesity, lacking adequate shelter, poor

hygiene, withholding love and affection, as well as maternal drug and alcohol use during pregnancy.

Determining the Presence of Abuse or Neglect

According to Palusci and McHugh (2016), injuries to the skin, such as burns and bruises, are the most common injuries resulting from physical abuse. In cases of bruising, they noted the importance of identifying the stages of the bruises, being aware of where bruises typically occur based on the age of the child, and being able to determine patterns and spacing of bruises, such as bite marks, bruising that is in the shape of an object, and number of bruises. In instances of burns on the skin, those evaluating the child need to understand how the appearances of accidental burns differ from intentional burns (Palusci & McHugh, 2016). Intentional burns are often patterned from the use of an object or from submersion in hot water. Additionally, Palusci and McHugh noted that healthcare professionals need to be suspicious when a child presents with bone fractures, stating that fractures of any kind can be indicative of abuse.

Healthcare Professionals and Barriers to Identifying and Reporting Abuse and Neglect

There are many barriers that prevent adequate identification and reporting of abuse and neglect. Some research suggests that these barriers begin early on because physician residents do not receive sufficient training in the area of child maltreatment, leaving them unprepared when they complete their residency and transition to becoming independent practitioners. A Canadian study examined qualitative data collected from 29 resident physicians and analyzed their perceptions on the connection between their roles as physicians and intervening in cases of abuse and neglect (Laupacis et al., 2022). The

researchers concluded that while these residents acknowledged it is part of their responsibility as medical professionals to appropriately identify cases of abuse and neglect, they felt that they needed additional training and education on what signs to look for and how to intervene.

Other research suggests that barriers for physicians persist well into their careers. For example. Petska and Sheets (2014) proposed that it is particularly difficult for primary care pediatricians to identify abuse or neglect due to having close relationships with families and believing that there is a low risk for abuse in the household. These researchers also argued that pediatricians may minimize the injury and not want to expose the family to an investigation by authorities or to further intrusive medical examination. Sheets et al. (2013) noted that when physicians perform additional examinations for other signs of abuse, their suspicion of abuse wanes if they find no other signs of injury, leading them to abstain from making a report. Eniola and Evarts (2017) purported that primary care pediatricians "lack the confidence and training to diagnose" child abuse and neglect (p. 330). In addition to lacking confidence, Eniola and Evarts found that lack of experience in assessing and diagnosing maltreatment, trouble speaking with caregivers, limited support from or access to social workers or other social support services, as well as a lack of defined protocol for completing an assessment lead to lack of adequate assessments and reporting. A study conducted with physician and nurse practitioners in Canada by Joh-Carnella et al. (2023) revealed that participants largely expressed positive views about reporting concerns of abuse and neglect. However, some participants reported feeling hesitant about making a report due to the impact it might

have on the family, not completely understanding the role of child welfare, and "fears of threats and legal retaliation from caregivers" (Joh-Carnella et al., 2023, p. 5).

Many abused children are brought to emergency departments (ED) for evaluation. Sheets et al. (2013) state it is important for physicians in the ED to "keep a high index of suspicion" (p. 47) when treating children. There are several injuries that should automatically prompt further investigation for abuse. These include baby blues, burns, bonks (on the head), bruises, bites, and breaks, also known as the "six B's" (Sheets et al., 2013). Tiyyagura et al. (2015) conducted a study with 29 healthcare professionals who work in an ED. These professionals were comprised of 16 nurses, nine physicians, and four physician assistants. Research participants identified several barriers, including wanting to believe the caregiver, inability to identify signs of abuse and neglect, being biased in favor of caregivers, and complications associated with working in an ED (Tiyyagura et al., 2015). Furthermore, they identified barriers to reporting identified abuse and neglect, such as length of time it takes to make a report, being worried about becoming involved in the legal system, and that their concerns were unfounded. Additionally, Burrell et al. (2016) report there is not an identified protocol for obtaining information when child maltreatment is suspected or for documenting these conversations.

An additional barrier is more related to the patient being treated, particularly when it comes to a child who is being sexually abused. Sanders Jordan and Hatfield Steelman (2015) note that children who are sexually abused often have difficulty disclosing their abuse to others out of fear of being further harmed or not being believed.

Social Workers and Barriers to Identifying and Reporting Abuse and Neglect

Current research regarding lack of identification and reporting of abuse and neglect by social workers in medical settings is quite limited. In fact, the majority of recent research pertains to child protection social workers. However, even with this limited research, several barriers that prevent social workers from adequately assessing for and reporting abuse and neglect have been identified.

One common barrier is that definitions are often unclear and left to individual interpretation. For example, oftentimes, a 'reasonable suspicion' is needed to determine if a child is being mistreated (Wekerle, 2013), which can be interpreted differently among social workers (Crowell & Levi, 2012). Crowell and Levi (2012) conducted a study with more than 1,200 participants who were identified as mandated reporters. Of these participants, 265 were social workers. They noted that these professionals varied on how they defined 'reasonable suspicion (Crowell & Levi, 2012). This problem presents itself with other terms. For example, Schilling and Christian (2014) also note that 'neglect' can be difficult to define and quantify, reporting 'neglect' may have different definitions to those who are treating the child and involved in assessing for abuse and neglect.

Another barrier for social workers is the ability to determine the presence of abuse and neglect. According to Schilling and Christian (2014), physical abuse is often difficult to detect due to the absence of witnesses to the event, many child victims of abuse are not yet verbal and can't tell anyone what happened, and the sustained injuries are very general and not necessarily specific to abuse. Tufford et al. (2015) completed a study with 23 graduate social work students, new social workers, and experienced social

workers. They were presented with various scenarios and were asked to identify incidents of neglect. Only a small number of participants were able to recognize the signs of child neglect (Tufford et al., 2015). Additionally, when neglect was appropriately identified, study participants failed to act, reporting they did not know how to address their concerns with the patient and family. A final finding of this study was that the social work students were more likely than experienced social workers to recognize the signs of neglect (Tufford et al, 2015).

These results are confirmed in a later study completed by Tufford et. al (2021) in which social workers were exposed to several simulated vignettes in which abuse and/or neglect were present. More than half of these participants (11 out of 19) justified why they did not want to make a report to authorities. In this study, 19 social workers with varying degrees of experience were exposed to simulated vignettes in which child abuse and neglect were present in each scenario. These social workers then had to share their decision-making process and why they would or would not report concerns they had about abuse and neglect in the various vignettes. While more than half of the participants in this study recognized signs of child maltreatment, the majority of them indicated they did not want to initiate a report to authorities. Reasons for not reporting included not wanting to disrupt the relationship between the social worker and the family and believing that the child's caregiver did not intentionally try to cause harm. These researchers (Tufford et. al, 2021) reported that level of experience for the social workers had no impact on their decision about making a report.

