

ADVISOR

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The American Professional Society on the Abuse of Children™
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Keep moving forward

Editor: Carlomagno Panlilio, PhD



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The American Professional Society on the Abuse of Children in Partnership with the New York Foundling

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Editorial

Carlomagno Panlilio, PhD

...whatever you do, you have to keep moving forward

I cannot believe that it has been two years since Dr. Lisa Schelbe and I were given the opportunity to guide the *Advisor* toward new beginnings. We are grateful to have provided members of the APSAC community with a platform from which to share their experiences in fulfilling the promise to meet the needs of children, families, and communities. Although it saddens me to see a transition in our editorial team as Dr. Schelbe completed her term, I count myself lucky enough to have benefited from her guidance and mentorship. It is my hope to continue the pursuit of the goal and vision she put in motion during her tenure as Editor.

In her inaugural editorial for the *Advisor*, Dr. Schelbe highlighted the challenges that we as a field were faced with, which included the pandemic, racial injustices, and political tensions. She acknowledged our ongoing progress toward addressing these major challenges, and it continues to ring as true now as it did then that “we’re not there yet” and that “APSAC members are at the frontline...making a difference.” For example, despite the downward trend in COVID infection and death rates, there continues to be over 1,000 people dying every week (<https://covid.cdc.gov/covid-data-tracker/#datatracker-home>), highlighting the need to remain vigilant of the risks for and consequences of this disease for the children, families, and communities we work with. Social injustices continue to permeate our communities despite best efforts to promote diversity, equity, and inclusion practices.

For example, according to the Federal Bureau of Investigation (<https://cde.ucr.cjis.gov/LATEST/webapp/#/pages/explorer/crime/hate-crime>), biases related to race/ethnicity/ancestry continue to make

up a large percentage of hate crimes in the United States, increasing from 54% of 7,287 reports in 2019 to 64% of 7,287 reports in 2021. Anti-black or African American hate crimes rose from 27% in 2019 to 31% in 2021, still making up a large proportion of race-based hate crimes that continue to this day. We are also seeing an increasing trend in lesbian, gay, bisexual, and transgender hate crimes from 4% to 6% in the same time period, which may continue to rise with the passing of multiple anti-LGBTQ state laws such as those restricting gender-affirming health care (http://apsaclibrary.org/alerts_all.php#). We continue to see bias against women with the systemic and systematic dismantling of access to a full spectrum of medical care that includes abortion with the overturning of *Roe v. Wade*. This is particularly concerning given that such access is deemed essential health care by the American College of Obstetricians and Gynecologists (<https://www.acog.org/advocacy/abortion-is-essential>).

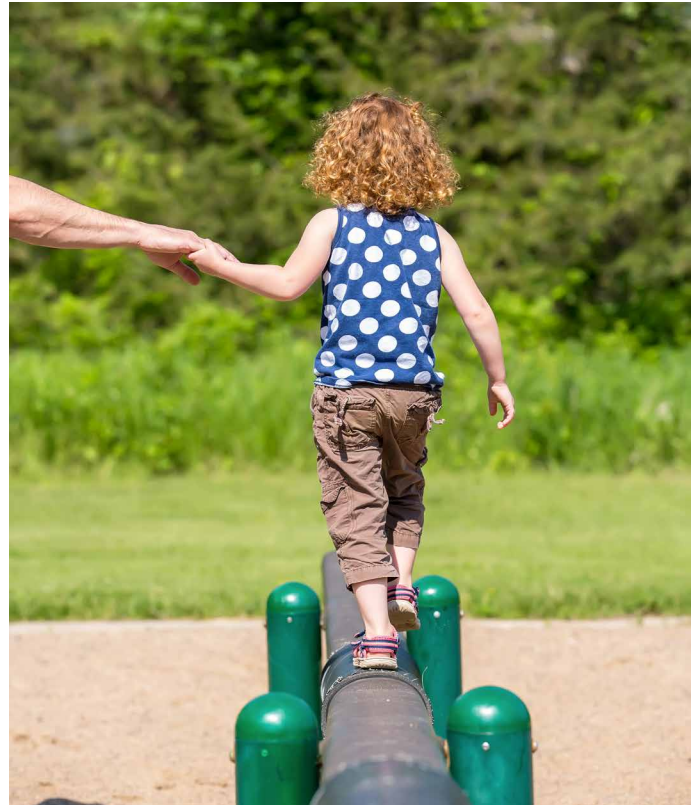
Unfortunately, these basic human rights have become fodder for politics that continues to thicken the tension and further the division of our country. Such basic human rights should not reside in a political aisle and instead should be a concern for everyone. APSAC members continue to be in the frontline, and regardless of policies being passed or revoked, each of you continues to meet the needs of our most vulnerable children, families, and communities. Despite limits on resources placed on our communities, each of you continues to find innovative ways to help families and to help each other. I echo what Dr. Schelbe had previously said in that “context matters” and these are the contextual factors that continue to influence the work that you do in the prevention of child maltreatment. The work that you do is made more difficult in these trying times and I continue

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to believe that we need to maintain our connection with each other and find support from one another. We do this no matter what the challenging context is, and if possible, embody what Dr. Martin Luther King Jr. said in a 1960 speech delivered at Spellman College that, “if you can’t fly then run, if you can’t run then walk, if you can’t walk then crawl, but whatever you do you have to keep moving forward.” As interdisciplinary professionals in the field of maltreatment prevention, creating a network of support can only help to strengthen our resolve to maintain forward momentum and continue to help uplift the children and families in our communities.

To this end, I am grateful to have been given the opportunity to follow in the footsteps of my dear friend, Dr. Schelbe, and to assume leadership of the *Advisor* as its Editor. Her leadership is a tough act to follow but, as mentioned at the opening of this letter, I promise to continue her vision and goal for the *Advisor*. I remain committed to bringing in empirical, practice-oriented articles that will be presented in a manner that can easily be translated into practice and policy. I will continue to increase emphasis on racial equity as is consistent with the APSAC Board of Directors’ position statement on eliminating systemic racism and implicit bias in the child maltreatment field (<https://www.apsac.org/fighting-racism-and-bias>). This is particularly important, as we are starting to see many in the field return to “business-as-usual,” to continue the fight against racial injustices. Therefore, each *Advisor* issue will continue to include a social justice commentary section that will continue to shine a mirror to ensure that we hold ourselves accountable to the promotion of equity.

I will continue to solicit new authors and new voices to bring in new and different perspectives in the community and the articles that we present. I therefore encourage our members, especially in practice across the frontlines, to submit practice-based articles that can provide other members with insights into what works (and what doesn’t) when delivering services to children and families in the communities. For far too long, most evidence-



based interventions have been implemented with the expectation of fidelity, yet most communities may not match what was used in empirical studies. Therefore, I welcome members to share their experiences and insights. As part of expanding perspectives and voices, I am also hoping to bring in voices from education given that schools, though a major source of CPS referrals and location for universal prevention efforts, have been absent in our conversations. As such, I encourage you to reach out to members of the education community who are your friends, colleagues, or multidisciplinary team members and ask them to join our APSAC community and share their voices through the *Advisor*.

I am excited to be in community with each of you and encourage you to reach out to me so we can have a dialogue. I would also like to recognize and welcome Ms. Crystal Marks, who has recently joined our team and is our new Director of Publications and Member Services. I can be reached at panlilio@psu.edu and Ms. Marks at cmarks@apsac.org.

Cultural Considerations for Families Involved in the Child Welfare System: A Focus on Middle Eastern and North African (MENA) Families

Marina Bassili, PsyD

Abstract

This article aims to examine cultural factors that impact ethnically diverse families who come into contact with the child welfare system and, more specifically, to highlight limitations regarding applications with Middle Eastern and North African (MENA) families. Much of the existing literature is focused on Latinx and African American/Black families in the United States. For this reason, researchers first aimed to highlight some of the specific, unique barriers that non-English speaking and non-Spanish speaking ethnically diverse families face when interacting with the legal systems. Many of these are first- or second-generation immigrant families whose native cultures and languages are not widely represented in the United States. Then, using a case study based on a first-generation immigrant family from North Africa, we provide an exploratory analysis of the additional disparities that MENA families may face outside what is commonly known to affect all ethnically diverse families. The case study is based on an interview completed with a social worker who was directly involved in the case. It underscores the need for more inclusive resources, including but not limited to interpretive services; doing due diligence to limit separation, when possible, in dependency cases; the need for more comprehensive cultural education for providers; and the need for additional research aimed at supporting these families.

Keywords: child welfare, dependency, culture, acculturation, immigrant families, cultural parenting practices, MENA, Middle Eastern, North African, Arab

Introduction

In 2021, Netflix, a media production company, aired a short series, *Maid*, which documents a young White woman, Alex, navigating the dependency system. Viewers learn that Alex is a victim of intimate partner violence, which she slowly learns to recognize herself only as the show goes on. In her efforts to shield her daughter from the violence, she stumbles into family court and is accused of unlawful removal of her daughter. From here, a custody battle ensues and Alex quickly has to learn what it takes to “prove” to the Court that she should be reunited with her daughter.

Although the series is a fictionalized representation, it portrays the harsh reality for many, along with the numerous catch-22s (i.e., situations in which the solution is also the cause of the problem) in the series. For example, Alex has to find employment quickly to demonstrate that she can provide financially for her daughter but does not have the funds to pay for daycare so that she can work. While seeking stable housing, she is met with barriers such as long waitlists for Section 8 housing, or landlords refusing to accept her housing aid. Like many who find themselves interfacing with social services, Alex struggles with poverty and homelessness, while battling her own mental health issues and the effects of inter-generational trauma.

MENA Families

In considering the series' rising popularity, the question has been raised, would this show have been a hit if Alex was Black? What if she was Latina or of Asian descent? The question begs us to take a step back and recognize that the plight of Alex, while difficult, has its advantages: Alex is a White, English-speaking, United States native with a high-school education and at least some access to social supports. In one episode, Alex sits in Court and attempts to make sense of the legal jargon being exchanged between her ex-partner's attorney and the judge, while she is *pro per* and has no legal background. All she hears is "legal, legal, legal."

Now, imagine you are Alex, but you cannot speak English, or it is not your native language. In another scene, Alex finds herself seeking assistance at the social services office and imagines her case worker calling her "White trash." Alex is easily able to snap out of it. Now, imagine if she was a Latina immigrant who had internalized a stereotypical bias of being perceived as "milking the system." Although the show does employ a number of characters representing people of color to subvert race-based realities that exist outside of the television series, these realities nonetheless exist.

Ethnically diverse families in the United States have long-faced disparities in the child welfare system. Even so, there are differences when comparing these disparities among different ethnically diverse groups navigating the child welfare system. For example, there may be advantages to being a person of color navigating "the system" when one is Black, or Latinx, compared with individuals who are non-English or Spanish-speaking immigrants, such as many Middle Eastern and North African (MENA) immigrants. More often than not, for a Black person in the United States, one's native language is English. This is not the case for many individuals of MENA descent living in the United States. While this is just one simple example of a potential advantage, it provides insight into some of the challenges that MENA families might face at the outset upon becoming involved with Child Welfare Services.

Of note, for the purposes of this article, the words *African American* and *Black* as well as *Child Welfare Services* (CWS) and *Child Protective Services* (CPS) will be used interchangeably. In addition, although there exists controversy around the term, *Middle Eastern* will be used interchangeably with *MENA* to describe people whose backgrounds are from the various Middle Eastern, West Asian, and Arabic-speaking North African countries (e.g., Egypt, Libya, Morocco, and so on), including but not limited to the Kurds and Assyrians, as well as immigrants from modern-day countries of the Arab world, Iran, Israel, Turkey, and sometimes Armenia.

Racial and Ethnic Distribution in the United States

Before one can begin exploring the specific challenges that MENA families may face upon coming into contact with CWS, it is important to first provide context about the demographic makeup of the United States. U.S. Census data from 2020 reveal that the White population remained the largest racial or ethnic group in the United States with 204.3 million people identifying as White alone. The Black or African American population, at 46.9 million, was the second-largest race alone or in combination group (outside of the "Some Other Race" alone or in combination group, which surpassed the Black or African American population at 49.9 million; Jones et al., 2021). Meanwhile, the Hispanic/Latinx population, which includes people of any race, was 62.1 million in 2020.

It should be noted that the aforementioned statistics may be misleading and inaccurate due to the way in which U.S. Census data are gathered and reported. Although beyond the scope of this article, some important considerations regarding U.S. Census data are that different terms (e.g., *Hispanic*) mean different things to different people, and historically, there have been advantages to claiming whiteness on the Census (e.g., due to segregation and discrimination, and efforts to avoid racialization; Demby, 2014). In

other cases, identification with “whiteness” could be a result of cultural assimilation.

Furthermore, the legal definitions of these race categories often differ from the social definitions, and the Census does not make a distinction between the terms *race* and *ethnicity*. According to the American Psychological Association (APA) (2020), *race* refers to physical differences that groups and cultures consider socially significant; *ethnicity* refers to shared cultural characteristics such as language, ancestry, practices, and beliefs. As such, these statistics fail to accurately account for individuals who may perceive themselves as being of one racial group but of a different ethnic identity (e.g., a person who racially identifies as Black and ethnically identifies as Hispanic). Similarly, many individuals of Latinx descent may check off “White” on the Census rather than Hispanic (e.g., because they do not speak Spanish and identify as Latino rather than Hispanic). However, they may not actually identify as White in their day-to-day life. This is apart from individuals who identify as mixed or multi-ethnic, or whose personal preferences on how they self-identify do not align with the categories offered by the Census, even when a “check all that apply” option is given.

To add an additional layer of complexity to the matter, the U.S. Census Bureau defines *White* in a way that differs from the colloquial use of the term. Specifically, the Bureau defines *White people* to be those “having origins in any of the original peoples of Europe, the Middle East, or North Africa.” Therefore, based on U.S. Census data alone, it is unknown how many individuals of Middle Eastern or North African descent actually reside in the United States. On one hand, many MENA individuals do not self-identify as White. On the other hand, counting MENA individuals in the “White” category may serve to overrepresent the group colloquially thought of as “White” (e.g., individuals living in the United States who are of European descent).

Efforts have been made to trace the number of MENA immigrants (i.e., individuals who are foreign-born and later emigrated) in the United States, and these efforts may provide a more accurate picture of the number of individuals who claim MENA descent. The first wave of migration from MENA regions dates to the late 1800s, though estimates of how many immigrants resided in the United States at that time vary. As of the 1920s, it was estimated that between 50,000 and 123,000 immigrants from MENA countries resided in the United States (Harjanto & Batalova, 2022). Since the 1800s, two major waves of immigration occurred: the first, from 1948 to 1966, was triggered by political instabilities in the region such as the Arab-Israeli war (Harjanto & Batalova, 2022). In 1965, the Immigration and Nationality Act ended the national-origins quota system, which gave preference to migration from northern and western Europe, resulting in the third wave. It is estimated that in 1980, there were about 224,000 MENA immigrants living in the U.S. (Gibson & Jung, 2006). In comparison, between 2000 and 2019, the MENA immigrant population doubled from 596,000 to 1.2 million, with about 68% immigrating from the Middle East and 32% immigrating from North Africa (Harjanto & Batalova, 2022). Although immigration increased, as of 2019, this population still represents less than 3% of the U.S. foreign-born population of 44.9 million (Harjanto & Batalova, 2022). Based on the 2019 American Community Survey (U.S. Census Bureau, n.d.), the highest proportions of MENA immigrants originate from Iraq (20.7%) and Egypt (17.1%). When looking beyond the immigrant population to the total number of Americans of MENA descent (i.e., beyond first- and second-generation immigrants), some Arab-American organizations place the estimate at 3.7 million Americans (Arab American Institute, n.d.).

