Stakeholders Code Book Combined

Facilitators to Medical Evals of IPV-exposed children

- Acad/pediatric centers with radiologists, MRIs, resource heavy
- Reimbursable services
- Caregivers engaging in services
- **Team approach/partnerships/relationships/support amongst community providers (CPS) and medical providers, Child abuse experts**
- Presence of standardized policies in hospital/community

Benefits of a program to evaluation IPV-exposed children:

- Giving families peace of mind that child is physically ok (Families getting medical questions answered)
- Reassurance for CPS/social workers that child is physically ok (reduces burden of having to assess child's physical wellbeing especially in setting of parental minimization of violence)
- Especially helpful in non-verbal kids/babies
- Opportunity to intervene before worsening violence – prevent further exposure
- Support for parent through child's evaluation/focusing on the family's needs, not just the child
- Evaluation as first step in healing process for children/families

Benefits of Evaluations

- Discovery of an injury important for a child's outcome
    - Increasing child's safety
- Prevention of additional injuries
- Disclosure of an injury during interview
- Addressing ongoing/unmet medical needs
- Empower/engaging caregiver
- Mental health assessments of children

Evaluation of INJURED CHILDREN

Medical Evals of Injured Children

- Standard practice for exposure to violence
- No formal policy on evaluation of IPV exposed kids
- Standard/routine/objective aged based cut-offs for evaluation if injured after dv exposure
    - SS / MRI for routine evals
    - <2 (preverbal) esp with standard eval
        - <2, SS, < 6mos, MRI/head imaging, referral to CPT, CPS
    - Gray area for 2-5, physical exam?
    - >3, trauma sensitive / forensic interview (older children may disclose)
- Presence of injuries may change likelihood & nature of evaluation, safety planning

- If injured in IPV incident, fall under standard physical abuse work up guidelines/ Similar to evaluation of sentinel injury

Evaluating Uninjured Children

- No official policy in uninjured IPV exposed children
- Younger age are more likely to get testing
- Interviewing older kids
- Would not do full eval of uninjured child exposed to IPV, physical exam only
- Recommends standardized eval by cps/medical after ipv exposure regardless of presence of injury

Challenges of the ER as a setting:

- Emergency department environment/volume/chaos/competing responsibilities of staff
- Not knowing the family/not having the full story
- Not family or child friendly/not able to accommodate other children
- Time commitment (Lengthy ER visits (based on facilitation, sw eval, ed volume))
- Patient/family perception of the ED as a "scary place"
- Pediatric ER providers (sw) or DCF unable to align with parents' needs (this may differ from the IPV advocate)/Peds ED not caregiver-focused
- Adult health care providers uneducated about complexity of DV and demonstrate judgement when assessing victims
- Cost (might be more costly)
- Increasing workload for providers
- Not trauma focused or family centered

Challenges with the program:

- Lack of central coordination (including SS need, how, when follow up) / continuation of care if children don't show up / how to manage parental refusals
- Lack of clarity in ED process
- communication with ED or DCF
- Parental buy-in/parental refusal of eval
    - Lack of parental understanding about the program (perception child was not injured during eval and not knowing what is involved in the evaluation such as SS)
    - Logistical challenges (transportation, no gas money, paying for parking, money, no car seats, Skeletal survey is a second visit, childcare for other children!)
    - Framing of program as voluntary
    - Not wanting father to know about the eval (fear of abuser's reaction)
    - DCF supervisor dependent (are certain supervisors more successful with having children evaluated), leadership support
    - Worried about risk / discomfort of SS
    - Fearful of what can happen to their children
    - Parents not aware of program
- Increasing workload/wait times for providers (ED, DCF, SW)
    - Program adding to ed workload/increasing wait times

    - Increasing DCF workload (not wanting to wait in ed for hours
    - Added workload for social work
- How to interpret injuries
- Variable support from dcf leadership
- ED provider previous negative experience with DCF
- Propagating DCFs negative image in community
- Complexity of IPV cases
- Concern about maintaining victim's confidentiality
- Concern about dissuading victim from seeking help for self
- Expensive process/concern about insurance coverage
- Concern about negative patient experiences (Press Ganey)
- Challenges with frontline provider/DCF buy-in of the program
    - Buy-in related to acuity of incident
    - Prevalence of IPV so great, hard to know who really needs eval
    - Concerns about targeting high risk/low resource families (propagating racial bias)
    - Fishing for injuries/Suspicious of research
    - Belief that there needs to be more data/evidence