Fleming et al. (2015) conducted similar research in the United Kingdom. Participants included 105 social work students and 40 experienced social workers. They were presented with various vignettes and were asked to identify if the children were at risk for abuse or neglect. Similar to the study conducted by Tufford et al. (2015), social work students in this study perceived a higher risk for abuse and neglect than the experienced social workers. The results also demonstrated that the experienced social workers came to their conclusions as a result of the perceived risks their assessment would have on their professional reputations (Fleming et al., 2015).

Other studies have shown that children are not appropriately evaluated for signs of abuse or neglect. Wood et al. (2012) conducted a study at the Children's Hospital of Philadelphia (CHOP) regarding 1,400 children who were admitted for ingesting toxic substances. These children were under the age of six and were admitted to CHOP for ingestion of substances, including illegal substances, various medications, and household cleaning products. Only 13% of these children and their families were evaluated by a social worker during their admission. Most of these ingestions were deemed to be accidental incidents. However, social workers had concerns for neglect on the part of caregivers in 7% of the children they saw. Additionally, social workers were concerned that approximately 2% of these children were poisoned intentionally. Social workers at CHOP only reported 4% of those children with concerns for intentional poisoning to the appropriate authorities (Wood et. al., 2012).

In regards to childhood sexual abuse, Kenny and Abreu (2015) suggested that many mental health providers, including social workers, have had limited or no training

in this area. A 2014 study regarding child sexual abuse in England due to a decline in reporting of these incidents concluded that social workers were lacking in knowledge and comprehension of the problem (Kwhali et al., 2016). A study conducted by Klein et. al. (2021) focused on school social workers and their role in identifying sexual abuse among students. These researchers emphasized the importance of social workers being knowledgeable about the signs displayed by children who may be experiencing sexual abuse and how to appropriately illicit additional information so they can engage in the next steps of keeping the child safe.

In a study conducted in Canada, social workers in the field of child protection were provided with a series of vignettes and asked to rate how they would respond to each scenario (Stokes & Taylor, 2014). Results of this study demonstrated that social workers viewed the vignettes in which neglect was noted as less severe and needing less attention than those in which physical or sexual abuse was occurring.

Krase and DeLong-Hamilton (2015) conducted a study to investigate how well current social work programs prepare students for their role as mandated reporters in the United States. Through the course of their research, the authors were unable to locate any specific regulations regarding what type of training and education should be provided to social work students regarding mandated reporting. Ultimately their research demonstrated that there is not a standard of educating and training students about mandated reporting in social work programs in this country. Additionally, Ross et al. (2022) suggested that social work students do not receive enough education or training on their role in working with abuse and neglected children and concluded that enhanced

instruction for social work students is crucial to effectively managing cases of child abuse and neglect.

Suggestions for Increasing Identification and Reporting

Leetch et al. (2015) made several recommendations for improving the ability to identify abuse and neglect in hospital settings. They proposed that a thorough history should be obtained from all caregivers and any witnesses who were present. Leetch et al. (2015) also emphasized the importance of interviewing older children without the presence of family members or caregivers, but with the presence of a child life specialist or a social worker. Older children should also be asked about school and caregivers should be asked if they are concerned that someone may be abusing their child(ren) Klein et. al (2021) provided a series of questions that social workers can ask children if they suspect they are being sexually abused. These questions focus on the home environment, sleeping arrangements, the use of photographs, their relationships with others, exchange of money, school attendance, and the use of alternative names.

Schilling and Christian (2014) suggested a community approach to improve identification and reporting. This includes a wholistic approach that addresses the physical and mental health of children and their families. A concerted effort placed on increasing training and education provided to the general public on child maltreatment has also been recommended (Ho et al., 2017).

For physicians, Eniola and Evarts (2017) made several recommendations, such as increasing training during residency, providing continuing education on child maltreatment, and creating subspecialty training for pediatricians and family

practitioners. Participants in the study also made some of their own recommendations, including providing screening tools for staff in medical offices, providing training on how to conduct interviews with patients and caregivers, and the development of simulation programming. Sanders Jordan and Hatfield Steelman (2015) also recommended incorporating routine regular abuse and neglect screenings during office visits.

Burrell et al. (2016) proposed standardizing the way information is obtained when abuse or neglect is suspected, including what information should be gathered for both the medical and social history of the child, and the use of checklists and structured assessment instruments. In a study with 103 children's hospitals, Garton Crichton et al. (2016) found that 86% of respondents believed the use of screening tools increased identification of child maltreatment. Respondents also reported they believe the use of screening tools decreases bias when evaluating for abuse and decreases the risk of fault by the medical facility.

Of course, even with these suggestions, preventing abuse and neglect should be the first step in decreasing the number of child victims. A study conducted by Zielinski et al. (2017) implemented the use of a tool called WE-CARE in pediatrician's offices to identify psychosocial characteristics that are correlated with child neglect. These characteristics were identified as inadequate access to food, unemployment, use of nicotine, alcohol, or other substances, insufficient childcare, being homeless, not completing high school, and the presence of domestic violence. This screening tool was

easily implemented by health care providers and helped identify families at risk in order to provide preventative services.

Kenny and Abreu (2015) suggested more training needs to be provided to those working in the mental health field when it comes to sexual abuse to better understand when and how victimization starts, as well as being able to identify and assess children who are being abused. Harrell and Wahab (2022) conducted a study in which they explored ethical dilemmas for social workers as mandated reporters. In this study a total of 16 social work textbooks were reviewed for information and guidelines on mandatory reporting. They discovered the majority of textbooks did not provide specific instruction on policies related to mandated reporting. These researchers further noted that the textbooks did not explicitly state the legal and professional consequences that could incur if a social worker failed to complete their duty as a mandated reported. They argued these ill-defined components create a state of uncertainty and confusion for social workers about their role as mandated reporters.

Palusci and McHugh (2016) acknowledged the roles that professionals who interact with children have in preventing and intervening when abuse or neglect is suspected. They noted the role these professionals have when interacting with each other, suggesting even further cooperation where those who work in healthcare train other professionals to recognize physical signs of abuse. Sanders Jordan and Hatfield Steelman (2015) and Morris et al. (2022) also emphasized and promoted collaboration among various healthcare professionals to increase identification and reporting of child maltreatment. Balsley et al. (2019) concurred with these researchers, suggesting that

creating a standard of care is critical to ensuring all members of the healthcare team communicate and work together to competently identify child maltreatment and provide the appropriate interventions. Additionally, Young et al. (2020) suggested creating a standard of care specific to social workers in the medical setting in order to illicit specific responses when questioning patients and families when abuse or neglect are suspected.