Cultural Considerations: Working With Ethnically Diverse Families

Rogers and Bryant-Davis (2020) wrote,

“Community support is the outgrowth of collectivistic values, and when these values are disregarded and disrupted, Black people experience another form of historical trauma; the systematic destruction of Black families and communities has been observed from the capture and enslavement of African people to contemporary policies that economically penalize families with two parents living in the home. (p. 14)”

Based on the population of the United States, the systematic destruction of Black families is evident, as African American children disproportionately enter CWS at higher rates and exit at slower rates. Research has indicated that ethnically diverse families are more likely to be reported for child maltreatment compared with White families (Child welfare practice to address racial disproportionality and disparity, 2021). Black children continue to be taken from their homes, remain in foster care for longer periods, and are less likely to receive comprehensive services and reunify with their families compared with White children. Rogers and Bryant-Davis (2020) attribute these disparities to environmental and educational gaps in access to resources and opportunities as well as correlations with poverty and single-parent homes. Research further supports these assertions because when class and other risk factors (e.g., home and social environment, caregiver capability, and patterns of maltreatment) are controlled, Blacks have lower rates of abuse and neglect than Whites (Rivoux et al., 2008). However, high-poverty neighborhoods still exist due to governmental policies that purposely kept and still keep Black incomes low, which results in smaller

disposable incomes and fewer savings that ultimately pose barriers to accumulating wealth (Rothstein, 2017). Without accumulating wealth, poverty will continue to be a leading cause of the systematic destruction of Black families.

Another rationale for the systematic destruction of Black families is that CWS was not originally designed to serve the Black community. Child Welfare Services was developed toward the end of the 19th century along with the settlement house movement to serve the needs of thousands of poor and working-class White families who had emigrated from Europe. Due to this, the Black community had to develop its own social welfare agencies to care for the poor, aged, and dependent. It is notable that in the 19th century, the Black Church became the major catalyst for the creation of numerous institutions such as credit unions and banks, homes for the elderly, homes for unmarried mothers, orphanages, hospitals, schools, and colleges (among free Blacks during slavery and after slavery ended; Hamilton, 1986). Many of the developed resources were destroyed as a result of racial conflicts, such as in the Greenwood District. On May 31, 1921, a Black man was arrested for riding in an elevator with a White woman, which led to a confrontation at a courthouse in Tulsa, Oklahoma. This led to the White residents, some armed by the city, killing hundreds of Blacks and destroying the Greenwood District, which then was one of the wealthiest Black communities in the country (Hannah-Jones, 2021). The Greenwood District was known as Black Wall Street. In addition to tragedies such as the Greenwood District that occurred all over America, the ending of segregation, which led to the integration of various institutions, also contributed to the demise of many social welfare agencies. Furthermore, while CWS was not originally designed to serve the Black family, societal trends and institutional policies have inadvertently resulted in disparate impact on racial minorities (i.e., discriminatory effects).

In recent years, Latinx communities' involvement with CWS has steadily increased (Detlaff, 2008). Similar to Black children, Latinx children experience

different case outcomes and have lower rates of reunification than their White counterparts. Exploration of the factors that Latinx children face is essential to the literature since they are the largest ethnically diverse population in the United States. Recent research has noted that the proportion of Latinx children with substantiated reports of maltreatment has more than doubled in the last 20 years, the population of Latinx children in foster care has similarly risen, and substantiated reports were higher than for Black children (Davidson et al., 2019). However, one thing to note is that Latinx children are more likely to be placed with relatives than White children. Substantiation rates are relatively comparable between Latinx children and White children, though Latinx children are slightly more likely to have a report substantiated. Latinx children tend to be younger than White children when they are removed from their homes, and female Latinx children are more likely than Latinx male children to have abuse reports substantiated by CPS workers (Davidson et al., 2019). Furthermore, the researchers evinced that Latinx children spend less time being assessed due to being removed in a shorter period of time, and more time in out-of-home placements (Davidson et al., 2019).

Another factor of consideration for Latinx families in the context of social services is their immigration status. Latinx children whose parents are immigrants are more likely to live in poverty, which impacts risk of entering the system. However, immigrant families and especially those who have undocumented or noncitizen members have very low utilization of public services, thus limiting their interaction with mandated reporters. This could be related to beliefs that they are ineligible for services, fear of consequences due to their immigration status (e.g., deportation), and federal/state policies that prevent them from using those services. Several studies show that language barriers and factors related to immigration status also impact the experiences of Latinx families throughout their interactions within CWS (Davidson et al., 2019). Language barriers put Spanish-speaking Latinx children at higher risk of removal and termination of parental rights, chiefly

in areas with non-Spanish-speaking providers. Moreover, even in areas with Spanish-speaking reunification services, they are limited, and bilingual providers are scarce. In addition to a limited number of providers, there is a limited number of bilingual investigators. The limited number of bilingual investigators means that misinformation often occurs at the time of initial investigation. Investigators may rely on neighbors or their children to interpret, hindering the ability of caseworkers to make accurate decisions and provide services that will benefit the families. Lastly, immigrant families often experience high stress levels because of issues such as struggling with acculturation, difficulty obtaining jobs, and language barriers, which often are not considered when a case is developed.

Cultural Considerations for Non-English and Non-Spanish Speaking Families

Non-English- and non-Spanish-speaking families have concerns similar to those of Black and Latinx families, such as the systematic destruction of families via poverty, lack of cultural sensitivity, and immigration status. However, they are compounded with the finite investigators and providers who speak their native language, as well as a lack of information or misinformation about these families' cultural beliefs and practices. This is evident even in the current literature, which is limited with respect to non-native U.S. families who immigrate from countries outside of Latin America or Asia. These units are the minority group of ethnically diverse families who receive services. Thus, discussing and addressing the disparities they face is vital.

While the majority of families who come into contact with CWS are White, many are of other racial and ethnic backgrounds (Puzzanchera & Taylor, 2020). According to the Child Welfare Information Gateway, in 2019, American Indian and Alaska Native children made up 1% of the child population but accounted for 2% of the foster care population, while African American children accounted for roughly 14% of the child population and 23% of the

MENA Families

foster care population (Annie E. Casey Foundation, 2020; U.S. Department of Health and Human Services [USDHHS], 2020). White children made up half of the child population but represented only 44% of the foster care population. Latinx children were overrepresented in 20 states in 2018, despite having historically been underrepresented in foster care at the national level (Puzzanchera & Taylor, 2020). Meanwhile, some racial and ethnic groups are underrepresented in the child welfare system, though it is unclear whether underrepresentation is due to a lower occurrence of child maltreatment among these populations, or if it is caused by underreporting driven by either cultural norms or cultural perceptions that others (e.g., mandated reporters) have about these groups (Cheung & LaChapelle, 2011; Maguire-Jack et al., 2015).

A landmark study published in 2012, which compiled the first national data available concerning the involvement of children of immigrants in CWS, reflected that most children are of Hispanic/Latinx descent (approximately 67.2%), followed by non-Hispanic White (14.8%), non-Hispanic Black (10.0%), and non-Hispanic Asian (7.5%; Dettlaff & Earner, 2012). These children were categorized as “living with a foreign-born parent” and comprised 8.6% of all children who came to the attention of child welfare agencies in the United States at that time (i.e., due to various allegations of abuse or neglect). It should be noted that, among these children, 82.5% were born in the United States. No information was available with respect to other ethnic groups, such as those of Middle Eastern descent, potentially due to their small numbers at a national level, or due to the ways in which race and ethnicity are categorized and reported, or both. Although there is some research specific to immigrant families of Asian descent (Hou et al., 2016; Maiter & Stalker, 2010; Rhee et al., 2008; Chang et al., 2006), most of the literature groups together all immigrant families or primarily focuses on Latinx immigrants, as this group comprises a majority of ethnically diverse individuals who are not of the majority population in the United States.

This is important to highlight, as immigrant families represent one of the largest and growing populations in Western societies (Budiman et. al., 2020), but information regarding specific sub-groups is scarce. Although there are overlapping factors that likely apply to families immigrating from all parts of the world, and from which data can be extrapolated, there are some clear limitations to these findings in the literature as they might apply to families from less-studied backgrounds (i.e., non-Latinx, non-Asian American families) who nonetheless come into contact with the child welfare system, even if it is to a lesser degree. Many of the considerations, including risk and resiliency factors, highlighted in the literature may not be generalizable. Moreover, ethnically diverse populations are often grouped into a single ethnic group, instead of investigating different nationalities separately (e.g., Chinese or Korean, vs. Asian; Lebanese vs. Middle Eastern). Such grouping leads to overgeneralization while overlooking the influences of distinct cultural norms and attitudes (Huisman, 1996).

Similarly, stereotypes regarding their cultural beliefs and practices stemming from the media or current cultural sensitivity trainings may be misapplied or overgeneralized to families whose cultural practices are less known, leading to additional cultural barriers and even subconscious dehumanization at times. Some examples include preconceived notions and perceptions of Middle Eastern culture that have been shaped primarily by political relations between the Western world and regions that make up what is known as the Middle East (i.e., the Levant, North Africa, Iran, and Turkey; Shaheen, 1985). Such perceptions may include preconceived notions about religious beliefs, conservative values, cultural dress, and phenotypic presentation that, in reality, vary immensely from country to country, region to region, and from one family to another.

More broadly, assumptions may be made about certain cultural practices or beliefs that do not apply to all families of any one cultural or ethnic background. Thus, a family may not be viewed as a unique set of individuals, but rather categorized

under a label. Above and beyond harmful stereotypes, there is also an increasingly hostile public attitude toward immigrants (Dettlaff & Earner, 2012), which can result in further isolation and the development of a protective sense of fear and paranoia. This is above and beyond racial biases, such as those based on phenotype, which the research has demonstrated to impact the treatment and outcomes of ethnically diverse families involved in child welfare.

For immigrant families in particular, a number of risk factors exist that can lead to elevated risk of involvement in the child welfare system, such as traumas sustained in the home country (e.g., due to political or religious persecution), and other difficulties associated with migrating to another country, including separation from loved ones. However, it is important to recognize that most immigrants choose to leave their countries because the financial, social, or political situation in their own country has left them with no other options (Segal & Mayadas, 2005). More often than not, parents are in search of better prospects if not for themselves, then for their children and later generations. Professionals who work with these families should thus work to build up the family unit while providing support and education about the practices of the host culture. This strategy seeks to avoid dismantling the family unit and causing further traumatization for immigrant families already under stress.

Additional risk factors that are often faced by immigrant families include financial challenges, including lack of employment opportunities and inadequate financial resources, the loss of previously established support systems, loneliness and isolation, and language barriers (Finno et al., 2006; Maiter et al., 2009). These factors fall into the larger umbrella term of *acculturative stress*, which results when individuals lack the skills or means necessary to interact with—and flourish in—their new environment (Berry, 2006; Lakey, 2003). In addition, increased parenting stress has been observed in immigrant parents, who may no longer feel that they are in control (i.e., in the parental role) and have lost a sense of closeness to their children. This can be a function

of differences between the majority culture (to which the children often more easily assimilate and adopt, to a degree) and the culture of origin, or as a result of other stressors (e.g., mother figures who traditionally would not work being required to obtain employment, etc.).

Immigrant families in the United States, especially those whose native language is not Spanish, also often face the added challenge of interpreting the laws and social norms of the majority population or host country, which often differ in important ways from their native culture (e.g., parenting norms). Moreover, they must do so with limited support and resources, even those as simple as the translation of materials into their native language. Oftentimes, parents rely on their children to translate important information, which can be viewed negatively by the host culture as contributing to parentification or, at the very least, as developmentally inappropriate. Another risk factor that has been well-established in the literature and is associated with increased risk for involvement is poverty (Bywaters et al., 2016). In many Western countries, immigrant families live far below the poverty line. For many, this can result in allegations of neglect and children's removal from their natural homes (Miller et al., 2012). Due to the struggle with poverty, the family system can be dismantled instead of being supplied with resources.

An additional challenge is that child-rearing practices that are deemed acceptable and non-abusive by the host culture are socially constructed. In many Western cultures, Eurocentric ideals may be so widely accepted that they are adhered to as the standard, rather than as one of many acceptable approaches to child rearing. Meanwhile, many families who come into contact with CWS are of other backgrounds, although the majority of families who continue to come into contact with CWS are White (Puzzanchera & Taylor, 2020).

Moreover, legal mandates are often vague with the intent of allowing for case-by-case decision making and intervention. However, in practice, the effect is oftentimes that more punitive measures are taken, and a one-size-fits-all approach is applied based on

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precedence, rather than on cultural responsiveness. This is especially true for legal mandates related to the use of physical discipline or corporal punishment. For example, in California, *child abuse* as classified under Penal Code 273d occurs when a person willfully inflicts upon a child any cruel or inhuman corporal punishment or inflicts an injury resulting in a traumatic condition. However, the research indicates that immigrant families involved with child welfare hold varying cultural values and beliefs about child rearing (Fontes, 2005; Earner, 2007; Dettlaff, 2010; Reisig & Miller, 2009). Thus, what is regarded as an appropriate form of discipline in one culture may be labeled as inappropriate or even abusive in another, and vice-versa. Families for whom there is limited information or knowledge about their respective cultural practices, such as immigrant parents, are then at risk for having their parenting practices categorized as abusive by the mainstream culture, which holds predominantly Eurocentric child-rearing values.

Specifically, with respect to corporal punishment, which is the most prevalent allegation in ethnic minority families that come to the attention of CWS, some researchers question whether or not the institutions responsible for identifying cases of abuse hold biases that lead to this overrepresentation (e.g., Maiter et al., 2004). This is because the same proportion of cases (i.e., allegations of physical abuse) are ultimately substantiated in the immigrant compared with the non-immigrant/native population. Even in the literature, while it is noted that different ethnic and cultural groups hold varying beliefs about the use of corporal punishment, such practices are categorized as “violent” in nature and painted negatively. This is not to discount or negate the potential harms associated with exposure to such practices, which are well-established in the literature on trauma and physical abuse (Malinosky-Rummell & Hansen, 1993; Putnam, 2006); however, it highlights the need for understanding and education for both families involved with child welfare as well as the professionals who are charged with identifying and substantiating cases of true

abuse. For example, in some cultures that use corporal punishment, the focus may be more on the intent of use as a protective disciplinary practice, rather than on inflicting harm or stemming from anger. Unfortunately, misunderstandings about the extent to which corporal punishment is viewed as normative in a certain sub-culture and the degree to which it is used can then lead to increased child welfare involvement and subsequent family disruption, as appears to be the case for one of the two families described. This effect is compounded when there is a lack of training and education within the system on how to serve families in a culturally responsive way, as well as a lack of cultural representation within the network of professionals who are available to serve these families.

Additional factors that the current literature highlights are as follows: the taboo of disclosing information about the family to people outside of the family or immediate social support network (e.g., high conflict in the home, maladaptive parenting practices, the presence of intimate partner violence, etc.), stigma against seeking professional help, a lack of trust in professionals who represent the mainstream culture (or who are simply from a different background, i.e., “other”), and cultural values of loyalty to the family and the importance of the family unit, which may look different for non-Westernized cultures (Maker et. al., 2005). In addition, other cultural values may reflect a hierarchical or authoritarian style of parenting that emphasizes obedience and respect from children, while simultaneously placing strong value on closeness, protection, and interdependence within the family (i.e., fostering intra-familial, communal bonds versus independence and individualism, the latter which are more reflective of Western cultural values; Ma et. al., 2013). Although these values are often considered risk factors within the literature, some researchers suggest that they be viewed as sources of resilience to be used in a strengths-based, individualized approach to intervention rather than a generalist approach.

Cultural Considerations for MENA Families

The International Organization for Migration (IOM) defines the *MENA region* as including Algeria, Bahrain, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco (and Western Sahara), Occupied Palestinian Territories, Oman, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, the United Arab Emirates, and Yemen. Despite many shared values, it is important to note that these countries differ vastly in terms of racial and ethnic composition, religious composition, and economic development. While most MENA individuals identify as either Muslim or Christian, Jews, Hindus, and other religious groups are also represented in MENA countries, though in much smaller numbers (Haboush, 2007). Traditionally, identification with one's religious background often precedes identification with one's nationality, and religion affects all aspects of life, including child-rearing practices and views regarding mental health services (Haboush, 2007). Thus, it is important to assess for and consider a family's religious identification as well as their degree of observance of their faith in order to provide culturally sensitive intervention (Haboush, 2007). Furthermore, it is just as important for practitioners to develop an understanding of the religious background from which a family comes in order to adapt their practice to align more with a family's cultural intersects and demonstrate respect for the family's faith (O'Leary et al., 2020).