Challenges identified by CPS staff in IPV situations

- Children protective of parents
- Financial dependency on offender
- Getting fathers involved, difficulty with cooperation
- Immigration issues
- Lack of standardized work-flow
- Mental health and substance use contribute to challenges with IPV situations
- Minimizing violence
- Moms tolerating violence for stability
- Outcome case dependent
- Parents coaching children
- Parents fearful/worry about DCF taking child
- Parents not allowing interviews of their children
- Proving emotional impact on children
- Women who are not open to services
- Working the system

Challenges/Barriers in setting of IPV and routine evaluation

- Need more SW access
- Unclear how to evaluate uninjured IPV exposed kids
- Poor buy in if high frequencies of negative studies
- Inherent conflict in advocating for children / caregivers
- Unclear what to do if injury is found (safety planning)
- IPV groups prioritize moms wellbeing, child safety secondary
    - Not likely to get child evaluated for abuse
- Push back from IPV groups when trying to identify abused children

- Tension/conflict between IPV groups/child protection groups (CPS, CAPs) / structural antagonism/IPV group may variably report to cps even when child injured
- Complex relationship btw caregiver / complex problem
    - Dependance on abuser for finances/housing
    - Leaving abuser not always an easy option
    - Separation of child and parent
    - Caregiver inability to protect in setting of DV
    - Caregiver also victim, revictimizing through eval
    - Caregiver minimization of violence in home
    - Not wanting to punish/blame non offending caregiver
- Burden on System (new from complexity of IPV)
    - Medical eval lower priority in IPV case
    - Thinking about unintended consequences (burden on system/cps) of mandating a medical eval
    - Police/ CPS have more negative perceptions in community
    - Overwhelming ed/clinics (if every case to be seen)
- Challenging process for community ED providers/general pediatricians (not enough resources)/Barriers in community sites (distance, cost, inconvenience, training, imaging) that might prevent providers from undertaking eval
- Lack hospital based or CPS based guidelines on eval of ipv – exposed kids
- Limited psychological/mental health resources
- Pandemic related issues (worsening IPV, remote providers)
- Mandated report to CPS may be a barrier to care and caregiver engagement
- CPS involvement may escalate situation/violence
- Lack of recognition of IPV as a risk by medical provider
- IPV may interact with race and SES and thus propagate shame, bias
- Gender/culture/'immigration status may impact DV disclosure
- Concern of DV disclosure worsening safety for victim
- Providers not aware of IPV in family
- Speaking to non-offending parent without offending parent present
- focusing on individual victim, not family
- Am I doing more harm than good? (struggle- harm vs. good for these families, revictimizing the caregiver who is already a victim, risk/benefit factor before eval)
- Kids not likely to spontaneously disclose IPV
- Insurance paying for screening
- Concerns related to the CURES ACT
    - Abuser access to chart
- Risk of radiation from eval (risks of eval)
- Parental refusal
- Bias in who is screened

Community Response – sub group cps, ipv

- CPS reporting: Exposure to DV an acceptable report to CPS but NOT mandated to report
- CPS reporting: Automatic report to CPS if child involved in IPV

- Variable practice and response related to evaluating IPV exposed children (need to reduce variation, CPS worker - based, county vs state based, no routine eval)
- CPS should standardize the eval in young kids exposed and injured in IPV
- Relationships btw IPV groups/Medical providers strengthens response (IPV groups help with training providers and frontline staff, Real time IPV advocate presence in hospital (Warm handoff, task forces like CAB)
- One approach: Everyone gets information about IPV (similar to signposting) (not singling out people)

Approaches to involving CPTs in IPV cases

- CPT accessible via phone/chart or through connection with SW
- System of IPV referral outside of medical record(taking into context safety)- connects w/ medical record
- Use of EMR to refer to patients and collect data (Automatic involvement of CPT based on age and location of injury)
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Optimal way to evaluate exposed and injured children