Research related to social workers in particular not appropriately addressing or reporting abuse and neglect was quite limited on a large scale, not just for social workers who work in a medical setting. Conversely, research related to physicians and nurses not reporting concerns for abuse and neglect were more abundant. This lack of available research on social workers in the medical field led to a less robust literature review section. However, it also allowed me to hone my area of focus and develop appropriate questions to ask research participants. Additionally, the research that was conducted provided consistent results over the years, allowing me to further tailor the research questions.

Summary

Information obtained during the literature review clearly defines a gap in which child abuse and neglect are not being identified appropriately in pediatric medical settings and when correctly identified or suspected, the appropriate actions are not being taken to address the safety and well-being of the child. The most significant gap noted, and where limited research was present, was related to social workers employed in pediatric medical settings. The following section will review the research design selected, including how participants were selected and data obtained.

Section 2: Research Design and Data Collection

Social workers and medical professionals are mandated by law to report child abuse and neglect. The problem that was the focus of this study is that medical social workers often do not identify or report child maltreatment. The purpose of this study was to understand why medical social workers do not appropriately identify signs of abuse or neglect and why they do not report it when the signs are identified. By examining the process in which medical social workers interview children and families as well as examining their decision-making process when determining whether or not to report their concerns, I sought to extrapolate the contributing factors that play a role in the interview and decision-making process. In the rest of this chapter, I explain the research design and methodology used, the plan to analyze the data obtained, and the ethical procedures implemented to protect study participants, closing with a summary.

Research Design

For this qualitative study, an action research approach was chosen. Action research consists of an approach in which a specific problem is investigated with the goal of identifying solutions that can be implemented to help improve that problem (Bradbury, 2015). This approach was used in individual interviews with medical social workers to examine their experiences in interacting with children and families where abuse and neglect were present in addition to their experiences with reporting concerns for abuse or neglect. Action research was an appropriate design for this study as the objective was to examine why medical social workers sometimes fail to assess for and report signs of

abuse and neglect, and to determine solutions that can be put into practice to help alleviate the problem.

Methodology

Individual interviews with social workers employed in various pediatric medical settings in the United States were utilized to obtain the data. The experiences of medical social workers regarding working with patients and families where abuse or neglect are present were explored during the interviews. More specifically, the interviews were centered on the social workers' experiences identifying signs of child maltreatment and their decision to report concerns for abuse and neglect to the appropriate authorities. Additionally, the experiences of social workers and their interactions with other members of the healthcare team were explored.

Participant Selection

Interviews are a common method employed when trying to obtain qualitative data (DiCicco-Bloom & Crabtree, 2006). According to DiCicco-Bloom and Crabtree, the goal of qualitative research interviews is to enhance an area of knowledge that is rooted in life experiences and the meanings these experiences have for those who are being interviewed. For the purposes of this study, social workers from pediatric medical settings across the United States were asked to participate in individual interviews. The goal was to engage with medical social workers with various years of experience, including those who were licensed and unlicensed, as well as those who were currently receiving supervision for licensure.

Purposive sampling is used when a researcher wants to focus on a group of participants who share a unique set of common qualities or characteristics (Etikan et al., 2016). Because this project focused on social workers employed in pediatric medical settings, purposive sampling was used.

Data Analysis

Once the interviews were completed, the information was transcribed and then coded. The responses provided by participants were divided into specific categories and assigned code words and phrases for the purpose of analyzing the statistical results (Groves et al., 2009). The results of the research were reviewed multiple times, and research participants were offered the opportunity to review the data to ensure that the data were accurate.

Ethical Procedures

Ethical behavior in research is a cornerstone of the NASW (2021) Code of Ethics. There are several factors to consider when upholding strong ethics in research. Prior to beginning the research, informed consent was obtained from all participants (Groves et al., 2009). This included disclosing the potential risks and benefits associated with their participation, explaining the details of the study, and informing participants how long the study was expected to last (NASW, 2021). Study participants were also informed of anything that might hinder the protection of their private information. Steps were taken to protect participants from sustaining any emotional, mental, emotional or physical harm during the study (NASW, 2021). Institutional Review Board (IRB) approval (02-06-20-0664596) was obtained before the study was conducted.

Data have been contained on a password-protected drive, and the identifying information has been removed to ensure the anonymity of all participants. The password-protected drive will be destroyed no sooner than 5 years after the completion of the study.

Summary

This chapter outlined the methods that were used for completing this study. Information regarding the design of the study, how the participants were chosen, and how the data were analyzed was discussed. Finally, the ethical procedures were reviewed. The findings of the study will be presented in the following section.

Section 3: Presentation of the Findings

The purpose of this study was to determine why social workers in pediatric medical settings fail to adequately assess for abuse and neglect and do not report to the appropriate authorities when concerns or signs of abuse or neglect are present. Data were collected via individual interviews with research participants. The research questions also served as the interview questions. They were as follows:

- What barriers do medical social workers experience when needing to assess and report concerns for abuse/neglect?
- What measures can be put in place to help medical social workers identify signs of abuse and neglect and to report these signs?

A total of five current pediatric medical social workers and one former pediatric medical social worker participated in this study. Three social workers were from Florida, two from Texas, and one from Tennessee. Experience working in a pediatric medical setting ranged from less than 1 year to 21 years. All but one social worker was licensed in their respective states. The sole participant who no longer worked in this setting cited her experiences related to social workers not adequately assessing or reporting their concerns to the appropriate authorities and conflicts with physicians as the reason for leaving her position. This social worker was not licensed at the time she worked in the hospital but is licensed now. The majority of the participants agreed that social workers underreport in the same way that nurses and physicians underreport, as previously mentioned. Each research participant presented a variety of reasons as to why social workers do not report based on their individual experiences working in a pediatric medical setting. The

techniques utilized to analyze the data as well as the findings from the interviews will be presented here.

Table 1

Participant Demographics

	State	Licensure	Work setting	Currently in setting	Years in setting
Participant 1	FL	Yes	Hosp/Peds	Yes	6
Participant 2	FL	Yes	Hosp/Peds	Yes	21
Participant 3	TX	Yes	Hosp & clinic/Peds	Yes	2
Participant 4	FL	No	Hosp/Labor & delivery	Yes	4
Participant 5	TX	No	Hospital/Peds	No	> 1
Participant 6	TN	Yes	Hospital/Peds	Yes	1

Data Analysis Techniques

Data collection started after receiving IRB approval (02-06-20-066459). It occurred over the course of a year, as the research was started at the beginning of the pandemic and resulted in some challenges recruiting participants. I initially planned to focus on pediatric medical social workers in Florida. However, after receiving minimal responses from eligible participants, the data pool was extended to all pediatric medical social workers in the United States. Additionally, an interview with one of the participants was delayed after she contracted COVID and needed time to recover. An adequate number of participants were recruited after I joined various Facebook groups for social workers and posted a flyer about the study in these groups. Initially, there were nine social workers who indicated that they were interested in participating in the study. However, three of them stopped corresponding after previously expressing interest, leaving six total participants.