In terms of additional cultural values, it is also important to consider that MENA culture is largely patriarchal and authoritarian with an emphasis on family honor (Al-Krenawi & Graham, 2000; Erickson & Al-Timimi, 2001; Haboush, 2007). Similar to Latino, Asian, and Native American cultures, MENA culture is also more collectivistic than individualistic. That is, where Western culture emphasizes individual achievement and autonomy, MENA culture emphasizes community and its interests, or the collective good (Haboush, 2007). However, the extent to which MENA individuals residing in the U.S. may identify with collectivistic

versus individualistic culture can vary depending on a number of factors, including their immigration history and level of acculturation. For example, such ties to an individual's country of origin may be different for a first- or second-generation MENA immigrant compared with a third- or fourth-generation immigrant. This is because families who have immigrated more recently are believed to move through several "stages of acculturation" in which they may alternately accept and reject parts of their own and the dominant culture before establishing a more integrated cultural identity (Erickson & Al-Timimi, 2001). In the United States, the majority culture is Westernized and historically has been described as being composed of individuals who identify racially as White (Ortiz & Flanagan, 2002).

Thus, when considering immigrant populations from the MENA region, it is also important to consider personal history of immigration in some depth, as it provides a contextual framework for potential risk factors for entry into CWS as well as important treatment considerations (Maker et. al., 2005). Moreover, it is important to consider a potential history of personal as well as intergenerational trauma. Since the late 1880s, many MENA families have immigrated to the United States as a result of political instability or war in their country of origin, or due to religious conflict or persecution. More recently (i.e., since the 1990s), the Gulf and Iraq Wars, as well as the Arab Spring rebellions, have resulted in increased immigration from MENA countries to the United States. These families may arrive with symptoms of posttraumatic stress disorder (PTSD), have lower levels of education, fewer economic resources, and maintain closer ties to their country of origin (i.e., remain less culturally assimilated; Erickson & Al-Timimi, 2001; Nassar-McMillan & Hakim-Larson, 2003). Thus, there are varieties of reasons for which an individual or family may leave their country of origin and immigrate to the United States, ranging from individuals who immigrate as refugees to those immigrating with a high level of educational achievement and financial resources in pursuit of better opportunities in the United States. Because individual experiences can

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impact functioning in a multitude of ways, especially those related to traumatic experiences, it is important to obtain a detailed narrative of the circumstances under which immigrant families came to reside in the United States when initiating contact.

As previously indicated, immigrant families are often faced with a number of psychosocial stressors, related to experiences both in their country of origin and upon immigrating to a new country. Research indicates that individuals perceived as being of Arab descent have experienced significant racism and discrimination since the 1980s, largely due to media coverage of crises such as TWA Flight 847, a flight from Cairo to San Diego that was hijacked by terrorists in 1985, as well as the 9/11 terrorist attacks on the United States in 2001 (Abraham, 1994; Abeulezam et al., 2017). Stereotypes of Arab or MENA populations have also developed as a result of such media coverage and have also been influenced by concerns of religious fundamentalism and Islamic radicalization; other stereotypes stem from association with terrorist conflict in recent decades (O’Leary et al., 2020).

To assess the potential impact of psychosocial stressors, including experiences of trauma and discrimination, on a family’s functioning, it is therefore important for providers to take the time to obtain a thorough psychosocial history. It is just as important, if not more important, for providers to challenge such stereotypical discourses in society at large and to address their own potential biases to dismantle prejudice (O’Leary et al., 2020). To that end, it can be helpful for practitioners to focus on identifying convergences rather than divergences between Western practices and traditional MENA practices (i.e., to focus on similarities and shared views on child protection; O’Leary et al., 2020).

Even though there is still limited research with respect to how to work clinically with MENA families in general, much less when coming into contact with CWS, the existing literature indicates the need for culturally sensitive counseling that conveys respect for the family’s values, even when they may differ from the provider’s personal values

(Haboush, 2007; O’Leary et al. 2020). For example, although a provider may be uncomfortable with the patriarchal aspects of traditional MENA culture, the provider should acknowledge their worldview and potential biases to effectively and respectfully collaborate with the family. Furthermore, the provider should be concerned with maintaining family cohesion and stability in ways that are culturally congruent, including avoidance of interventions that may threaten family unity (e.g., direct challenges to parental authority), as such interventions can lead to breaches in the working alliance, lead to family disengagement, and potentially result in the family terminating contact (Dwairy & Van Sickle, 1996).

Meanwhile, hospitality is strongly emphasized (Haboush, 2007). As such, providers taking extra steps to express interest in a family’s culture, such as offering tea (*shai*) upon initial contact can ensure families feel welcomed and thereby facilitate rapport. Along with such strategies, due to cultural values emphasizing respect for authority, providers should not assume that simply because a family appears to be comfortable in the working alliance that they will outwardly voice any disagreement with proposed interventions (Al-Krenawi & Graham, 2000). It is important for providers to adopt a more assertive, educational role in the provision of services, as this will align more closely with family values and potential expectations while assessing for levels of compliance or agreement in other ways. In other words, providers might rely more on other information (e.g., communication with community members or religious leaders, nonverbal signs, etc.) to help determine a family’s level of comfort and compliance with an intervention plan.

Finally, in traditional MENA culture, emotions are not as openly expressed, with the exception of anger in males (Al-Krenawi & Graham, 2000). Above and beyond outward emotional expression, certain topics are generally considered taboo and are not openly discussed, let alone with individuals outside of the family unit. Such topics include violence in the home, as well as topics related to sexual issues (e.g., sexual orientation, contraception, and sexual

abuse). Therefore, interventions that encourage open expression of emotions and discussion of such topics may alienate more traditional families (Haboush, 2007; Dwairy & Van Sickle, 1996). Moreover, when such topics are central to treatment or are the reason for which the family is coming into contact with CPS, it is important to establish strategies to account for potential fallout within the family (e.g., shame and rejection of the child who has made a disclosure about abuse, which can further traumatize the child; Abu Baker & Dwairy, 2003). It is common in MENA culture to look to the ethno-religious community, especially religious leaders (i.e., priests or imams), as well as relatives for social support and advice (Abu Baker & Dwairy, 2003; Nassar-McMillan & Hakim-Larson, 2003). On this basis, one strategy suggested in the literature is to establish alliances with religious figures in the community who may be able to facilitate communication between providers and the child's family, including extended family, to mitigate complications as a result of rejection of the child (Abu Baker & Dwairy, 2003).

Methods

Researchers conducted an interview with a social worker, Mr. Mina Youssef, who was directly involved in the following case. Mr. Youssef is a Licensed Clinical Social Worker (LCSW) in the state of California who was employed by CPS in three counties between 2012 to 2020. Mr. Youssef is of Coptic (Egyptian) heritage and reported being one of three social workers in the region who was Arabic-speaking and of MENA descent out of approximately 300 social workers.

Mr. Youssef had three primary roles within CPS, which he described as investigative social worker, case-carrying social worker, and placement-finding social worker. In the course of his employment in these specific roles, he estimated having worked with approximately 500 families from a broad range of cultural backgrounds, only a small minority of whom were of MENA descent. He was unable to provide estimates of the demographics with which he worked most due to being assigned to different

regions with varying demographic makeup, but he indicated the majority of his clients were of Latinx backgrounds. At times, he would be asked to assist other social workers working with MENA families because of being bilingual in English and Arabic and due to his own MENA heritage (as applies to the case outlined next). Additional information regarding Mr. Youssef's credentials and experience may be provided upon request.

It is important to note that this case remained open and active as of the dates on which Mr. Youssef was interviewed in November 2021. His interview was conducted via a video-conferencing platform over two sessions and was recorded with his permission. No identifying information was provided directly to the authors, due to the ongoing nature of the case. Thus, all information provided here was received second-hand, and the authors of this manuscript did not directly interact with the family involved. Mr. Youssef further indicated he was not the primary social worker on the case but was asked to assist due to his experience in the field and shared cultural background with the family.

Case Background

The following case study places into perspective a number of the aforementioned risk factors and barriers that MENA families, as well as other non-English and non-Spanish speaking families, may face when coming into contact with the child welfare system in the United States. This case involves a Coptic family that recently immigrated from Egypt to the United States. The family, consisting of a single mother and three children (ages 11, 6, and 5), was referred to Child Protective Services due to allegations of physical abuse. The mother did not speak English, and English was a second language to the children. No additional demographic information was made available to the authors.

The case was referred to CPS by the school after "Michael," an 11-year-old boy, told his teacher he did not want to go home because he was afraid his mother would hurt him. When CPS workers arrived, they discovered a mark on his chest and

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the child reported his mother had “stabbed” him. The mark did not look like a stab wound but rather was a very small mark, which Mr. Youssef described as “something little to nothing.” However, Michael reported his mother hits him when they are at home, as well as his 6-year-old brother and 5-year-old sister. When the other children were interviewed, they denied any physical abuse. Similarly, when the mother was interviewed, she denied any history of physically disciplining the children. It was noted that she appeared to respond in the negative (i.e., answered “no” to all questions) when asked about any form of inappropriate disciplinary practices.

Based on the discrepancy between the mother’s and Michael’s reports, a case was formally opened. A non-Egyptian, non-Arabic-speaking worker was assigned to the case. Michael eventually recanted his statement, saying he made up the accusation that his mother had stabbed him. However, he stated his mother did use corporal punishment, such as with a sandal, which is very common in Egyptian culture. The mother’s adamant denial of any and all allegations led to problems between herself and the case worker and raised questions about the credibility of her statements. Based on Mr. Youssef’s report, the mother did not view any of the practices in which she was engaging as potentially physically abusive, but rather as normative disciplinary practices. Overall, the mother’s stance that she would never harm her children led to difficulties acknowledging that, by child welfare standards, her disciplinary practices were harmful and warranted intervention. Ultimately, CPS determined the allegation to be substantiated, which resulted in the removal of all three children from the home. It should be noted that Mr. Youssef indicated that he believes the mother’s practices, while potentially problematic, were not warranting of a substantiation of physical abuse and subsequent removal (i.e., based solely on the minor injury of his chest). Furthermore,

he stated that, were the mother able to speak the same language as the case worker, she may have been able to advocate for her family’s needs and explain their cultural values and practices.

The court ordered for the case to be open for 6 months from the day of Jurisdiction Disposition, approximately 9 months since removal. The children were placed in a resource home together because the mother did not have any relatives living in the state, and she was unable to identify any other supports who could house the children. The mother was eventually granted supervised visitation with the children. During visitation, the social worker noted that the mother appeared to be making references to the school or the court in Arabic and advised her that she could not speak to the children about the case. The mother indicated that she was not talking to the children about the case and explained she was telling them when she might pick them up, and so on. However, similar events took place during subsequent visitations and the social worker requested an amendment to the family’s plan to include a restriction for the mother to speak to the children only in English.

At a subsequent visitation, the mother slipped and spoke to the children in Arabic. It should be noted that Mr. Youssef indicated the mother did not speak to the children about the case, but simply spoke to the children in their native language by accident. Nonetheless, the social worker recorded the interaction as being in violation of the court mandate and reported it to the Court. The case was further prolonged as a result, and relations between the parties involved in the case became increasingly negative. For example, although the mother continually requested for the children to be placed in a Coptic home, minimal efforts were made to accommodate the mother’s request. To date, the children have not been placed in a culturally congruent home.

Key Issues:

- Language barrier between the mother and professionals involved in the case.
- Limited availability of case workers with a cultural background similar to the family's.
- Limited knowledge within the Agency regarding normative cultural parenting practices and cultural values, including discomfort in sharing private family matters with individuals outside of the family unit.
- Minimal efforts to locate an appropriate resource home for the children (i.e., a Coptic family) to maintain ties with the mother and maintain the same ethno-religious structure for the children (e.g., attending Coptic services on Saturdays and Sundays, using the Arabic language in the home with the children, etc.).

Discussion

The key issues highlighted in the preceding case study demonstrate a number of limitations to effective intervention with ethnic minority families when interacting with the dependency and delinquency system. The most obvious limitation in this case was the linguistic barrier between the assigned case worker and the mother. Although attempts were made to mitigate the impact of the language barrier, via consultation with Mr. Youssef, who could relate to the family on a linguistic and cultural level, these efforts were inadequate. The lack of understanding on the part of the assigned social worker in terms of the mother's ability to effectively and naturally communicate with her children in a language she could not speak proficiently had clear consequences for the family. Moreover, had the social worker assigned to the case been able to understand the mother from the outset of the family's involvement, they may have been able to develop a working alliance and mutual understanding. Rather, this case was prolonged and complicated by the lack of a working alliance between the family and the professionals involved.

Several additional factors that resulted in the potentially unnecessary separation of the children from their family and broader community may have been avoided had the assigned case worker better reflected or understood the cultural norms and values of the family to which they were assigned. The obstacles this family faced in interacting with CWS also highlight the need for providers to take and maintain a stance of cultural humility, or an openness and eagerness to learn about other cultures and the intersectionality of those cultural identities, rather than a stance of authority. Based on this case, it appears the case worker involved made limited efforts to understand the mother's perspective, resulting in an increasingly negative relationship and likely prolonging the reunification process. Moreover, although the mother was eventually granted visitation, there are clear indicators of a lack of cultural sensitivity and responsiveness in the manner in which visitation was executed. For example, the mother was forced to interact with her children in a way that was unnatural to her during visitation by being barred from speaking to her children in both her own and their own native language. In addition, the children were removed from their Coptic ethno-religious community and their home only shortly after immigrating to the United States themselves. Had ancillary efforts and measures been taken, a family from their own community might have been recruited to foster the children after all efforts were made to maintain the family intact.

Moreover, on a policy level, the legal mandates leading to the substantiation of the allegation of physical abuse did not, and do not, account for ways to address the differences in child-rearing practices among families of immigrants from cultures that condone the use of corporal punishment. One such intervention for this family may have been to educate the mother regarding the legal mandates of her state and the use of corporal punishment first, prior to asking about the use of inappropriate disciplinary practices. This may have resulted in more openness and understanding on the mother's part, rather than defensiveness, and ultimately would have strengthened the alliance between the case worker and the parent.

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Although it was not explicitly raised as an issue in the case study above, an additional cultural consideration that can come into play is when a cultural gap exists not only between the family and the providers involved in service provision but also within the family itself. As with many immigrant families, there may be differences between the host country's norms and values, the parents' native country's norms and values, and those of the children who are often caught in the middle and share values passed down by their parents and those that they may adopt from the "host" culture.

Overall, this case highlights the need for increased cultural responsiveness from the outset of contact between ethnically diverse families, particularly those who may be unfamiliar with the societal norms of the majority culture (e.g., due to recent immigration and the existence of language barriers). It also emphasizes the need for broader representation in the stakeholders who create and implement policies that impact families who come into contact with CWS to reflect the people being served. By encouraging broader cultural representation and engaging culturally diverse individuals in creating policies, the child welfare system can more adequately and appropriately address safety concerns in a way to preserve the family whenever possible, rather than separate them. Finally, this case highlights the lack of appropriate interpretive services, whether it be due to limited resources or availability or lack of due diligence on the part of CWS.