- Minimizing risk to children (emphasizing/prioritizing safety)
- Family centered approach/ Family centered evaluation/services
- Leveraging child's eval to engage caregiver (to take time to discuss impact IPV has on kids more seriously)
- Balancing rights of children and caregivers
- Mental health/trauma follow up (use medical eval to engage in mental health)
- Psycho/developmental eval of children critical after exposure to IPV
- Centralized services for adults/children (housing cps, caps, IPV)
- Clinician-factors
    - Minimizing blame of non-offending caregiver
    - Being a good clinician (compassionate)
    - Knowledge that IPV has major health impacts
    - Building Trust for patients in the medical system
    - Keeping IPV in DDX
    - Meeting patients where they are in the journey of IPV
- Where/how eval should happen – variable feelings
    - ER ideal for work up in infants, urgent evals
    - Older children Child advocacy center or primary care physician-trusted provider (PCP may need support)
    - Younger children, non acute, CAP
    - Outpatient SS, evaluation is possible
- multi track system / Need to stratify risk
    - Acute response- eval in ed (if injured/ in the crossfire)
    - Non acute response -Other CAC, trauma informed response (child friendly, less acute care), PCP

Facilitation / Facilitators of Evaluation:

- caregiver awareness/buy-in about program expectations and logistics (need parental understanding of rationale and logistics of program)
- IPV advocacy for parent at time of child's evaluation
- Ongoing DCF staff training/education about engaging IPV-exposed families
- Child Abuse Pediatricians and Social workers as trusted facilitators
- Framing for mom why this is so important/persuasion of parents→ emphasizing child safety
- Program Adaptability
    - Iterative process- needs more tweaking
    - Flexibility/adaptability with the process
    - Willingness to Change to make it better for providers/patients
    - Presence of community advisory board
- leadership support key (if DCF supervisors buy-in, workers more likely to)
- Buy-in and awareness by frontline providers due to understanding rationale for program and having the belief that children should be assessed (understanding importance of medical eval)
- Understanding IPV doesn't occur in isolation

Needed to Standardize Polices /Procedures

- Need better data to inform standard eval for injured and uninjured kids in context of IPV (need for more research to guide practices)
- Law/polices to mandate child evaluation when exposed to IPV, tied to funding
- Routine/standardized, consensus approach is key (Decrease bias in eval)
- Need process in place for positive findings
- TRAINING of Providers/Professionals
    - Education of medical providers, cps investigators, shelters, IPV groups before implementing standardized evaluation
    - Need appropriate process of screening (quality screening) to identify IPV
    - Need equipped providers with skills/education (Protocols and guidelines, referral process for ed providers, order sets, what to do when ipv disclosed)
    - Training not sufficient to change practice / Need to practice skill (ipv identification/resources)
    - Creating access to IPV resources

Prevention Efforts

- Educating on healthy relationships
- educating caregiver about impact of IPV on child

Caring for Families Exposed to IPV- ED Social work perspectives

- Building trust with child
- Building trust with families- role of ER provider/SW
- Call 911, don't need to know any other numbers
- Day-to-day needs that need addressing when considering leaving IPV
- Discussing natural supports

- Enrolling in school
- Getting daily medications
- Honesty
- Letting caregivers know that you're a mandated reporter early on
- Making actual connection to DV advocate while in ED
- Making referrals to IPV services
- No blame/only support/meeting women at stage that they are in
- Not bringing home resources
- Reflection about children (using visits as an opportunity to reinforce impact of child)
- Reinforcing the decision to leave
- Safety first/assessment of safety
- Safety planning (mom and children)
- Support for children through parent's evaluation
- Utilizing services (IPV, DCF) before making new referrals
- Validation of feelings

Facilitators to CPS role in DV

- Families accepting services
- Honesty with parents
- Offenders taking responsibility
- Pre-existing relationship between family and DCF
- Providing parenting support/education
- Realizing psychological trauma for children (children emulating behaviors)
- Supporting family (holding kids while talking to mom) helping logistically
- Trust

Emotional Trauma for IPV victims/families

- Challenges of starting over
- Gaining safety at the cost of everything you know
- Psychological trauma for children and mom
- Uncertainty
- Vulnerability

Parental Perspectives

- Advice for HCPs
    - Safe words
- Barriers to leave
    - Financial Dependence
    - Repeating domestic violence cycle
    - Using children as pawns
- Facilitators
    - DCF Helping Families
    - Good/honest communication from DCF
    - Open to trauma follow up for children

    - Positive experience with DCF
    - Recognizing psychological trauma in children as a result of IPV
- Needs
    - Wanting to be heard/listened to
- Reaching Out
    - Comfort with reaching out for help in the future
    - More comfortable reaching out for help after experience with the program
    - Previously reached out for help
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