Once the interviews were completed, the information was transcribed and then coded. The recorded interviews were transferred to my laptop and saved as individual files for each interview. Each interview was then transcribed into separate Word documents utilizing Microsoft transcription. The interviews were transcribed verbatim. There were several instances in which some words and phrases were not accurately transcribed. I resolved this issue by returning to the recorded interviews and making the necessary corrections in the Word documents to ensure the transcription results were accurate.

After making corrections and ensuring the accuracy of the transcriptions, the Word documents containing the transcribed interviews were split into two columns. The column on the left-hand side contained the transcription, and the other column was utilized to begin documenting common themes from the transcribed interviews. I reviewed the research questions and responses one at a time and documented any themes that emerged into the other column. This process was repeated for each interview. Each transcription was reviewed multiple times to ensure that all possible themes were identified.

Next, the themes that emerged were divided into specific categories and assigned code words and phrases for the purpose of analyzing the results (Groves et al., 2009). This was done by creating another Word document and creating two columns. The themes that emerged were copied into the left-hand column, and the other column was used to begin developing codes. A total of seven codes were developed during this process.

Finally, all research participants were provided the opportunity to review the transcriptions to substantiate that they were accurate and to add any points of clarification.

Content validity is an important component of research and is utilized to ensure that the data collected are thorough and sufficiently mirror the thoughts and ideas conveyed by research participants (Brod et al., 2009). Several steps were taken throughout the process of collecting and coding data to ensure content validity. In addition to recording the interviews with research participants, I took handwritten notes to reflect nuances picked up in tone of voice, pauses in the expression of thoughts, and thoughts I had while completing the interviews. Member checking was implemented by emailing the completed transcripts to each research participant to allow them the opportunity to confirm the accuracy of the data collected and to provide clarification or any additional information (Naidu & Prose, 2018). Data source triangulation was achieved by confirming that research participants shared similar experiences and thoughts related to the topic being studied (Carter et al., 2014).

Findings

Research Question 1: What Barriers Do Medical Social Workers Experience When Needing to Assess and Report Concerns for Abuse/Neglect?

Education and Training

Numerous reasons were presented by research participants as to why social workers may not adequately assess for neglect and abuse or report their concerns if abuse or neglect is suspected. The theme that was discussed by all research participants related

to education and training. Social workers' levels of education, training, and knowledge manifested in various ways from research participants and spanned many facets of social work. From the formal education social workers receive while in school, to policies at their place of employment and required continuing education, research participants identified several areas of concern that contribute to social workers' inability to assess for and report abuse and neglect. One social worker stated, "I think some of it is like education, and knowledge base, and expertise. You know, I think it's a lack of education, which is sad."

As one social worker stated, courses on child welfare, neglect, and abuse are not required to earn a social work degree unless the student is also pursuing a certificate in child welfare. While it is not possible to cover every topic in social work while in school, this was identified as a barrier to pediatric medical social workers having an understanding of their role as mandated reporters and of the criteria for determining if a report of harm should be made. One social worker who taught a child welfare course indicated that many of her students did not know what number to call if they felt a report needed to be made. Expanding further on this topic, research participants recognized that as social workers engage in continuing education to enhance their knowledge base or pursue licensure, courses on child abuse and neglect are not mandated.

Nearly all the social workers interviewed indicated that they were required to participate in training on child abuse and neglect upon being hired and then at annual intervals thereafter. However, these social workers believed that more training is needed. One social worker stated, "every social worker should have some kind of training,

looking for signs of abuse and neglect" more than once a year. Another social worker who reported receiving annual training stated, "it's basic information for everyone in the hospital" and "it just glosses over abuse, neglect, and abandonment." Two social workers who previously worked in child welfare indicated that they had a greater understanding of assessing for abuse and neglect and when it is necessary to make a report because of their background.

One research participant noted the differences in training and educational opportunities available for various disciplines in healthcare. Specifically, she discussed how Continuing Education Credits are offered for other medical professionals working in their hospital systems, such as physicians and nurses, but not for social workers. She stated that social workers are required to seek this education on their own and obtain it from outside of the hospital. This also means that most of the expenses for these training courses are covered by the social worker and not the medical system for which they are employed.

Some of the social workers acknowledged that lack of education and knowledge is more prevalent among social workers who are new to the medical setting, work part time, or work on the only on the weekends when staffing is limited and there are not many other social workers available to ask. When comparing these social workers with social workers who work full time in the medical setting, one research participant stated, "They don't have the experience that we do. They don't have enough experience to basically make the decision on their own."

Interactions With the Medical Team

One area of discussion that was mentioned by several research participants was the lack of a team approach to situations in which abuse and neglect are suspected. One social worker from Florida with more than 20 years of experience working in a pediatric hospital emphasized the importance of collaboration and communication amongst all members of the healthcare team. This social worker stated that it is important to acknowledge that each professional in the medical setting has a different skill set and area of expertise and that every professional involved in the care of the patient has valuable feedback to provide. She further explained that social workers may develop a greater understanding of the family dynamics as they develop rapport with families while completing the biopsychosocial assessment. The social worker's unique skill set in building rapport and completing this assessment helps in gathering important information about family dynamics.

The relationship between social workers and other members of the healthcare team presented as a barrier to social workers taking the appropriate steps when they had concerns that a child was being abused or neglected. More specifically, research participants focused on the dynamics between social workers and physicians. One social worker from Florida suggested that less experienced social workers are hesitant to discuss their concerns with the physician because they are worried about how they will be perceived by the physician, or they do not want to make the physician angry. She stated that some social workers "get very uncomfortable with the authoritarian type doctor" and that causes the social worker "to feel powerless" when communicating their concerns.

Another social worker from Florida who worked in a pediatric hospital noted that less experienced social workers or social workers who were not part of the full-time staff would often not report concerns for abuse or neglect because a physician told them not to. This social worker further commented that when there is a disagreement between the social worker and physician or social worker and other members of the healthcare team, it is viewed as if the social worker has done something to intentionally impact the child and family in a negative manner. She further stated that this happens most often when the physician or healthcare team has bonded with the family.