A number of important limitations apply to this case study and the conclusions extrapolated in our review. First and foremost, the researchers had only second-hand knowledge of this case and relied exclusively on the respondent's self-report of his involvement in the case. Given that he was not the primary social worker, this poses a potential limitation to the reliability of his report. For example, the researchers were unable to corroborate his narrative of the case as well as the extent of his involvement in the case. Further, it is unknown if there were additional measures taken in the comprehensive

assessment and service provision with this family (or that have since been taken) to more sensitively and adequately provide for their unique needs. Nonetheless, although the exact details of the case could not be confirmed, the conclusions the researchers have drawn from the case are valuable and highlight important clinical considerations that are consistent with the literature. In addition, while this case study may not be fully representative of families from other cultural and ethnic backgrounds, and the issues raised are not exhaustive, they suggest a need for more inclusive resources, including but not limited to interpretive services, extra steps taken to limit separation when able in dependency cases due to unforeseen ramifications (e.g., removal from a safe community and cultural practices), and more comprehensive cultural education for providers.

Conclusions

While exploratory, this review of the literature and the preceding case study involving an Egyptian immigrant family highlight a number of challenges that both ethnically diverse families who come into contact with the dependency systems, as well as the providers charged with offering the best care to these families while maintaining children's safety face in many Westernized countries such as the United States. Families whose native language is not English and whose native customs do not reflect those of westernized countries experienced obstacles that may not exist, or that may exist to a lesser degree, for other families such as White, Black, or Latinx. Where language barriers exist, options for self-advocacy and access to resources and education are limited. Furthermore, languages that do not have a dominant presence in the United States (depending on geographic location), including even written materials, may require translation. This exposes the additional barrier of finding interpreters who not only speak the language but are certified to act as interpreters, which often leads to individuals relying on family members or even their own children to translate. For the family discussed in case one, access to a parenting class or widely distributed parenting resources may have been limited if not available in

the mother's native language, Arabic, and in her own dialect. Depending upon parents' level of education and socioeconomic status, there may be additional added layers limiting accessibility and resulting in greater disparities in outcomes.

With respect to implications for practice, first and foremost, the authors suggest a framework of cultural humility and prioritizing the best interests of the children involved, keeping in mind that Western values of "best interests" may be different than those of the families who are stakeholders in cases similar to those described above. With respect to real-life implications, the authors also highlight the importance for providers to meet families where they are at and treat them as the experts on their own needs, which are unique to each family. As it stands, CWS in the United States, despite noble intentions, often causes more disruption and traumatization to families than it does good. While the authors do not opine on how reform may benefit the system, some helpful direction can be taken from efforts made to improve upon child welfare involvement with indigenous peoples, namely through the Indigenous Connectedness Framework (Ulrich, 2019), which promotes adaptation to a culture's history, customs, and ways of life while emphasizing familial and communal relationships. For collectivistic cultures, such as the ethno-religious minority families described above who are also immigrants to their host nation, such efforts to focus on maintaining relational continuity—whether it be through extra measures to avoid removal from the home, measures to ensure connectedness to important religious and cultural institutions and customs, or efforts

to maintain cultural congruence when possible between providers, resource families, and the client family—can have a profound impact and reduce traumatization in these families. The literature has shown that placement with family can often benefit children, barring significant safety concerns (i.e., immediate harm), by allowing them to preserve familial ties. Furthermore, children in kinship/relative placements have fewer behavioral issues and fewer placements while in foster care than children in non-kinship/non-relative foster care.

It is also important that agencies and policymakers seek to increase the representation of various cultures through outreach to the community and increased education. With increased representation, families who are overrepresented in the child welfare system may feel it is safer to engage in services rather than to fear or reject them. For groups that are underrepresented, efforts to increase representation and thereby make available more culturally congruent providers may allow space for families to advocate for themselves when they need assistance and resources. In many families, instead of teaching children to "keep quiet" about disciplinary practices or even violence within the home when speaking to educators or healthcare providers, there may be a shift to an openness to ask for help with parenting or to seek out services and education. Overall, this research, although exploratory, highlights the need to conduct more specific investigation into how to honor and meet the unique needs of various sub-cultures, and to avoid the generalizations cited in the literature that can have negative real-life implications for vulnerable families and children.

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Sub-Saharan African Immigrant Parents and Child Protection in the United States: Considerations for the U.S. Child Welfare System

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Abstract

The sub-Saharan African (SSA) immigrant population in the United States has continued to grow since the 1970s. Despite SSA immigrant families facing elevated risks of becoming involved with U.S. child welfare systems due to their intersectional identities as Blacks, immigrants, and predominant low-income status, there is limited research focused on how this population understands the child welfare system in the United States. This qualitative study sought to bridge this gap by gaining insight into the dynamics between SSA immigrant parents and U.S. child welfare systems. Using purposive and snowball sampling techniques, 15 SSA immigrant parents in Delaware and Pennsylvania were recruited for this study. Two major themes emerged from the interview data: risk factors and protective factors. Eleven subthemes emerged within the two major themes. The study highlights perspectives of SSA immigrant parents on the U.S. child welfare system. These perspectives provide important considerations for the U.S. child welfare system.

Keywords: sub-Saharan Africans, immigrants, child welfare, risk factors, protective factors

Introduction

The sub-Saharan African (SSA) immigrant population has continued to grow in the United States at a steady rate. According to the U.S. Census Bureau (2014), the number of foreign-born Africans in the United States grew rapidly within a 40-year span (1970 to 2008-2012), from about 80,000 in 1970 to about 1.6 million between 2008 and 2012. The SSA foreign-born population particularly saw a significant jump—from 130,000 to 1.5 million—between 1980 and 2013, including a significant 13% increase from 1.3 million to 1.5 million between 2010 and 2013 alone (Zong & Batalova, 2017). Echeverria-Estrada and Batalova (2019) found that there were a little over 2 million immigrants from sub-Saharan

Africa in the United States as of 2018. Though the SSA population constituted a small fraction (4.5%) of the 44.7 million immigrant population in the United States as of 2018, its increase of 52% between 2010 and 2018 far outpaced the 12% growth rate for all immigrants in the United States during the same period (Echeverria-Estrada & Batalova, 2019). For the purposes of this research, and based on the U.S. Census Bureau's 2010 data, sub-Saharan Africa encompasses all African countries except for Algeria, Egypt, Libya, Morocco, Sudan, and Tunisia.

Zong et al. (2019) estimated that 18.2 million children, or 26% of the 70 million children in the United States, live with at least one immigrant parent. In recent years, child welfare agencies and juvenile courts have become increasingly involved with immigrant families. Traditional reasons like child abuse or neglect, as well as the recent spike in unaccompanied minors and deportation of parents, have

significantly contributed to the rates of involvement of immigrant parents and their children with the child welfare system in the United States (Finno-Velasquez & Dettlaff, 2018).

Studies have found various factors that impact immigrant populations' relationships and interactions with the child welfare system in the United States. In their groundbreaking Third National Incidence Study of Child Abuse and Neglect (NIS-3) study, Sedlak and Broadhurst (1996) found that families earning less than \$15,000 per year were 22 times more likely to experience child maltreatment than those with higher incomes. Stokes and Schmidt (2011) added that immigrants, especially those who are newcomers, are less likely to find high-paying jobs, which can elevate child maltreatment risk levels for those families. Dettlaff and Earner (2012) also found that immigrant families have a higher chance of living below the federal poverty level than their American counterparts, with more than half of immigrant children living in poverty.

Studies have found an association between parental stress and increased propensity for child abuse and neglect (e.g., Dettlaff & Earner, 2012; Rasmussen et al., 2012). Dettlaff and Earner (2012) noted that migrating from one country to another can be stressful and traumatic, and that factors including culture shock and adaptation to a new environment can create anxiety that can affect the relationship between immigrant parents and their children. Specifically regarding culture shock, Critelli (2015), for example, argued that the difference in cultural norms and child-rearing practices, coupled with immigrant parents' lack of understanding of their rights and responsibilities within the U.S. framework of child welfare laws and policies, play a significant role in real or suspected incidence of child abuse and neglect. Also, Rasmussen et al. (2012) established that SSA immigrant families have a higher chance of getting involved with the child welfare system because of differences in cultural practices, citing most West African cultures' use of corporal punishment as an example.

Lack of social support networks is another factor that has contributed to the incidence and prevalence of child abuse and neglect among immigrant families. Rasmussen et al. (2012) noted that the feeling of an unsecured environment, along with the challenges associated with finding a job without reliable supports, can negatively affect immigrant parents' parenting responsibilities. Mugadza et al. (2019) also found that some immigrant parents in Australia bemoaned the struggles that come with the lack of extended family supports to help them (immigrant families) go about finding economic opportunities.

Little evidence exists on factors that prevent SSA immigrants from becoming involved with the U.S. child welfare system. Two common protective factors that are repeatedly mentioned in the literature are social support and adaptation to the host country's child welfare practices. These two protective factors apply to the overall immigrant population, as opposed to just SSA immigrant families. Immigrant families who adapt to their new country's child-rearing practices have been found to have lower risk of becoming involved with the child welfare system in the new country. Cheah et al. (2013), for example, found that many newly arrived Chinese immigrant parents in the United States become more flexible and less restrictive in their parenting, as they come to understand that parenting laws in the United States differ from those in China. Focusing on African immigrant parents, Alaazi et al. (2018) noted that African immigrant families use a hybrid of African and Western disciplinary practice, a forced but deliberate blend of traditional African and Western child disciplinary practices, to raise their children.

Research has found the availability and utilization of social supports to be an important factor in preventing families from being involved in the child welfare system. While this is not widely studied in African immigrant parents, one study by Bailey et al. (2015) found that in Latinx families, particularly those who are Spanish speaking, social support from neighbors, friends, and members of the

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community was an important factor in preventing child abuse. Expanding beyond immediate social support, the study also showed that involvement in the community via schools and churches was also protective (Bailey et al., 2015).

As the preceding review of the literature portrays, SSA immigrants are at increased risk for becoming entangled with the child welfare system in the United States due to intersectional and other factors. Though some existing studies have found factors such as poverty, racial discrimination, lack of informal and formal supports, and worker bias as contributing to the overrepresentation of Black children, including those from SSA immigrant families, in the U.S. child welfare system (e.g., Cénat et al., 2021; Chibnall et al., 2003; Child Welfare Information Gateway, 2016; Dettlaff et al., 2020), a very limited number of these extant studies focused on immigrants of SSA descent (e.g., Mugadza et al., 2019; Rasmussen et al., 2012). There is the need for more SSA immigrant-specific studies to increase our understanding of the dynamics between SSA immigrant families and the U.S. child welfare system, and this study addresses some of these dynamics.

Methodology

The purpose of this study was to explore SSA immigrant parents' perspectives on the child welfare system in the United States. Approval for the study was obtained from West Chester University Institutional Review Board (IRB). Included in the IRB application was a recruitment letter, recruitment flyer, and online screening survey to determine study eligibility. Once eligibility was established, participants were invited for a qualitative, 12-question interview.

Participants for this study were recruited in Pennsylvania and Delaware. The study included SSA immigrant parents over the age of 18 who previously raised or were currently raising children in the United States. Participants were offered a \$20 Amazon gift card for participating in the study.

Purposive sampling and snowball sampling were used to recruit participants for this study. Study invitation materials were distributed using a recruitment letter and flyer sent via email to community and civic organizations catering to specific needs for immigrants from sub-Saharan Africa. These organizations were selected due to contacts various study team members had with individuals from these agencies. Members of the study team approached individuals in their networks who met the eligibility criteria for the study. Additionally, participants who completed the study were asked if they knew anyone who would qualify for the study and were provided with study materials to distribute to those who would be eligible.

Based on the purpose of the study, the study team developed a semi-structured interview guide containing qualitative questions to conduct the interviews. The interview guide asked questions on knowledge of a child welfare system in the United States and in the participant's home country, awareness of child welfare policies and laws in the United States and their home country, thoughts on how child welfare laws and policies in the United States affect SSA immigrant parents, perceptions of why children enter the U.S. child welfare system, factors that contribute to entering the U.S. child welfare system, steps to prevent the participant's child/children from entering the U.S. child welfare system, community resources available to prevent children from entering the U.S. child welfare system, similarities and differences in the child welfare system in the United States and home country, and recommendations for improvement of the U.S. child welfare system.

Descriptive statistics for the study sample were obtained using an online screening survey that was used to determine study eligibility. Data collected included age, gender, country of origin, marital status, overall household size, employment status, and number of children. Informed consent forms were emailed to eligible participants, and signed consent forms were returned to the investigators before the interview.

All interview sessions were conducted over the Zoom platform with audio recording only and stored in a password-protected file. Interviews were 45-90 minutes in length, and interviewers transcribed them using transcription software before the study team verified them. Verified transcripts were imported to Dedoose version 8.3.43 for qualitative data analysis. In the first-order thematic step, the two interviewers each reviewed their transcripts, highlighted relevant statements, and coded the statements. In the second-order thematic step, the interviewers reviewed the codes together and clustered them into themes. This step also involved consolidating redundant codes from the first step and ensuring reliability of the coding for all transcripts. During the overall synthesis phase, various themes were categorized into risk factors and protective factors. Following the overall synthesis process, overall themes for risk and protective factors were selected based on the number of times they appeared in the data along with poignant quotes to represent each theme.

Results

Seventeen eligible participants were recruited for this study. Of that, 15 (88%) eventually participated in interviews. Seven (46%) participants identified as females, and the other eight (53%) identified as males. Geographically, a significant proportion of the participants (12) resided in Pennsylvania, with the remaining three living in Delaware. The participants originally migrated from across six SSA countries, including Ghana, Kenya, Nigeria, Senegal, Sierra Leone, and Côte d’Ivoire. Each participant had lived in the United States for at least five years at the time of the interview. All interviews were conducted in English with one exception where the participant spoke French; this interview was conducted by a study team member who was bilingual in French and English. All participants met the inclusion criteria for this study. Participant demographics are presented in Table 1.

Table 1
Participant demographics

Demographic	N (%)
Gender	
Male	8 (53.3)
Female	7 (46.7)
Age (mean ± sd)	46.4 ± 9.2
Country of Origin	
Côte d’Ivoire	1 (6.7)
Ghana	2 (13.3)
Kenya	2 (13.3)
Nigeria	4 (26.7)
Senegal	4 (26.7)
Sierra Leone	2 (13.3)
Marital status	
Married	14 (93.3)
Not married	1 (6.7)
Number of children currently living at home	
0	2 (13.3)
1	3 (20.0)
2	5 (33.3)
3	3 (20.0)
4	1 (6.7)
5	1 (6.7)

All study participants were employed in various sectors including healthcare, social services, hospitality, and self-employment. All participants were married, and one participant had had an interaction with the child welfare system in the United States at the time of data collection. Although

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the other 14 participants had never been involved with the child welfare system in the country, responses from all 15 participants revealed certain factors that were found to either contribute to or guard against SSA immigrants' interaction with the U.S. child welfare system.

Two major themes emerged from participants' interview responses: risk factors and protective factors. Within these two major themes emerged eleven subthemes. The six risk factor subthemes that emerged from the data were parental mental health and substance use issues, child abuse, child neglect, low income, unfamiliarity with child protection laws, and culture shock. The five protective factor subthemes that emerged included home training, avoidance of abuse and neglect, responsible parenting, social supports/networks, and community resources.

Risk Factors

Interview responses from participants revealed the six previously mentioned risk factor subthemes as pervasive factors that cause SSA immigrant families to come in contact with the U.S. child welfare system, especially child protective services (CPS). Each of the subthemes is presented below and supported by poignant and representative quotes from participants.

Parental Mental Health and/or Substance Use Issues

Responses from participants indicated that an SSA immigrant parent is at more risk of becoming entangled with the child welfare system if the parent struggles with mental health and/or substance use issues. Participant #5, who was from Ghana, shared how parental mental health struggles can draw parents into the child welfare quagmire: *"I think it is more the mental [health] issue in terms of the parents where they are not able to handle their parenthood."*

On how parental mental health issues lead to SSA immigrant parents becoming involved with the U.S.

child welfare system, Participant #12, a Nigerian, said: *"I understand that some parents are into drugs. I understand some parents are into heavy alcohol. So, that might make those parents to start abusing their children, which will now attract the attention of DHS."* Other participants' perspectives on how parental mental health and substance use issues instigate the involvement of the child welfare system with SSA immigrant families were similar to those shared by Participants #5 and #12.

Child Abuse

Participants noted child abuse is one of the most common reasons why SSA immigrant parents and their families get involved with the U.S. child welfare system. For example, Participant #3, from Senegal, identified "physical, sexual, emotional, and psychological abuse" as specific forms of child abuse that can cause the involvement of CPS into the families of SSA families. Most participants singled out physical abuse as the major child maltreatment risk factor that triggers CPS investigations. For example, Participant #6, a Nigerian, said: *"There are a lot of reasons why children [of sub-Saharan African immigrant parents] end up in child protection. Child abuse—physical abuse [for example]. Some sub-Saharan African immigrant parents abuse their own children."*

Participant #8, a Kenyan, said, *"My understanding is that in very minor cases of things that us as Africans we perceive to be minor, you can end up losing your child for something as simple as just caning a child... And they [child] can go to school and say, 'My dad slapped me,' or, 'My daddy caned me,' and you will find that they [school] don't take that on face value."* This quote perfectly summed up the role that physical child abuse, regardless of the severity of the act, plays in inviting CPS into the families of SSA immigrant families.

Child Neglect

Participants also extensively described child neglect as a leading risk factor for SSA immigrants to become entangled with the U.S. child welfare

system. Overall, child neglect was the most discussed risk factor in this study. Participants' descriptions of what constitutes child neglect ranged from physical and emotional forms of neglect to medical and educational forms of neglect and lack of supervision. These various forms of child neglect were partially encapsulated in Participant #2's, a Kenyan, response that if you are a SSA immigrant parent and you *"don't bring your child to school, neglect your child, don't feed your child,"* then you will become involved with the child welfare system. On educational neglect specifically, Participant #2 noted that as a SSA immigrant parent, you will be in trouble with CPS *"when you know that it's time to send your child to school, to register your child for school, and you don't do that."*

Participants' responses notably highlighted lack of supervision as a neglect issue that engenders the involvement of CPS with SSA immigrant families. For instance, Participant #10, who was Senegalese, tied lack of supervision to child endangerment, noting: *"When the child is in danger because they were left alone in the house by themselves, or the parents are in the situation like being a drug user and cannot take care of the child."* Participant #15, who was from Sierra Leone, recalled the experience of a SSA immigrant friend: *"I know a bit of story with one of my friends who because of a little bit of error, they said she left the child unattended, and she just went to purchase a bread and by the time she came back cops were called, and the cops took the baby and she was shamed and taken to court and then to jail and all this stuff."*

Similar to participants' identification of physical abuse as the leading form of child abuse, participants also identified physical neglect as the most prevalent form of child neglect. Participant #9, who was from Côte d'Ivoire, for example, intimated: *"I know some situation like if the mother is not able to take care of the kids, they [CPS] take the kid."* Participant #12, a Nigerian, said, *"I know that if you have any problem with the kids or maybe if they [CPS] think you're not taking good care of the kids, they can take them away from you and give them to foster parents,"*

which appeared to echo Participant #9's perspective on physical neglect as the most common form of child neglect.

Low Income

The fourth subtheme that emerged under the risk factor theme was low income among SSA immigrant families. Participants described the significant roles that low income, including inadequate financial and other resources, plays in elevating the risk of SSA immigrants becoming entangled with child welfare system. For example, Participant #15, a Sierra Leonean, said: *"Inadequacy or insufficiency of resources can lead to children being malnourished or underfed. Those children may not be active in school because there is not enough income to upkeep them, and at the end of the day if that comes to the attention of social services in school, then that can lead to the child being taken away."*

Similarly, Participant #1, a Ghanaian, linked low income among SSA immigrant parents to difficulties with childcare services, and with balancing childcare and work duties, as a likely outcome that can engender child neglect, saying, *"They [sub-Saharan African immigrant parents] will need some sort of childcare and sometimes due to issues around income, one would have to stay home and the other would have to work to take care of the child. But if they do not have enough income where one would just have to work and the other stays home, they would have to juggle with trying to take care of the child and work."* Participant #1 noted that childcare and work balance challenges are unalienable factors that engender child neglect.

Unfamiliarity With Child Welfare Laws

As the fifth risk factor, participants described how lack of familiarity with the complex policies and laws of the U.S. child welfare system has led to many SSA immigrant families becoming embroiled in it. Participants pinpointed the lack of education on CPS laws and misconception of how the law works as risk-elevating factors for CPS involvement in SSA immigrant families. On the lack of education on

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CPS laws, Participant #3 from Senegal, for example, noted that SSA immigrant parents are “...not well educated about what exactly is appropriate and what’s not appropriate. I often find that there’s a lot of not only miseducation but also misconceptions of how the system is supposed to work and for the responsibilities of a parent.”

Participant #12, a Nigerian, distinguished between African child protection practices and those in the United States, using the distinction to drive home SSA immigrants’ misconceptions of how CPS laws work. Participant #12 said, “In Africa you can just leave your kid and run out to buy something and the neighbors that are there will help you take care of the kids. It is not [like] that here, and most times you have to take your children to all the things you need to do. Some of them don’t know this law and they leave their kids and go out to do stuff and by the time they’ll come back, maybe people will...call child welfare on them.”

Culture Shock

Participants profoundly discussed the sixth and final risk factor, culture shock, as they found this factor to be one of the leading causes of SSA immigrant families’ entanglement with the U.S. child welfare system. Participants contended that, in many cases, SSA immigrant families attract the attention of CPS due to the families’ African cultural practices running afoul of child welfare practices and laws in the United States. This contention was summed up by Participant #11, a Senegalese, when they used their own practice as an example: “Where I’m from is a kind of different culture; you can corporally discipline your child. We don’t call it abuse. Some Africans beat their kids—you can do that—but here, it is not the case. Sometimes I tell my kids to not violate the rules. Sometime after I warn them, I can beat them. To be honest with you, I don’t consider that as an abuse. It is educational. Even though I try to do my best to apply the United States law with the kids, I’m not hundred percent following the laws. I think it is a cultural issue there.”

Participants also noted how SSA immigrant parents are shocked to find out that U.S. child welfare laws are actually enforced, unlike those in the parents’ home countries. For example, Participant #15, a Sierra Leonean, opined that people from Africa are often surprised about how child welfare policies in the United States are taken very seriously, which in turn becomes a cultural shock that affects them in diverse ways, including their struggle to reconcile their native childrearing practices with those of the United States.

Protective Factors

Interview responses from participants pointed at five protective factor subthemes as pervasive reasons that protect SSA immigrant families from involvement with the U.S. child welfare system. Each of the five protective risk factor subthemes is presented below, supported by poignant and representative quotes from participants.

Home Training

Responses from participants indicated that SSA immigrant parents attributed good home training, which includes religious upbringing of children and parents and nurturing children in the home, as a protective factor preventing them from involvement with CPS. Participant #4 from Nigeria said, “So, from my own culture, we believe in training the children and bringing them up in the fear the Lord and admonition. We don’t really, we don’t spank children, but we train them very well to be obedient. So, I cannot recall any Nigerian that has any issue with DHS. I don’t know anyone.” Participant #2 from Kenya mentioned: “So, for me I really don’t do it for the child welfare system; I do it for the well-being of my kids. I don’t believe in physicality screaming my child or any child.” It is important to note that parents mentioned that the choice to nurture their children is not out of fear of CPS, but out of concern for the well-being of the children.

Avoidance of Abuse and Neglect

Education and knowledge of the U.S. CPS was noted as one of the reasons behind less involvement with the CPS. Participant #15 from Sierra Leone said they were “...very quick to educate myself with listening to people that there is this system called child protection service, that’s always geared towards the welfare of the kids and they are advocates for kids and they make sure that kids are taken care of even by their parents. Any violation of the child’s rights, the parents are going to feel some severe consequences—sometimes imprisonment or fine or withdrawal of the child from the parents.”

Additionally, participants mentioned that obeying current laws in the United States was a factor in preventing their involvement with CPS; this was a conscious effort on the part of the parents. Participant #13 from Nigeria said: “So I follow the law. Like I said, we came here with a different mindset, we came with our culture from Nigeria. But whatever they say is the law, you have to follow it. I think that’s it. If they say don’t beat your child, you don’t do it [beat your child]. All you need to do is talk talk talk to your children.” These two quotes suggested that participants’ knowledge of CPS could have been gained from purposefully seeking the knowledge, or as a consequence of wanting to understand all the laws of the United States.

Responsible Parenting

Two participants explicitly mentioned responsible parenting as a way to avoid involvement with CPS. Participant #1 from Ghana centered their comment around supervision, describing, “keeping an eye on them, to ensure that I’ve given them the best care I can as a father. And one of the things I have done as a family, I have to work and my wife had to sacrifice her time staying home to take care of the child is something we agreed on as a family for now.”

On the other hand, Participant #15 from Sierra Leone centered their comment on parents providing basic essentials for children, saying, “Of course, it’s only just to go the extra mile. If you’re supposed

to work one job, then you have to do two jobs. Your income is not going to be a hundred percent what you need, but at least you can provide what is necessary as far as a parent, all that to meet the demands [of their children], not all but the basic means so that you keep up.” From these quotes we see that the issue of responsible parenting can take different forms. The definition of what constitutes responsible parenting also differs between study respondents. The central idea of this theme is that providing and guiding one’s child/children is a way of preventing them from ending up in the CPS.

Social Support/Networks

Participants repeatedly mentioned social support and social networks as ways that African immigrant parents have avoided involvement with CPS both personally and for others. Networks can be local, like in Participant #8 from Kenya’s comment: “Normally what happens, migrants kind of, for the most part, they live in a kind of knit, tight knit society, whereby if somebody comes here from sub-Saharan Africa, they tend to look for people of their own. For example, I’m from Kenya. If I go somewhere, my first thing is to look for others from Kenya. Can I meet any Kenyans or anyone from Africa? Then from there you relate and you get to learn that, you know what? You can’t do this, you can’t do that. And just by sharing and hearing other people’s stories, we really learn a lot from our fellow brothers and sister.”

Over time, with increasing numbers of immigrants of African descent across the world, wider networks have been formed. Participant #2 from Kenya, gave an example of one such network, saying: “We are very supportive of each other. I see cases all the time like this one group of Kenyan women in the U.S. and Canada that has about 20,000 members where are people always getting help. People will post ‘I’m a single mom and this happened and that happened’ and people contribute \$50,000 like that.” Social support and networks are responsible for the education of new immigrants to the laws and policies of the United States, help with transitioning families to new neighborhoods, and provide a source

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of general information for all people within the network.

Community Resources

Community resources was the last protective factors subtheme that emerged during these interviews, and this subtheme was closely linked with social support and social networks. Participants discussed the availability of community resources that were designed to aid children and families in need, like Participant #15 from Sierra Leone, who explained: *“So, you think about the resources that are here, the number of nonprofit organizations that provide services to give help to struggling families are very good. They are more than you can ever imagine.”*

Participant #8 from Kenya went further to describe specific resources that are helpful in preventing African immigrant parents from involvement in CPS, saying: *“In the United States, they have a lot of resources. Even before the father and the mother come in, in terms of helping even a child, they have a lot of free resources. Like you can be given things like stamps, you can enroll in things like CHIP, if the parents are not able to [provide insurance for the child].”*

Knowledge and access to community resources serve in the same capacity as social support and networks in that they provide African immigrant parents with information that is helpful in educating them about the community and what resources are available to them. Community resources also serve as an avenue for African immigrant parents to share information with others about their experiences and provide vital services to the community.

Discussion

There is limited research on the dynamics of the SSA immigrant population in the United States and the U.S. child welfare system. With the SSA immigrant population in the United States seeing a steady increase over the last several decades, this study set out to gain the perspectives of SSA immigrant parents on the U.S. child welfare system,

including their understanding of the child welfare system’s laws, policies, and practices. To better capture participants’ perspectives on the U.S. child welfare system, it was imperative to know whether participants had had any encounters with the child welfare system and what steps or protective factors, if any, had helped or enabled them to avoid interactions with the child welfare system.

Only one participant had been directly involved with CPS in the past. Though the other 14 participants had never had a direct interaction with the U.S. child welfare system, they all enumerated and described many risk factors that they found to elevate SSA immigrants’ risks of entanglement with it. These risk factors include parental mental health and substance use issues, child abuse, child neglect, low income, unfamiliarity with child protection laws, and culture shock. The results indicate that an SSA immigrant family may encounter more than one of these risk factors, which could elevate their vulnerability of becoming entangled with the U.S. child welfare system. Conversely, the data also indicated that SSA immigrant families utilize diverse methods and resources to counteract the risk factors. These protective factors include home training, avoidance of abuse and neglect, responsible parenting, social support/networks, and community resources.

Four of the six risk factors found in this study—parental mental health and substance use issues, child abuse, child neglect, and low income—are extensively researched in extant studies. In fact, a plethora of existing studies have concluded that Black families are more likely to encounter these four risk factors (e.g., Cénat et al., 2021; Chibnall et al., 2003; Child Welfare Information Gateway, 2016; Dettlaff & Boyd, 2021; Dettlaff et al., 2020). The parental mental health and substance use risk factor, for example, corroborates earlier studies that have found positive correlations between this risk factor and various forms of child maltreatment that trigger the involvement of CPS agencies (e.g., Chemtob, et al., 2013; Dubowitz et al., 2011; Kepple, 2017). Similarly, the child abuse and child neglect risk factors find ample support in extant

studies, as child abuse and neglect are responsible for nearly all interactions between families and child welfare agencies in the United States, including SSA immigrant families (e.g., Child Welfare Information Gateway, 2019; Lalayants, 2013; Lalayants & Epstein, 2005).

Unsurprisingly, child neglect was participants' most discussed risk factor. The current literature finds child neglect as the most prevalent form of child maltreatment that instigates the involvement of child welfare agencies with U.S. families (Antle et al., 2008; Courtney et al., 2005; Dettlaff & Earner, 2012). In addition, low income as a risk factor for child maltreatment and the resultant outcome of child welfare agencies' involvement with families, corroborates the findings of existing literature. The U.S. Centers for Disease Control and Prevention (2021), for example, found that a caregiver's low-income status was a major individual risk factor for child maltreatment and associated outcomes.

Unlike the four risk factors discussed above, the other two risk factors—culture shock and unfamiliarity with child protection laws—have yet to be extensively investigated. That said, Critelli (2015) found that, although many immigrant families do not intentionally abuse or neglect their children, differences in cultural norms and child-rearing practices play a role in incidents of suspected child abuse and neglect. Critelli's (2015) finding is corroborated by our data, which indicated that SSA immigrant parents' struggles to immerse themselves in American society while trying to maintain their native cultures, especially as they pertain to child-rearing, is a challenging transition process that sometimes results in child maltreatment and interaction with the child welfare system. Similarly, the data pointed to the susceptibility of SSA immigrant families to possible interactions with the U.S. child welfare system due to the families' lack of understanding of even basic child protection laws and policies, including the acts and failures to act that constitute child abuse and neglect in the states in which these families reside.

Social supports/networks are among the most studied

protective factors that emerged from this study. Family support has been identified as a protective factor against involvement with CPS (Davidson et al., 2019). Additionally, research finds that factors in the community including “family members and their informal social networks” are protective against involvement with CPS (Davidson et al., 2019). Responses from participants support these points; several participants remarked that community members and social networks help prevent African immigrant parents from involvement with CPS. While few studies have been conducted with African immigrant parents, Bailey et al. (2015) found similar impacts of social support for Latino parents.

Linking immigrant parents to community resources is one way to increase social support in immigrant communities and to get them the help they need regarding the health and welfare of their children (Maiter et al., 2009). Study participants repeatedly mentioned access to and knowledge of community resources, financial and nonfinancial, as one way to prevent involvement with CPS. Community resources mentioned in this study include money, healthcare, schools, community centers, and libraries. There is also an important link between social supports/networks and community resources, as many immigrants are made aware of community resources through others living in their communities.