This perspective was supported by a former pediatric hospital social worker from Texas. She recalled encounters with nurses and physicians in which she was discouraged from reporting her concerns to authorities, particularly when they had become bonded with a family. She stated that when the medical team forms an attachment with the family, "sometimes social workers don't want to rock the boat with people in the medical side." This participant went on to further state that some social workers lack the confidence to resist pressure from physicians, which results in not making a report. She shared that she had multiple experiences in which members of the medical team would become angry with her and ask her not to report if they perceived that there would be "unintended consequences, either for the family or the medical team." This social worker recalled an experience in which a particular physician reported her to her superiors and attempted to restrict her from notifying authorities when she was suspicious of children being abused or neglected prior to obtaining consent from this particular physician. She stated that the physician was able to successfully delay her making a report and it

"resulted in the death of one child and the serious injury of another." This incident compelled the social worker to resign from her position at the hospital because she felt she was being prohibited from doing her job and that she was unable to keep children safe. She stated, "it was my passion. It was my dream job and I had to leave it to make sure that kids would be protected."

Additional Findings

Several research participants noted that assessing for abuse and neglect in the workplace can be subjective in some cases, resulting in social workers rationalizing or truly believing that a situation does not need to be reported. For example, the medical staff and social workers completing assessments may have varying views of the situation. Their assessment and ability to determine if there is concern for abuse or neglect and whether or not a report needs to be made may be skewed by their own experiences, understanding or knowledge base, belief system, and personal biases.

Two participants, one from Florida and one from Tennessee, provided very specific examples of when this had occurred. One participant in Florida compared responses to substance-exposed newborns that she had experienced during her career as a pediatric hospital social worker. In this example, there is a White mother who has private health insurance, lives in a "good area," admits to using THC during her pregnancy, but the mother and baby are never tested, so a report to DCF cannot be made. The other side of this example is an African American mother who is insured by Medicaid, lives in a "bad part of town," has no or limited prenatal care, never admits to using substances, and

never gives any indication that she has been using substances, but the physician and treatment team make the decision to drug test this mother.

Other examples relate to varying perspectives on child welfare and the role it plays with children and families. A social worker who was formerly employed in child welfare discussed the stigma that is associated with child welfare and how this prohibits appropriate reporting when signs of abuse or neglect are present. He stated, "people have this stigma that child welfare comes to tear families apart and that's not the case." He further stated that the role of child welfare is to provide services and interventions to help keep families intact. This research participant also suggested that social workers who were involved in the child welfare system as children may have had a negative experience and do not want other children and families to go through what they did. Both research participants who previously worked in child welfare reported that this experience gave them an advantage over their peers and a better understanding of what situations need to be reported to authorities.

Several research participants identified that their places of employment provided vague policies and procedures in regard to child welfare and reporting. They also reported that limited training on this topic was offered within the medical setting, even though they were required to be knowledgeable in this area and expected to assess patients for signs of abuse and neglect. Several social workers indicated that they were required to participate in training upon hire and annually thereafter, but they contended that it was not enough to meet the educational needs of medical social workers. Some of the participants also postulated that there are not enough experienced social workers

available either in the work setting or for clinical supervision, so that those with less experience or who need additional guidance do not have access to someone with more experience or a greater knowledge base.

Social workers who participated in this study also indicated that terminology related to child welfare, abuse and neglect are vague and can be easily misinterpreted. Specifically, the word "suspicion" was cited several times as an example, with research participants stating that some social workers have difficulty differentiating between suspicion and evidence, when suspicion is all that is required to notify authorities about a situation they may be concerned about. One social worker stated, "the bar for making a CPS report is suspicion of, not evidence of." She further stated, "we don't have to know for sure. It just has to make sense and there has to be a concern."

Some participants recalled instances of social workers not taking ownership of their role as mandated reporters and relying on others to make that decision. Multiple examples were provided of social workers not reporting because they are relying on someone else to make the report, because they are waiting for a physician to tell them that a report needs to be made, or social workers not reporting because they have been specifically told by a physician that a report does not need to be made. Participants shared their experiences with fellow social workers saying, "the doctor told me not to report it" or "I'm going to wait and see what happens." These types of responses from social workers can lead to delays in reporting or not reporting at all, which can result to children being further exposed to physical, psychological, and emotional harm.

One participant also reported it is her experience that some social workers tend to do a "minimal job in assessing and feel very uncomfortable asking the right questions." She further suggested that these social workers engage in "minimal questioning" rather than getting more specific details, such as where the child and family were when the event occurred, was the event witnessed, and who else was there to help. Additionally, this participant discussed how some social workers do not know how to respond to varying degrees of emotions that families may experience and display while being interviewed by the social worker. For example, she noted that when parents or caregivers respond with anger or become upset, social workers become uncomfortable and do not know how to address the conflict. In her experience, social workers tend to withdraw and abandon their line of questioning rather than trying to deescalate the situation or to continue to work through the emotions and conflict they are being faced with. This social worker cautioned that while it is the role of child protective services to complete an investigation, social workers still need to be able to ask these questions and complete a thorough assessment of the family dynamics.

One participant from Texas who currently works in a pediatric medical clinic postulated that social workers do not report due to a "broken" child welfare system. She further stated that often times social workers believe they are making the situation worse rather than helping when making a report to authorities and that they are adding to a broken system and contributing to an already problematic situation. She also stated this belief allows social workers to begin justifying why a report should not be made in certain circumstances.

This same participant also acknowledged that when a social worker has a relationship with the family and has to make a report, the family knows that social worker made the report. She further postulated that once a family knows the social worker made a report, it can damage the therapeutic relationship. Not only does this impact the relationship between the social worker and the family, but it can also have a negative impact on the family members' relationships with each other. This social worker stated it requires time and effort to rebuild these relationships and, in some cases, the relationship is so damaged that it becomes irreparable. She stated this makes reporting "feel pointless." This participant stressed the importance of providing the patient and family with regular reminders that social workers are mandated reporters.

Research Question 2: What Measures Can Be Put in Place to Help Medical Social Workers Identify Signs of Abuse and Neglect and to Report These Signs?

Strategies for Improvement

Research participants provided many suggestions and feedback on how to overcome the problem of social workers not adequately assessing for abuse and neglect and not reporting those concerns once identified. The need for additional education and training was suggested by every social worker in the study, and several social workers expressed that some of this should occur in their workplace. Research participants suggested that hospital systems should offer more frequent training and one social worker recommended that they offer Continuing Education Credits to social workers in the same way they do for other medical professionals. Another social worker recommended that

hospital systems offer onsite supervision with a more experienced social worker to provide guidance and assistance when certain situations arise.