The last two protective factors, home training and avoidance of child abuse and neglect, are less studied. Our data suggest that SSA immigrant families use their native, culturally sound upbringing skills—which, among other factors, emphasize modeling good behavior, respecting one's caregivers, and following the tenets of personal self-control—to help them raise their children in ways that help them avoid abuse or neglect.

Limitations

There are some limitations to this study. First, most participants did not have personal experiences with the U.S. child welfare system, which would affect how these parents viewed the system. Also, the purposive and snowball sampling techniques

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employed in recruiting participants meant that we were left with participants with similar backgrounds and professions, limiting their diversity of experiences and, in turn, perspectives. It is important to state that perspectives of SSA parents who have personal experiences with the U.S. child welfare system may be different from those who have no experience.

Second, definitions of “child welfare” differed among participants, as some mentioned child welfare in a holistic sense and not as a government system designed to protect children. It is possible that this wording could differ across different countries, making it hard for us to capture systems similar to those in the United States. These different understandings could also affect perspectives of SSA immigrant parents as they may see the U.S. child welfare system as a way to raise children rather than a government entity meant to intervene in cases where children are at risk. While an understanding of all these perspectives is important, the lack of an operationalized definition may lead to unrelated conclusions.

Third, generalizability of the study’s findings is limited by participants’ employment and level of education, as well as their geographical location in the United States. Participants in this study mostly worked in formal jobs, which meant participants had acquired a certain level of education. Being educated meant that participants may have a better understanding of the U.S. child welfare system. Therefore, perspectives of these educated, formally employed SSA immigrant parents may not represent those of their less-educated, blue-collar SSA compatriots. Similarly, participants were drawn from two northeastern states (Delaware and Pennsylvania). Perspectives of SSA immigrant families in other parts of the United States might be drastically different from those of this study’s participants, especially as some child welfare laws, policies, and practices differ from state to state.

Generalizability of the findings is also limited by the number of SSA countries from which participants hail. Sub-Saharan Africa is made up of 46 countries,

but only six countries were represented in this study. This study did not capture possible differences in cultural experiences and values, including child rearing and protection, in the other 40 SSA countries and how those experiences and values shape the perspectives of African immigrant parents from those countries. This makes it difficult to generalize the perspectives of this study’s SSA immigrant parents to all SSA immigrant parents in the United States.

Study Implications

U.S. child welfare laws, policies, and practices can be enigmatic for United States-born citizens, and for immigrants, the laws, policies, and practices can exceed enigma due to the latter group’s intersectional identities of being Blacks and immigrants, as well as challenges with the U.S. sociocultural landscape. Despite this, research on SSA immigrant families’ understanding of how the U.S. child welfare system works is very limited. This study opens a window into SSA immigrant parents’ perspectives on the U.S. child welfare system, providing some useful considerations for the U.S. child welfare system.

First, the study revealed that SSA immigrant parents face some factors that tend to elevate their risk of interaction with the child welfare system. While some of the risk factors (for example, child neglect, child abuse, and low income) found in the study are very common among diverse families involved with U.S. child welfare system, the study also found an uncommon risk factor: culture shock, which existing literature finds as typical among immigrant families. With this knowledge, the U.S. child welfare system can adopt strategies that have worked well with immigrant families to work with SSA immigrant families in particular. It is important to stress that such strategies must be adapted to consider the cultural and social experiences of SSA immigrant families.

Second, the numerous protective factors possessed or utilized by SSA immigrant families serve as pertinent resources that can be tapped into by the U.S. child welfare system to promote the system’s primary goal of keeping families together. It is imperative to stress that these protective factors alone would

not be enough to keep SSA immigrant families from interacting with the child welfare system, but it would be efficacious and relevant for the child welfare system to take them into consideration.

Third, having these findings at its disposal can help the child welfare system to engage SSA immigrant parents in culturally sensitive and competent ways. For instance, the study shed light on SSA immigrant parents' culturally supported beliefs and practices of using corporal punishments and other disciplinary measures that are frowned upon in the United States. Understanding these beliefs and practices would enable the child welfare system to find culturally sensitive and competent ways to engage and intervene with SSA immigrant families.

Fourth, the study found that SSA immigrant parents generally have limited knowledge about the U.S. child welfare system. This finding opens the door for the child welfare system to sensitize SSA immigrant families to the U.S. child welfare system's laws, policies, and practices. This can serve as an effective preemptive measure that would not only reduce SSA immigrant families' risks for interacting with the child welfare system, but also save the system money and time that would have been devoted to intervening with SSA immigrant families who would have otherwise become involved with the system.

Conclusion

With limited research on how immigrants of African descent understand the U.S. child welfare system, this study sought to gain the perspectives of SSA immigrant parents on the child welfare system in the United States. Being Blacks in a country that has an overrepresentation of Black families in the child welfare system, it was important to investigate what SSA immigrant parents in the United States know about child welfare laws, policies, and practices in the country. This study revealed that SSA immigrant parents had a generally fair understanding of certain risk and protective factors that influence SSA immigrant families' interaction with the U.S. child welfare system. However, participants mostly viewed the U.S. child welfare system through

their own cultural lenses; participants interpreted the child welfare system in juxtaposition with the sociocultural expectations and experiences of their countries of origin. Overall, the study provides some considerations that can help child welfare systems in the United States to adopt strategies that are culturally aware when working with SSA immigrant families, whether proactively or retroactively.

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Reducing Infant Mortality in Low-Income Urban Neighborhoods Through Mobile Clinics Providing Access to Resources and Healthcare Providers: The Milk Truck Proposition

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Key Words: *Infant Mortality, Public Health Program, Intervention, Socioeconomic disparity, Minorities*

Abstract

High infant mortality in U.S. cities is partially the result of socioeconomic status and racial inequity negatively impacting access to preventative care, prenatal care, and nutrition. The majority of cases are confined to low-income neighborhoods where infant mortality is a function of poverty. Using Philadelphia as a model for low-income urban jurisdictions, we have designed a conceptual program that can be implemented nationally to address this problem. Public health programs have made progress, but targeted approaches are evidently needed to provide relief to neighborhoods left behind by current methods. Our group is proposing a targeted multi-focused program, the Milk Truck program, to improve education, access to resources, and follow through with prenatal and postnatal care in these neighborhoods via mobile outreach health clinics. The program is named and modeled after the concept of a 1950's milkman, where resources are brought to communities in need while requiring little effort on behalf of the recipient. The implementation of Milk Trucks will provide regular access points to prenatal supplementation and formula, food and childcare supplies via gift card/voucher exchanges, clinics providing lactation consultations, healthcare access education, and basic health screenings. Few public health programs addressing infant mortality and birthweight exist in the United States. Those that do have a very narrow focus or can be difficult to navigate and do not address many of the significant socioeconomic barriers low-income populations face. We believe that points of care focused on these underlying causes of high infant mortality in urban neighborhoods will decrease infant mortality rates and improve the quality of life for these residents.

Introduction

Infant mortality, which is death within the child's first year of life, is a serious public health issue in cities across the United States. The leading causes of infant death include birth defects, preterm birth, low birth weight, injuries, sudden infant death syndrome, and maternal pregnancy complications (Centers for Disease Control and Prevention [CDC], 2022). Unfortunately, poverty is a significant driver of infant mortality. For example, low-income mothers struggle to access proper nutrition, which can lead

to preterm birth, birth defects, and occasionally death. Additionally, low-income mothers are exposed to higher degrees of psychosocial and environmental stress, which has been linked to infant mortality (Class et al., 2013). A review of the geographical distribution between poverty and infant mortality rates affirms this relationship, as the poorest neighborhoods in cities like Washington DC, Chicago, Cleveland, and Philadelphia all have infant mortality rates far higher than both national and city averages (DC Health Matters,

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n.d.; Cleveland Department of Public Health, n.d.; Illinois Department of Public Health, n.d.). Such impoverished areas experience high rates of infant mortality not only from poor nutrition and stress but also because low-income women have less access to prenatal care (Osterman & Martin, 2018). Unsurprisingly, research shows that pregnant women who receive late-term or no prenatal care during their pregnancy are more likely to have infants with adverse birth outcomes like preterm births, low birth weights, and infant death (Tekka et al., 2018).

The link between poverty and infant mortality is further elucidated when looking at the intersection of race and income in relation to birth outcomes. Racial and ethnic minority communities, which are overrepresented on the lower range of the socioeconomic spectrum, experience disproportionately high rates of infant mortality. Individuals who identify as Black, Hispanic, and Pacific Islander have annual incomes 30-40% lower than those identifying as White (Semega et al., 2020). Black women in Philadelphia, for example, are three to five times more likely to have an infant die compared to Whites or Asian/Pacific Islanders, respectively (Murphey et al., 2018). The evidence makes clear that poverty and inadequate prenatal care are directly connected, which ultimately impacts infant health and well-being in low-income and minority groups.

Disparities in infant health and well-being are particularly evident in several major U.S. cities. In Atlanta, 35% of children are born into poverty; in Memphis, 35%; in Milwaukee, 33%; in Cleveland, 46%; and in Detroit, 43% (Hall et al., 2017). The impacts of this are not felt equally across demographics. Poverty disproportionately affects minority inner-city children to such a degree that Black and American Indian children are seven times more likely to be raised in neighborhoods of concentrated poverty than White children (Annie E. Casey Foundation, 2019). This disproportionate exposure to poverty among ethnic groups has lifelong consequences. Research has demonstrated that poverty's impact on health outcomes begins

the moment that fetal development begins. The two most noticeable outcomes are low birth weights and preterm birth, which can alter lifelong neurodevelopmental trajectories (Ahishakiye et al., 2019). Therefore, increased access to perinatal care mitigates not only infant mortality but also associated morbidity.

High infant mortality rates in U.S. cities are partly a function of socioeconomic status and racial inequity negatively impacting access to preventative care, prenatal care, nutrition, and postpartum resources. Therefore, infant mortality can serve as an indicator of the effectiveness of public health measures, namely maternal and child healthcare services. One such measure that can address the lack of access to care and quality nutrition in low-income and minority communities are mobile outreach clinics (Lorenz et al., 2016). We propose the conceptual use of mobile health clinics, which we call Milk Trucks, to improve prenatal and postnatal care by delivering education, breastfeeding assistance, nutritional assistance, and supplies directly to high-risk families. This conceptual program is aimed at promoting the well-being of children and reducing infant mortality via increased access to nutrition and healthcare resources. It uses the history of Milk Trucks as both an operational mechanism and metaphor for reaching families at elevated risk for infant mortality. Milkmen have long been viewed as friendly faces who provide needed resources directly to the doorstep, which this program hopes to capitalize on. The intent of the Milk Truck program is to increase accessibility to perinatal care in low-income neighborhoods while balancing the effort required on behalf of the patient to utilize the provided resources.

Evidence

Previous public health programs implemented in the United States that target infant mortality provide a framework for the Milk Truck proposal and suggest that it can both reduce infant mortality and improve pediatric well-being. For example, prior to the launch of the Baltimore City Health

Department's B'More for Healthy Babies project (BHB) in 2009, the Upton/Druid Heights neighborhood suffered from an infant mortality rate of 15 deaths per 1000 live births (Desmon, 2021). The BHB program focused on increasing access to prenatal care and primary care services through extensive outreach measures and provided prenatal and postnatal education to targeted groups in the community, primarily acting to provide resources like breastfeeding support, parenting classes, and coordinating access to public health services. Ten years into the BHB program, the Upton/Druid Heights neighborhood's infant mortality rate has dropped by 75% to 3.8 deaths per 1,000 live births (Desmon, 2021). The Milk Truck proposition draws from the BHB program's success while also providing additional resources like nutritional interventions with its proposed MommyEats program. The Milk Truck proposition also addresses several socioeconomic barriers to care through its dispersed mobile health clinic model, something not seen in the BHB program. Overall, the BHB program serves as a foundation and proof of concept for the effectiveness of neighborhood-specific interventions, which we expand upon with our Milk Truck proposition.

Certain communities have also benefited from programs providing gift cards and coupon books as incentives for continued prenatal care. The Alabama Medicaid Agency launched Healthy Beginnings, an incentive program that provided coupon books in exchange for pregnant mothers visiting their physicians or a health clinic, which was believed to aid in adherence to prenatal care guidelines (Ingram et al., 1993). Other programs providing conditional cash incentives to marginalized communities have shown similar improvements in prenatal care (Barber & Gertler, 2009). Our proposal thus incorporates incentive-laden practices as a means of building community trust and increasing participation in the Milk Truck program.

The Milk Truck program also acts to build upon growing public health movements to increase breastfeeding as a means of improving infant health.

One study that assessed the percentage of new mothers who have attempted breastfeeding found that major cities like Philadelphia are well below the national average of women who have ever breastfed (Murphey et al., 2018). This trend has unfortunate consequences for developing children, as data indicates that infants who are not breastfed or do not receive breast milk have increased incidences of infection, childhood obesity, type 1 and type 2 diabetes, immunologic disorders, and sudden infant death syndrome (SIDS) (Murphey et al., 2018). For mothers, a lack of breastfeeding is correlated with an increased incidence of breast and ovarian cancer, gestational weight gain, type 2 diabetes, and metabolic syndrome (Stuebe, 2009). Ultimately, breastfeeding or feeding infants breast milk benefits both mother and child. The CDC addressed the issue of breastfeeding in its Healthy People 2020 Law and Health Policy Program report, which set a goal to increase the number of breastfed infants across the United States. International public health groups have also recognized a need to improve breastfeeding rates. The Baby Friendly Hospital Initiative (BFHI), launched jointly by the World Health Organization and the United Nations Children's Fund, is one example. This initiative outlines ten specific steps to improve breastfeeding outcomes, and hospitals that employ this framework are seeing improved long-term breastfeeding success (CDC Foundation, 2020). The Milk Truck proposal can further expand such efforts by providing physical supplies and tools such as formula, breastfeeding pumps, and everyday childcare items directly to families. This initiative will also serve as an educational platform for mothers and pregnant women. It will emphasize the importance of breastfeeding, nutrition, and prenatal care in infant health through onsite consults with nutritionists, healthcare workers, and lactation specialists.

The Milk Truck program also seeks to address the issue of food insecurity and its impact on infant well-being and mortality. Nationwide, many low-income urban neighborhoods, wherein infant mortality tends to be elevated, are food deserts. A Yale University study found that low-income

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neighborhoods have less access to healthy food and lower quality produce compared to high-income neighborhoods; this trend also exists in Philadelphia (Andreyeva et al., 2008). A Drexel University study found that residents of low-income Philadelphia neighborhoods were 40-50% less likely to live within a half mile of a grocery store compared to higher-income neighborhoods (Go Red for Women, 2020). Additionally, the majority of these residents work low-income service jobs. The compounding effects of limited access to nutritious food and limited financial resources make it incredibly difficult for pregnant women and mothers to access proper nutrition in these neighborhoods. The Milk Truck program provides transportation and financial resources as a means of overcoming these systemic barriers.

Intervention

Overview

The Milk Truck proposition is a community-centered outreach program that emphasizes the nutritional needs of mothers and infants. This intervention aims to address gaps in prenatal and postnatal care and to provide services that can mitigate contributing factors to infant mortality. The program will focus on needs including transportation, nutrition, access to providers, childcare supplies, and contraception, as summarized in Figure 1 below. The target demographic will be low-income individuals who are pregnant or have a child under the age of 2 years old. Trained healthcare professionals will be employed to serve as a link between mothers and their primary care physicians. These individuals will help with disease screening, facilitate medical enrollment with a primary care provider, and communicate/coordinate with healthcare providers. The Milk Truck program proposes community outreach using trucks staffed by a physician, nurse, social worker, and two healthcare navigational aids. This proposed intervention will reduce infant mortality and low birth weight while increasing access to the various resources outlined below, improving the quality of life of our youngest

residents. This program aims to improve nutrition and access to care from the point of conception through the first 2 years of a child's life. The second year of life was determined as an endpoint to allow for a slow transition from Milk Truck resources starting at the infant's first birthday. The additional year will allow for increased flexibility in situations where the transition is prolonged due to socioeconomic barriers or extenuating circumstances. This is on top of 2 years being a common age wherein children have been weaned off breastfeeding.