The most experienced social worker in the study made several assertions about social workers' interactions with the medical team. This included communication and collaboration, other members of the medical team having a greater understanding of the social work role, knowledge level, and skill set, as well as social workers being able to communicate, advocate, and make their own decisions. She explained that the University she is employed at has a simulation lab in which actors are used to simulate realistic medical scenarios. During these simulations participants from various medical specialties are present and have to respond to the scenario that is being acted out. Similarly, another research participant proposed incorporating vignettes as a training tool.

Finally, several social workers emphasized the importance of pediatric medical social workers understanding the role of child protective services and how they can benefit children and their families. One social worker who was previously employed in the role of a child protective investigator stressed the importance of social workers understanding the assessment process, additional services that can be implemented to support families, as well as terminology related to child welfare. A specific term that was mentioned by several research participants was "suspicion." They expressed concerns that some pediatric medical social workers do not understand that suspicion is the minimum requirement for making a report and that they are not required to provide proof that a child is being abused or neglected. One social worker stated it would be beneficial to have child protective services provide presentations for the social work team.

Incidental Findings

Several other topics were mentioned during interviews with research participants. One Florida social worker reported that while it is the responsibility of the social worker to report suspicion of abuse and neglect, it is presented to the child's family that the entire team is concerned and not just one person was involved in making the report. A Tennessee social worker stated it is his experience that physicians want to "over report." This was expanded on by other social workers who indicated that conflict also arises between them and other members of the medical team when a physician or nurse feels that something needs to be reported but the social worker disagrees. Several examples of this occurring were provided by research participants, with most of these incidents occurring in the context of race and class.

A second finding was related to the times social workers are actually present in pediatric hospitals and how this impacts children who may be abused or neglected. Some social workers who work in a hospital reported that they do not have social workers on site or available to respond 24 hours a day. This lack of coverage leaves vulnerable children without the interventions, resources and support they need until the following morning when social workers return to work during normal business hours. Research participants stated they have reminded physicians and nurses that they are also mandated reporters and that they need to report any concerns they have to the appropriate authorities.

Summary

The purpose of this study was to develop a greater understanding as to why social workers employed in pediatric medical settings do not adequately assess for abuse and neglect or fail to make a report when signs of abuse or neglect are present. The two strongest themes that emerged during this study were related to education for social workers and the relationship between social workers and the healthcare team. Additional reasons were related to social workers interactions with families, feeling like they are operating within a broken system, not understanding the role of child protection services, not understanding terminology, and lack of clearly defined policies and procedures in the workplace. There were two primary incidental findings that emerged throughout the course of his research as well. The first including the medical team wanting the social worker to make an abuse or neglect report and the social worker is not in agreement and that some hospitals do not have 24-hour social work coverage for children who come in to the emergency department or are admitted to the hospital overnight.

The following section will address how the results of this study are applicable to professional social work practice and how this new information will enhance the knowledge base of current social workers as well as social work educators on the micro, macro and mezzo levels of practice. I will also explain how the results of this study directly correlate with the NASW Code of Ethics. The results of this study will be applied to make recommendations for professional social work practice. Finally, how the results of this study have the potential to effect social change at various levels of social work practice will be discussed.

Section 4: Application to Professional Practice and Implications for Social Change

The purpose of this study was to develop a greater understanding of and insight into pediatric medical social workers and their role in assessing and reporting child abuse and neglect. More specifically, the study focused on why they do not adequately assess for signs of abuse or neglect and why reports do not get made when suspicion for abuse or neglect is present. Primary findings of this study demonstrated that social workers lack adequate training and guidance and that their decision-making regarding abuse and neglect is influenced by the beliefs and actions of other members of the medical team. These findings may inform social work practice and extend knowledge in the field by identifying an area in which social workers need additional training and support. Furthermore, the findings identify specific deficits that can be addressed through additional education, communication, and advocacy.

The following sections will review how this study relates to ethical practice in social work and the NASW Code of Ethics. Recommendations and solutions for social work practice will be identified and discussed. Finally, the potential impact for positive social change will be discussed.

Application to Professional Ethics in Social Work Practice

Participating in ethical practice and being at the forefront of social change are among the most basic tenets of being a social worker (NASW, 2021). Appropriately assessing and reporting abuse and neglect is an ethical practice that social workers are accountable for. The results of this study can be applied to professional social work practice in a multitude of ways and indicate multiple areas in which social change can

occur. Responses from research participants clearly illustrate the need for pediatric medical social workers to abide by the Code of Ethics. They also highlight the need for changes to occur in education, relationships with others, and practices employed by pediatric medical social workers.

The NASW (2021) Code of Ethics provides very specific guidelines that social workers are expected to abide by. This research study addresses every ethical principle highlighted by NASW. Starting with Service, the NASW Code of Ethics states that the main objective of a social worker is to "help people in need and address social problems." In regard to Social Justice, the NASW states that social workers are supposed to engage with and act in support of marginalized populations of people. Child abuse and neglect is a social problem that permeates this country, classifying children as a marginalized population. Social workers employed in pediatric medical settings are in a central and critical position to intervene by providing education and resources and notifying the appropriate authorities when needed. Social workers have a duty to protect children and to advocate for their well-being in direct practice and by enacting policies that will keep them safe.

The third ethical principle, Dignity and Worth of the Person (NASW, 2021), states,

> social workers are cognizant of their dual responsibility to clients and to the broader society. They seek to resolve conflicts between clients' interests and the broader society's interests in a socially responsible manner consistent with the values, ethical principles, and ethical standards of the profession.

> Per the fourth ethical principle, Importance of Human Relationships, social workers understand that relationships between and among people are an important vehicle for change. Social workers engage people as partners in the helping process. Social workers seek to strengthen relationships among people in a purposeful effort to promote, restore, maintain, and enhance the well-being of individuals, families, social groups, organizations, and communities. (NASW, 2021)

When applied to pediatric medical settings and social workers' unique roles within these systems, they have continued opportunities to use their knowledge and communication skills to improve their relationships with other members of the medical team. This also affords social workers the ability to work closely with other members of the medical team to enhance their understanding of child abuse and neglect, and to help better meet the needs of these children and families who enter the hospital system. This should be done in the context of advocating for the safety and well-being of the children they have been entrusted to care for.

The final two ethical principles are Integrity and Competence. According to the NASW (2021), social workers have a duty to conduct themselves in a way that demonstrates they are trustworthy (integrity) and that they have a responsibility to engage in ongoing education to continue developing their knowledge base and skill set to benefit the individuals they serve (competence). The results of this study emphasize the need for social workers who are in positions to assess for abuse and neglect to receive continuous training and support for them to remain competent and credible members of the medical

team. This will also assist in their ability to complete thorough and accurate assessments and to provide the most appropriate interventions when dealing with this vulnerable population.

Recommendations for Social Work Practice

Action Steps for Social Workers

The need for ongoing training and education was emphasized by all research participants, and not just for social workers. One social worker in Orlando discussed a simulation program offered through the University of Central Florida in which live actors are used to mimic real situations. This participant suggested that simulation can be used to mimic a situation in which there are concerns for abuse or neglect of a patient. The simulation can incorporate the various disciplines of the healthcare team so that they can gain a better understanding of and perspective on what social workers are capable of in these situations.

While it is extremely important and beneficial for physicians to be educated on what it means to be a social worker and to develop a greater understanding of what social workers' skill set entails, it is equally important that social workers engage in continuing education. One research participant suggested that social workers employed in this area should be expected to maintain training and certification related to child abuse and neglect for licensure. She also proposed that social workers in this environment be provided with ongoing, active supervision by a more experienced social worker.

Social workers need to be mindful of the NASW Code of Ethics and how it applies to their roles as pediatric medical social workers. Social workers should

constantly analyze their own behaviors to ensure that they are practicing within the confines of the Code of Ethics. They should use the Code of Ethics to advocate for themselves, to advocate for the children they encounter, to stay up to date on current practice guidelines and educational opportunities, and to enhance their relationships with other medical professionals.

As mentioned previously, one finding of this study was that some medical institutions lack clearly defined guidelines and policies to assist social workers who are tasked with identifying signs of abuse and neglect. This presents a unique opportunity for social workers to become involved and advocate for policy changes in their places of employment. Social workers have knowledge and experience that differ from those of all other medical professionals and that only they can offer in these settings. This knowledge and experience affords social workers the ability to become actively involved in developing policies and procedures that will help guide them as they interact with the children and families they encounter in these medical settings.

Impact on My Own Practice

The findings of this research will impact my own practice as an advanced social work practitioner in a multitude of ways. I am employed by a large healthcare system in Florida that treats both children and adults. Although I currently work in the emergency department of a hospital licensed to treat adults, I spent many years working primarily in pediatric hospital settings. Additionally, children are frequently brought to the emergency department at this hospital for medical care due its proximity and accessibility to local residents.

Due to my years of experience as a medical social worker, I have been often tasked with precepting new employees, both social workers and nurses, who come to work in the care management department. Many of these new employees have no or limited experience working with children in this setting. I take my role as a preceptor very seriously and provide as much education as possible, particularly when a child is brought to the hospital under suspicious conditions. Additionally, I serve as a Qualified Supervisor for social workers who are seeking licensure.

While I do advocate for children and provide the appropriate interventions when I am concerned about abuse and neglect, at times there are disagreements with physicians or nurses about my decisions in these situations. I realize that as a result of this study, it has become abundantly clear that these conflicts with other members of the healthcare team often impede the completion of adequate assessments and reporting by medical social workers. This has reinforced the need for me to teach new employees and social workers whom I supervise how to advocate for themselves and how to address these conflicts when they occur.

During my early years as a pediatric medical social worker, I participated in a committee to overhaul the hospital's policy on child abuse and neglect. Looking back at this experience, I realize how uninformed I was about policy development and how vague the final product was in this instance. This experience, along with the results of this research study, has emphasized the importance of including social workers in the creation of social policies in the medical setting. It has also highlighted the importance of understanding what is stated in policies, how to interpret them, and who to go to for

additional guidance and support. In my role as a preceptor and a Qualified Supervisor, it will be necessary for me to make sure that the social workers I am responsible for have a thorough understanding of the policies and procedures related to child abuse and neglect.

Transferability to the Field of Social Work

Although the sample size for this study was small, the participants were practicing social work in three different states. As a result, the results of this study are transferable to the field of social work in a number of ways. All six social workers interviewed identified reasons why social workers do not adequately assess for signs of abuse or make a report when these signs are present. Some participants had firsthand experience of other social workers not reporting. It would stand to reason that this is also happening in other pediatric medical settings across the country. If social workers currently working in pediatric medical settings read this study, it may prompt them to examine their current setting of employment and their personal practice, as well as the practices of their social work peers. When applied to their current work setting and practice, these results may help other social workers feel less alone and frustrated with their experiences. Knowing that this problem exists in other settings may inspire social workers to seek out extra assistance and guidance, serve as mentors to their peers, or advocate for change in their workplace. Some of the suggestions for improvement that were identified in this study can also be applied to other pediatric medical settings.

Usefulness of the Findings

The findings of this study serve several purposes. Regarding social work practice, various pediatric medical settings can be examined to assess how social worker practice

is impacted when confronted with situations involving abuse and neglect and where changes can be made. Perhaps change could take the form of providing social workers with more education and opportunities for training so that they feel more confident in their responses when assessing for abuse and neglect. It could be helpful to create a space that is nonpunitive and nonjudgmental in nature for social workers to discuss their cases with their peers or to have a supervisor help them make informed decisions that will serve the best interests of their patients.

Regarding research, at the time this study was initiated, it was the first study of its kind. The results of this study have opened the door to an area that had not been previously explored. In turn, this study can foster further research in this area, resulting in other significant findings related to pediatric medical social workers that can be applied to social work practice. Additional studies can be completed with a larger pool of participants, and the areas of focus can be narrowed to include specific settings such as outpatient areas, or they can be widened to include greater diversity in settings such as hospitals, freestanding emergency rooms, clinics, and pediatricians' offices.

Social workers should play an active role in examining existing policies and amending them or creating new ones altogether. The results of this study demonstrate that policy changes can be made in several areas. Regardless of the setting, social workers are likely to come across situations that involve concern for child abuse and neglect. All research participants identified the need for additional education and training in this area. It would behoove schools of social work to adopt the policy that child welfare is a mandatory course for all students. Once employed in the field, pediatric medical social

workers would benefit from workplaces that provide clearly defined policies on child abuse and neglect assessment and reporting. At the state level, social work licensing boards can create policies mandating that social workers who work in areas associated with child welfare meet ongoing education and training requirements in order to maintain their licensure.

Limitations

There were several limitations to this study. The sample size for this study was relatively small. Additional research can be conducted on a larger scale with a larger participant pool that would include social workers with more diverse experiences from various pediatric medical settings. Five of the six research participants in this study worked in a hospital, and one had a dual role of working in a clinic and within the hospital. The participants represented the states of Florida, Tennessee, and Texas. Including participants from other areas of the country could help in investigating the experiences of social workers in different states. Exploration of other medical settings such as more clinics, freestanding emergency rooms, urgent care centers, and pediatricians' offices would be beneficial. Furthermore, completing this study with a focus group rather than individual interviews would have allowed for greater discussion and sharing of experiences.