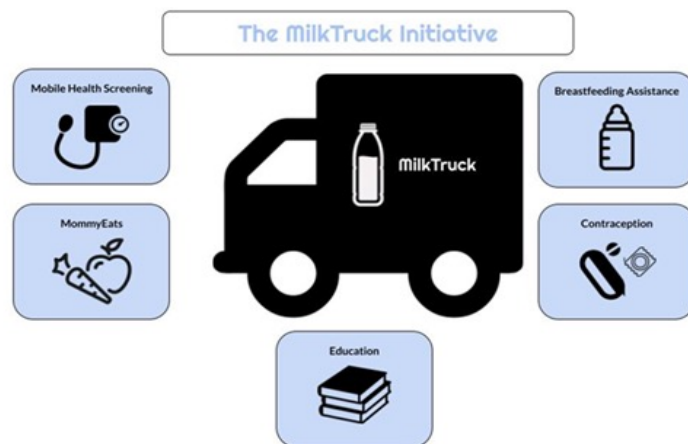


Figure 1. Summary of the major resources provided through the Milk Truck program. Mobile clinics will provide health screenings to patients. Clinics will also be a place of enrollment in our unique MommyEats nutrition program. Patients will be educated on the importance of nutrition, transitioning to long-term primary care, breastfeeding, and contraception at Milk Truck sites. Community members will also receive resources like formula, childcare supplies, and transportation funding.

Mobile Health Screenings

The Milk Truck program works in a similar way to food trucks: Maximize exposure by bringing resources directly to the population in need. This program focuses on neighborhoods with infant mortality rates exceeding those of surrounding areas.

Milk Trucks will have pre-established destinations in which the truck will park and “set up shop.” Providers on board will conduct prenatal health screening for diabetes, hypertension, and urinary tract infections as well as counsel patients on the importance of receiving such care longitudinally in an office setting. In this way, we hope to further support the identification of high-risk obstetric patients in order to further encourage better child health outcomes. Healthcare navigators will be on board to aid in transitioning expectant mothers to prenatal care at the offices of locally participating providers. Health records will be sent to participating obstetricians and pediatricians to ensure continuity of care. Mothers can receive supplies like prenatal vitamin supplementation and personal blood pressure cuffs at these mobile health screenings.

Maternal Nutrition

The Milk Truck program and its associated clinics will serve as access points for enrollment into our unique MommyEats program. The MommyEats program is designed as a virtual nutrition resource where patients will submit weekly food choices for review by staff nutritionists. This program aims to improve maternal nutrition through goal-directed incentives. Upon enrollment, patients will establish baseline eating habits with nutritionists, then work with nutritionists to develop incremental goals for improving these eating habits during their pregnancies. Patients who progress towards their individualized goals, as evidenced by weekly submission to the app, will receive gift cards and transportation vouchers. To incentivize mothers to stay in the program through the duration of their pregnancy and the first 2 years of the child’s life, patients will receive raffle tickets for each week they actively participate in tracking their food intake on the MommyEats app. Raffles will include prizes ranging from movie tickets and date nights to car seats.

Incentives

It is imperative that the target demographic “buys in” to the Milk Truck program and that socioeconomic barriers to care be mitigated. Therefore, transportation vouchers and gift cards will be provided to patients who receive prenatal care from one of our mobile clinics or participating providers. Vouchers will provide access to transportation via third-party ride-shares, like Lyft or Uber, and public transportation to ensure patient access to clinics as they transition from our mobile trucks to office-based care. Local clinicians who have partnered with the Milk Truck program will provide these destination-specific vouchers at the end of each appointment to improve access to long-term care for these mothers. Additionally, mothers can use gift cards distributed by clinicians and at Milk Truck sites to purchase childcare supplies, clothing, or food.

Feeding and Pumping

When a child is born, it is vital that parents understand how to provide optimal nutrition to support the child’s health and well-being. The Milk Truck program aims to provide mothers with supplies that they may need following hospital discharge. Most insurance providers, as well as the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), have programs in place that provide breast pumps. Therefore, our clinic staff will provide all the necessary documentation needed to guide new mothers through the process of acquiring their breast pumps. Milk Trucks will also be stocked with bottles and storage containers for mothers who wish to breastfeed but may be financially obligated to return to work shortly after delivery. The Milk Truck program, although primarily aimed at encouraging breastfeeding, will also be a distribution point for baby formula for mothers who may not be able—or want—to

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breastfeed. This program also recognizes that maternal nutrition is just as important during the postpartum period as it is during pregnancy. Thus, mothers will still be encouraged to enroll in MommyEats and have access to all incentive programs offered by Milk Trucks.

Breastfeeding Clinics

Each weekend, the Milk Truck will provide pop-up clinics aimed at teaching new mothers how to navigate potential challenges associated with breastfeeding. In addition to the designated physician, nurse, social worker, and two healthcare navigational aids on site, weekend clinics will be staffed with lactation specialists—nurses with specialized training in the breastfeeding process. Lactation specialists will lead group classes as

well as provide individualized support to mothers who require additional assistance. In addition to supporting breastfeeding, these clinics will also provide health screenings to mothers and mothers-to-be. The Milk Truck professionals will assess basic vitals, blood sugar, check weight, and screen for postpartum depression.

Nursing Kits

Patients that complete the weekend lactation class or can provide proof of gaining lactation education elsewhere will be provided nursing kits. Nursing kits will be equipped with a nursing brassiere, breast pads, nipple creams, and nursing pillows. Mothers will also be provided with a summary of nursing techniques provided in the lactation class.



Contraception

Contraception is vitally important to postpartum mothers. Data has shown that additional pregnancies within the first 12 months following birth are at the highest risk for adverse health outcomes for both the mother and the child (Teka et al., 2018). Therefore, the Milk Truck will provide contraception education as well as be a point of distribution/referral to an obstetrician for birth control. We believe that making this a point of emphasis in each patient contact will lead to an increase in contraceptive use and concordant improvement in birth outcomes.

The Milk Truck will be a voluntary program; therefore, to enroll patients, we will encourage local hospitals, clinics, and community resources to educate the public about this program. Milk Trucks will employ an electronic medical record system where patient information can be sent to the participating provider of the patient's choice. Additionally, paper records will be provided for the patients to bring to appointments themselves. One concern is that patients may choose to use the clinics as their only point of care, which will be discouraged. After a grace period, women and children will be required to have a provider on file whom they see at regular intervals. The incentives offered through the program also promote patients' transition of care to doctors' offices. The Milk Truck program's primary metric is to decrease infant mortality, which is defined as death before the first birthday. However, when determining eligibility for the program, we felt it was necessary to continue providing care out to the child's second birthday, as that is the point where most children have been tapered off breast milk. Once the child's first birthday has passed, social workers aboard the Milk Truck will approach the families about beginning the transition to other local resources.

Discussion

The Milk Truck program is a conceptual intervention designed for low-income urban neighborhoods to mitigate the impact of poverty on pregnancy and early childhood development. The proposed mobile

health clinics, which we call Milk Trucks, will improve perinatal care by delivering education, breastfeeding support, and childcare supplies directly to high-risk families. Healthcare workers onboard the Milk Trucks will actively link families to the appropriate next steps for their individual situations, whether that be scheduling a routine health screening, a 6-month prenatal care visit, or a 1-year postnatal visit for immunizations.

The impact of poverty on childhood well-being poses a serious public health threat. Poverty limits low-income mothers' access to important resources, which can have severe implications for a child. Stress, improper access to nutrition, and poor access to perinatal care can contribute to adverse birth outcomes such as preterm births, low birth weights, and infant death. In situations where the outcome is not fatal, the impacts of such situations should not be understated, as they negatively influence lifelong neurodevelopmental trajectories for the child. Therefore, children are born into environments that may negatively alter the course of their life while having no control over the situation themselves. Society has a responsibility to protect these children first and foremost by implementing practices to end structural poverty. However, a stop-gap program such as the Milk Truck program can aid in mitigating the lifelong impact of poverty on children.

A key aspect of the Milk Truck Program is its focus on integrating patients into the existing healthcare framework. A potential consequence of interventional programs is that once the patient loses access, low-income families fall back into the cycle of trying to navigate and access a complicated and intimidating healthcare system all on their own. To overcome the challenge disadvantaged communities face in accessing healthcare services, cross-sector collaboration is key. The collaboration that is required between community members, social services, and governmental agencies, as well as healthcare providers to mitigate the effects of poverty in these jurisdictions can no longer be shouldered purely by families themselves. The Milk Truck program involves professionals from

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multiple sectors to employ a multifaceted approach, ensuring patients are transitioned into long-term care and learn how to properly navigate resources for themselves.

This plan implements strategies based on evidence from previously successful interventional programs as well as unique strategies derived from conversations with pregnant mothers in Philadelphia. The Milk Truck program provides a distinct focus on lactation education following the CDC's Healthy People 2030 goal of improving breastfeeding among mothers (Hasbrouck, 2021). The program relies on a mobile approach to provide resources to the most disadvantaged communities. Along with education and supplies on the ground, transitioning patients to long-term care is an essential mechanism for sustaining these healthy habits well beyond the Milk Truck. We believe that points of care focused on these underlying causes of high infant mortality in urban neighborhoods will decrease infant mortality rates and improve the quality of life for these residents.

Limitations

An important concern regarding the conceptualized Milk Truck program is the significant coordination and financial support required for initial implementation. However, public health efforts such as mobile health clinics have been proven to provide significant cost savings and improve health outcomes in underserved communities (Yu et al., 2017). Another concern regarding this program is a lack of public awareness or understanding of what the program provides. Strong social media campaigning, television marketing, and point of contact marketing from healthcare providers can assist in overcoming this initial barrier. Throughout the program, regular patient interviews can be used to provide feedback on the program's utilization and public perceptions. The effectiveness of the Milk Truck program can be

monitored through changes in infant mortality rates over time in the target neighborhoods. Additionally, establishing a network of providers who will later act as points of definitive care needs to be considered in the implementation of the Milk Truck program. Recruiting providers could prove to be a substantial challenge; however, clinicians will likely be open to partnering with the program, as it can act as a referral service for providers.

Conclusion

To mitigate the impact of poverty on infant mortality and child well-being, we propose the Milk Truck program. This is a neighborhood-based intervention provides education, breastfeeding, nutritional assistance, and supplies directly to high-risk families through mobile health clinics. In this context, we define high-risk as pregnant mothers and individuals that are low-income, living in impoverished neighborhoods, and/or living in neighborhoods with reportedly high infant mortality rates. Such populations have further barriers to proper and adequate prenatal and postnatal care; therefore, our hope is to reach mothers right where they are.

A good deal of education is required to make sure a mother and her child—unborn or born—can lead healthy lives, making coordinated care vital in ensuring the health of future generations, no matter one's socioeconomic status. The phenomenon of disparate infant mortality rates within Philadelphia grossly underscores the lack of resources, health care, and education within obstetric-level care and this patient population. Healthcare hubs beyond the traditional office setting are necessary to help alleviate such disparities in our community. Ultimately, our program takes a holistic approach to pregnancy care through educating mothers beyond childbirth, since the work of improved infant mortality outcomes addresses nutrition, health screenings, and well-being support over the long term.

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Medical Child Abuse: A Guide for Child Protection Workers

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Abstract

Medical child abuse (MCA) is a complex entity that can take years to accurately diagnose and report to Child Protective Services (CPS). In cases of suspected MCA, CPS is faced with parents who appear to be caring advocates for their child, children who appear to have complex medical issues, fragmentation of medical care among multiple providers and hospitals, and a dearth of standardized protocols for safeguarding children. The purpose of this report is to provide a single, accessible resource on the management of MCA for CPS investigators and child welfare workers. Its intended use is for situations in which there is a referral to CPS made by a medical provider for a concern of MCA.

Keywords: *medical child abuse, Munchausen syndrome by proxy, factitious disorder imposed on another, child abuse, child maltreatment*

Background

History and Definitions

Medical child abuse (MCA) is defined as “unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker” (Flaherty et al., 2013). First described by Henry Kempe in “Uncommon Manifestations of Battered-Child Syndrome” (Kempe, 1975), the condition of a child suffering medical harm at the instigation of a caregiver has gone by many names: Munchausen syndrome by proxy, factitious disorder imposed on another (*Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2022*), pediatric condition falsification, child abuse in a medical setting, fabricated or induced illness, caregiver-fabricated illness in a child (Flaherty et al., 2013), and MCA. There are nuanced differences between these various definitions that primarily depend on whether the focus is on the child as a victim, the caregiver’s motivation, or both.

MCA was so named with the intention of placing focus on the *harm to the child* rather than the psychopathology or motivation of the caregiver. Whether the harm is the result of intentional manipulation by the caregiver, desire for secondary gain, untreated anxiety, or another cause, the definition of MCA applies when the child is suffering medical harm or potential harm at the instigation of a caregiver. Of course, caregiver psychopathology and motivation must be addressed if the long-term goal is rehabilitation with family preservation, but the first priority should always be safeguarding children from further harm.

Patterns

MCA involves exaggeration, fabrication, falsification, misrepresentation, or induction of illness in a child by a caregiver. In all its forms, MCA leads physicians and other healthcare providers to perform unnecessary medical investigations and interventions that threaten or

cause harm to a child. In essence, physicians become the instrument through which caregivers harm the child. MCA is differentiated from malpractice, in which a medical provider orders excessive, inappropriate, and harmful interventions in response to a *reliable* history from the caregiver (Roesler, 2010). In MCA, the history from the caregiver is *unreliable*, and the physician’s response to the unreliable history is what leads to harm. As described in the *APSAC Practice Guidelines*, “highly competent clinicians can be misled into providing unnecessary or harmful care to the child” (APSAC, 2017).

Many victims of MCA do have underlying medical disease(s), and it can be challenging to recognize MCA in children who start out with legitimate medical signs, symptoms, or diagnoses (Rosenberg, 1987). Nevertheless, MCA commonly involves several distinctive patterns of manipulation of the healthcare system by a caregiver (Flaherty & Macmillan, 2013), including fragmenting care among many medical institutions and providers, and exaggerating or misrepresenting the results of prior medical evaluations. As noted in the *APSAC Practice Guidelines*, “some abusers seek out clinicians who provide nonstandard or substandard care to further their goals” (APSAC, 2017). There is often an *overutilization of inappropriate* care paired with *underutilization of appropriate* care. The underutilized care often consists of mental health services and primary care (Jenny & Metz, 2020; Johnson et al., 2022). A case of MCA may involve all of these patterns or a subset. It may develop insidiously or abruptly (as is the case with suffocation or poisoning, i.e., direct induction of harm).

In addition to medical harm, victims of MCA are at risk of great psychological harm by being manipulated to adopt the sick role and experiencing social isolation as they are often removed from school and extracurricular activities because they are “too ill.” The children often have visual indicators of their falsified illness (e.g., intravenous lines, feeding tubes, glasses, wheelchair, walker). The caregivers

are sometimes very active on social media, seeking sympathy and sometimes funding pertaining to their child’s illness (Brown et al., 2014). Caregivers sometimes directly harm their child to “prove” the falsified illness. MCA can be fatal; the risk of mortality is 6%–9% (Jenny & Metz, 2020).

Medicolegal Context

To some CPS and child welfare workers, MCA will be a new concept. Although the harms of physical abuse or sexual abuse are relatively self-evident, it may not be immediately apparent to CPS and child welfare workers how excessive medical care can cause harm. While MCA research is in its relative infancy compared with some other forms of maltreatment, Figure 1 demonstrates the exponential increase in peer-reviewed publications relating to MCA over the past 50 years. To date, there are nearly 17,000 peer-reviewed publications on MCA. The breadth of existing research on MCA may help reinforce the validity of such concerns brought to CPS by a medical provider.