Recommendations for Further Research

Because this was such a small sample size, completing the study with a larger number of social workers from different pediatric medical settings in other states would help to determine how widespread this problem is. For example, the sole research

participant who worked in a clinic discussed how when child protective services needs to be involved, it is seen as a team approach, and it is presented to the family that the decision to report was made by the entire treatment team. Social workers in the hospital setting discussed frequent conflict with other members of the healthcare team when reports of harm needed to be made. The differences in these two settings and the role the social worker plays in the medical team are worthy of research and exploration.

Supplemental research could also include other states' requirements for social workers employed in pediatric medical settings in terms of continuing education and licensure. As some research participants suggested, requiring a certification in child welfare may be beneficial. Additionally, policies and procedures related to child abuse and neglect at a multitude of hospitals could be examined and compared.

Dissemination of the Findings

One way dissemination of the research findings could occur is via publication. This could include publication in journals that cater to social workers, medical professionals, and child welfare workers. Another way would be to create a presentation for key stakeholders, including social work students and educators, social work departments within the hospital setting, and other departments in the hospital, such as physicians and nursing. Because the majority of the research participants for this study were located through social media, specifically Facebook groups designated for social workers, the information could be disseminated back into these groups.

Implications for Social Change

The results of this research have led to several implications for social change. Collaboration and effortless communication between social workers and other members of the healthcare team, specifically physicians, is paramount to ensuring reports to the appropriate authorities are being made judiciously and in a timely manner. One research participant with over 20 years of experience working in a pediatric medical setting presented a scenario that emphasized the importance of better collaboration and communication between social workers and the medical team. This participant addressed near drowning events, which requires active communication and collaboration between social workers and other healthcare professionals when assessing patients and families after an event has occurred. For example, social workers need to communicate with physicians to ascertain if this a situation in which the caregiver stepped away or was distracted for a brief moment and the child was under water for a cursory amount of time or was the child under water long enough to sustain an anoxic brain injury. This research participant stressed the importance of collaboration and communication between social workers and the medical team to discern if a child abuse report needs to be made.

Every research participant emphasized the importance of continuous education and training in regards to assessing for child abuse and neglect. Most participants reported a minimal amount of training being provided by their employer and stressed the need for ongoing education. Participants also highlighted the need for medical settings to establish better guidelines in terms of how to assess patients and families for abuse and neglect, what signs and symptoms to look for, and what situations should be reported to

authorities. This will eliminate confusion and subjectivity when assessing patients and families and in the process of deciding whether or not a certain situation requires making a report.

Almost all participants who work in a pediatric hospital reported they do not have continuous social work coverage or coverage in the Emergency Department (ED), leaving extended periods of time in which social workers are not physically present. These participants spoke about the dangers and concerns when a social worker is not physically at the hospital and there is not an on-call system in place to reach a social worker during these situations. One participant noted scenarios in which the staff in the ED have concerns for abuse or neglect, but the patient is sent home from the hospital with the family and a social worker is not notified until the next morning. Similarly, one participant discussed scenarios in which patients are admitted to the hospital or held in the ED. However, again the social worker is not notified until the following morning that there are concerns for abuse or neglect. Both participants who identified this as a concern further postulated that even if a patient is admitted to the hospital, there is too large of a time in gap in which a concern was noted and a social worker was notified, leaving vulnerable children in the hands of potentially neglectful and dangerous caregivers. This also results in a significant lag time in which these caregivers are inadvertently provided an opportunity in which they have time to destroy evidence, collaborate on a story to tell authorities, and to coach children on what to say if they are old enough and able to communicate. These gaps in reporting promote the loss of valuable time in which DCF and law enforcement could be involved and actively investigating the situation. Both

examples highlight a need for the presence of a social worker 24 hours a day, whether physically stationed at the hospital, or an on-call social worker who can be contacted to respond to intervene in these situations.

Summary

This study was conducted to ascertain why social workers in pediatric medical settings neglect to adequately assess for abuse and neglect and fail to notify authorities when concerns for or signs of abuse and neglect are present. I initially planned to complete focus groups with pediatric hospital social workers in Florida. However, due to challenges with recruiting participants and being unable to complete in person focus groups due to the pandemic, these plans needed to be changed. The study was expanded to all states, included various pediatric medical settings, and individual interviews were completed. Ultimately, six social workers with varying degrees of experience working in a pediatric medical setting participated in this study. The data was coded by hand and was organized by being assigned specific words to categorize common themes.

Study participants identified two main reasons pediatric medical social workers do not adequately assess for or report concerns for abuse and neglect. The first reason, which was agreed upon by all participants, focused on training and education for social workers. All participants agreed that social workers do not get enough education and training on assessing for abuse and neglect even though they are working in roles that require them to be knowledgeable and to respond appropriately in these situations. The second reason focused on social workers' interactions with other members of the medical team. Research participants provided various examples and scenarios of this occurring,

including disagreements between social workers and the medical team about when to report, social workers being asked not to report, and one social worker stating she stopped working at a pediatric hospital due to a physicians attempt to prevent her from reporting her concerns. Additional reasons for not assessing or reporting included the social workers personal experiences and beliefs, vague policies and procedures in the workplace, social workers not completing a thorough assessment, social workers relying others to make a report, social workers not knowing how to respond to a family expressing anger, working a "broken" child welfare system, and the negative impact reporting has on the relationship between the social worker and the family. Research participants highlighted several strategies that can be employed to overcome these barriers, including more training and education, more support from experienced social workers, better communication with the medical team, and the development of clearly defined policies.

The results of this study plainly demonstrate that pediatric medical social workers are failing to appropriately assess for, identify, and report signs of abuse and neglect for a multitude of reasons. However, many solutions were also presented during the course of this research. I am hopeful that the information obtained throughout this process will be utilized in pediatric medical settings to improve social worker's responses to abuse and neglect, resulting in timely interventions for such a vulnerable population.

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Appendix

Interview Questions

1. What state do you live in?

2. How long have you been a social worker?

3. Are you licensed?

4. Do you currently work in a pediatric medical setting?

4. What type of setting do you work in (hospital, clinic, etc.)?

5. How long have you worked there?

6. What are some reasons you think social workers don't adequately assess for signs of abuse and neglect or don't report their concerns when they do identify the signs?

7. What other barriers do medical social workers face when assessing for abuse and neglect?

8. What are some solutions to help social workers identify signs of child abuse and neglect and follow through on reporting their concerns.

9. Are there any additional comments you would like to make or anything else you would like to add?