Figure 1. Peer-Reviewed Publications on Medical Child Abuse.

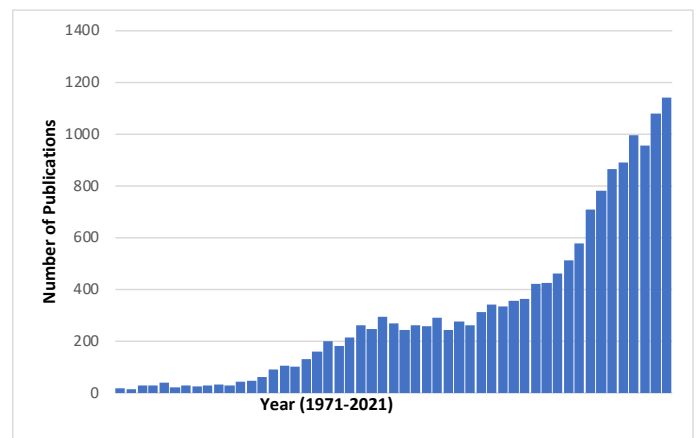


Figure 1 was derived from PubMed (September 22, 2022), the medical literature search engine of the National Institutes of Health. Each bar represents the number of articles published per year (i.e., not cumulative) relating to the following search terms: medical child abuse OR caregiver-fabricated illness in a child OR pediatric condition falsification OR child abuse in a medical setting OR factitious disorder by proxy OR Munchausen syndrome by proxy OR factitious disorder imposed on another

Medical Child Abuse

Despite the growing awareness about MCA among the medical community, it makes up less than 6% of reports to CPS (*Child Maltreatment*, 2020). Pathways to manage MCA in CPS, child welfare, law enforcement, and legal prosecution are sparse, and those available tend to be extensive, sometimes inaccessible, or state-specific (*Arizona Department of Child Safety. Investigating Involving Medical Child Abuse*, 2021; *Michigan Governor's Task Force on Child Abuse and Neglect. Medical Child Abuse: A Collaborative Approach to Identification, Investigation, Assessment, and Intervention*, 2013). Most CPS investigators and child welfare workers are not trained in case management of MCA. Faced with parents who appear to be caring advocates for their child, children who appear to have complex medical issues, and fragmentation of care among multiple hospitals and providers with varied medical opinions, CPS case workers and legal partners are often left with little direction for how to investigate and intervene to safeguard these children.

Aim

The purpose of this report is to provide a single, accessible resource on the investigation and management of MCA for CPS investigators and child welfare workers. Its intended use is for situations in which there is a referral to CPS made by a medical provider (rather than a community or family member) for a concern of MCA. **This resource draws upon relevant articles from the APSAC Advisor Special Issue: Munchausen by Proxy, and in particular, the practice guidelines on Munchausen by Proxy by the APSAC Taskforce.** It will highlight the important take-home points from these and other articles on CPS management of MCA, will place the recommendations in medicolegal context, and will give concrete examples of how to work with the medical providers and law enforcement throughout the investigation.

This resource will not focus on how a medical provider makes a diagnosis of MCA. For this, we refer readers to more comprehensive resources such

as the 2017 *APSAC Practice Guidelines* and the *American Academy of Pediatrics Clinical Report* (Flaherty & Macmillan, 2013). This article will also not focus on the law enforcement investigation, for which we refer readers to the article by Michael Weber in the 2018 *APSAC Advisor* special report.

CPS investigators and child welfare workers may share this resource with their colleagues in the medical field, law enforcement, and legal settings to promote a shared paradigm for case management.

Practical Application

Prior to the CPS Report

One of the most important things to know about MCA is that by the time a medical provider calls a referral to CPS, the pattern of care may be well-established and the threat of harm to the child quite prolonged, severe, and/or imminent. Because of the nature of MCA—the fragmentation of care, the misrepresentation by caregivers, and the manipulation of medical providers as the instrument of abuse—it can take years for medical providers to recognize the concern and gain consensus in the decision to make a report (Sheridan, 2003). Medical providers sometimes become quite enmeshed with the caregiver's false narrative and may have difficulty recognizing or accepting their role in the child's harm.

Unlike, for instance, a patterned bruise or a disclosure of sexual abuse, the threshold for mandated reporting of MCA is less straightforward. The determination that MCA is occurring often involves the engagement of the hospital's social work team, child protection team, medical provider meetings, record reviews, and innumerable attempts to converse with the caregiver and redirect the harmful pattern of care. When these efforts at clear communication and care redirection in the clinical setting are ineffective, or when a life-threatening event is imminent, a report should be escalated to CPS (Flaherty & Macmillan, 2013).

When the CPS Intake Comes In

1. **Screening.** For cases of suspected MCA, the screening decision should lead to an investigative pathway rather than an alternative response. Voluntary services are not appropriate for these cases, given the high level of deception and evasiveness inherent to the condition.
2. **Organizational Infrastructure.** If possible, it can be helpful to create a state-wide protocol for child protection workers and law enforcement responding to intakes for concern of MCA (*Arizona Department of Child Safety. Investigating Involving Medical Child Abuse, 2021; Michigan Governor’s Task Force on Child Abuse and Neglect. Medical Child Abuse: A Collaborative Approach to Identification, Investigation, Assessment, and Intervention, 2013*). It can also be helpful to assign one CPS investigator in each jurisdiction to receive additional training on this topic and be the primary investigator assigned to such cases.
3. **Early cross-reporting.** We recommend early cross-reporting to law enforcement, as these investigations can be complex and laborious. Working as a team from the beginning may help ensure that consistent communication between agencies is maintained as the case unfolds.
4. **Contact with the referring provider.** After reviewing the intake, and before contacting the family, the assigned CPS case worker should contact the medical provider(s) who made the report to better understand the concern(s) that prompted the report. This may be done in coordination with law enforcement if an investigator is assigned.

The first question to be asked is whether there is concern for imminent risk to the child—i.e., whether the child is at risk of death or serious decompensation if intervention does not occur immediately. If this is the case, immediate protective custody should be sought with the assistance of law enforcement, and direct

admission to the hospital may be indicated (APSAC, 2017). The reporting medical provider should be engaged in the decision about whether hospitalization is indicated, or if the child is medically safe to enter a foster home.

If the risk is not imminent, then the conversation with the reporting medical provider should focus on concrete and tangible examples of risk and harm. Ideally, a comprehensive medical timeline called a chronology will be constructed by a medical provider trained in assessing MCA (Flaherty & Macmillan, 2013). This may occur before or after the CPS intake is made. When it is not feasible to obtain such a chronology within the timeline needed for an investigative response, then the CPS investigator can work with the medical provider who made the report to clarify *specific* examples of risk and harm. The medical provider(s) who made the report should be asked to summarize the medical history and concerns for overmedicalization in written form in language that can be understood by non-medical audiences including investigators, attorneys, and judges. We have provided a letter template that may be shared with the reporting medical provider to help create this written summary (see Appendix).

5. **Initial investigation.** Early in the investigation—ideally before the instigating caregiver is notified of the report—CPS should collaborate with law enforcement to review all social media accounts owned by the caregiver. This is to look for examples of misrepresentation or secondary gain based on the presentation of the child as ill. CPS should request all medical records for the child and share these with law enforcement and with a physician skilled in reviewing such medical records. Law enforcement should obtain search warrants for the instigating caregiver’s phone and Internet search history, should review electronic communications in which the instigating caregiver has discussed the child’s health, and should conduct an early scene investigation (APSAC, 2017).

Trial Separation

Once imminent harm has been addressed and the earliest pieces of the investigation are underway, CPS is faced with determining a safety plan. Because of the complexity of these cases, the preponderance of perpetrators that are the child's primary caregiver (Sheridan, 2003), the physical and psychological threat to the child (McGuire & Feldman, 1989), and the inability to gain an objective assessment of the child while they remain in the care of the instigating caregiver, a trial separation is often indicated. Often, the true medical needs of a child with underlying illness cannot be evaluated unless they are separated from the instigating caregiver. As described in the *APSAC Practice Guidelines* (APSAC, 2017), "If the child's condition or functioning improves when sufficiently protected from the influence of the suspected abuser [...], many courts will use the concept of *res ipsa loquitur*, [or] "the thing speaks for itself" (p. 15).

If the risk of harm to the child is assessed as low, the driving factor of the instigating caregiver's behavior is anticipated to be anxiety (as opposed to secondary gain or factitious disorder imposed on another), and there is a second protective caregiver in the household who understands the concern for MCA and can take charge of the child's healthcare during the investigation, a trial separation may not be needed. If all three of these criteria are not met, however, a trial separation may be the only way to obtain an unbiased, objective assessment of the child's true medical needs.

1. Options for establishing safety through a trial separation. In some cases, a child may initially require hospitalization for evaluation and stabilization during which the instigating caregiver is prohibited from being at the bedside or communicating with the patient (APSAC, 2017). For children who are hospitalized, careful planning with the referring medical provider and inpatient medical team should be sought ahead of time to establish goals of the admission, a plan for weaning each medication and device, and discharge criteria.

Otherwise, there are a few options for how to initiate a trial separation in the home setting: (1) the instigating caregiver can move out of the home, (2) the child can be placed in kinship care with a friend or family member, or (3) the child can be placed with an unrelated foster caregiver. We recommend approaching these three options based on level of risk to the child and the degree to which family and friends of the instigating caregiver understand the concern for MCA and are willing to act protectively.

A friend or family member who downplays the concern for MCA may not appropriately safeguard the child to allow for an unbiased investigation. In cases of MCA, the denial of the instigating caregiver and their immediate social connections toward the possibility that abuse is occurring can be quite persistent. It is important to place the child in an environment where a completely unbiased assessment of their behaviors and medical needs can be attained. A guide for assessing the protectiveness of alternative caregivers is available in the APSAC special report on Munchausen syndrome by proxy (Giardino & Greeley, 2018; Sanders & Ayoub, 2018). This article recommends asking prospective alternative caregivers about the following:

- **Belief:** The alternative caregiver's ability to believe and accept the allegations
- **Protectiveness:** The alternative caregiver's ability to provide appropriate protection for the child
- **Impact of Allegations:** The impact that the allegations have had on the alternative caregiver
- **Communication:** The alternative caregiver's plans for communication with the instigating caregiver
- **Parenting Issues:** How home and caregiving duties are typically designated between the caregivers (if the prospective caregiver is a

spouse or co-parent)

- **Legal and Mental Health Issues:** Any outstanding legal matters or mental health or substance use concerns in the family
- **Knowledge and Needs:** The alternative caregiver’s understanding of the child’s health and any questions they may have

If the child’s condition appears to be medically complex, a medical foster home may be appropriate until unnecessary devices and medications are able to be weaned. If court proceedings are needed to obtain custody and carry out the trial separation, a summary letter from the medical provider describing concrete examples of risk and harm should be included (see Appendix).

2. **Safety planning for the instigating caregiver.** The 2017 *APSAC Practice Guidelines* note that safety planning for the instigating caregiver is recommended, particularly relating to suicidal ideation around emotionally-fraught circumstances, such as removal of the child.
3. **Interviewing the instigating caregiver.** Once immediate safety has been established for the child, CPS can work with law enforcement to interview the instigating caregiver. Any medical claims or diagnoses reported by the caregiver should be compared with the medical records, and any claims the instigating caregiver makes about their own health or educational background (such as specific medical training) should be verified (APSAC, 2017).
4. **Establishing a medical home and de-escalating medical care.** A key component of the trial separation is establishing a medical home with a primary care provider who will play an active role in care coordination, de-escalation of care, and boundary-setting with the instigating caregiver. Hospitals providing care should establish means to route all recommendations and referrals through this primary care provider. The goal of the trial is

to collect objective, reliable observations of the child that may facilitate medical improvements, including those related to nutrition, mental health, development, and weaning of unnecessary therapies, medications, and devices. Items are typically weaned one at a time to evaluate the child’s need for each individual medication and device.

To facilitate an unbiased assessment of the child’s medical needs, the instigating caregiver should be restricted from communication with the child’s health care team and from attending medical appointments with the child. The decision about whether or not the medical record should be blocked from the instigating caregiver (i.e., whether the caregiver should maintain access to an online patient portal) should depend on whether their access puts the child at risk of further harm.

5. **Guidance for foster caregivers.** Foster caregivers should be trained regarding how to assess the child’s behaviors and respond appropriately. For example, if a certain type of movement, behavior, or apparent need for mobility device by the child was rewarded by the instigating caregiver with affection, the new caregiver should be advised to give the child a great deal of positive attention and affection regardless of the presence of such behaviors or needs. Spells or behavioral episodes that are determined to not be dangerous are often best responded to with “benign neglect,” meaning to not give specific attention to the behavior. The caregiver should also be aware that certain behaviors may be a response to the stress of separation and change in the child’s daily routine and environment. The new caregiver should be encouraged to respond to all such behaviors by reminding the child that they are safe and loved.

Whenever there is question about the true nature of the child’s behavior or symptoms, sources of potential bias in the child’s environment should

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be considered. For example, if the child is in the physical custody of a caregiver who does not believe the concerns for MCA are legitimate, transitioning the child to an unrelated foster caregiver or arranging for a direct admission to the hospital may allow for a more unbiased assessment of the child.

6. **Additional sources of information.** Information from outside observers, such as school or daycare, should also be sought to gain an accurate assessment of the child's medical needs. Since the instigating caregivers often isolate and “homeschool” the child, the observations of other family members or acquaintances of the family may be sought as well (again, keeping in mind that the deception inherent to MCA may leave many friends and family of instigating caregiver in denial of the possibility of MCA).
7. **Length of trial separation.** The trial separation should be long enough to capture any symptoms commonly reported by the instigating caregiver. For example, if the caregiver reports several seizures per month, the separation should be at least one month. The separation will often require much more time—on the order of months to years—to achieve all rehabilitative steps needed for safe reunification.

Visitation

If visitation with the instigating caregiver is planned, supervision by an unbiased person who understands the concern for MCA is important. The CPS investigator or child welfare worker is often suitable for this role. The *APSAC Practice Guidelines* (APSAC, 2017) provide specific recommendations for visitation, including the following key components:

- The instigating caregiver should be restricted from preparing the child's food or providing them with any food, drinks, gum, candy, or mints, or anything they would put topically on their body.
- The child should be visible at all times.
- All verbal communication should be audible to the supervisor.
- Communication of all forms—verbal, nonverbal, and written—between the instigating caregiver and child should be monitored. Communication should be restricted from any mention of symptoms or medical needs. This should apply to both in-person as well as remote (i.e., phone or video chat) interactions between the caregiver and child.



Intervention and Service Provision

The context of maltreatment and family dysfunction that leads to MCA is arguably more complex than other forms of maltreatment. It often involves unrecognized caregiver mental illness (Bass & Jones, 2011; Sheridan, 2003) and a lack of insight into the harm being imposed. Prior literature has suggested that most instigating caregivers are females and have some degree of psychopathology, particularly cluster B personality disorders such as borderline, histrionic, sociopathic, or mixed personality disorder (APSAC, 2017; Yates & Bass, 2017). Anxiety, substance use disorders, somatoform disorders, and delusional disorders are also prevalent in these cases. A case series by Bass and Jones found high rates of somatoform disorders (57%), factitious disorders (64%), non-epileptic spells (32%), and pathological lying (pseudologia fantastica (61%) among instigating caregivers (Bass & Jones, 2011). Another case series by Bools, Neale, and Meadow in 1994 found that 72% of instigating caregivers had histories of somatic symptoms disorder or factitious disorder imposed on self, 21% had substance misuse, 55% had histories of self-destructive behaviors, and 89% had personality disorders (Bools et al., 1994). The instigating caregiver's tendency to fabricate illness in the child may be experienced as an overwhelming compulsion, comparable to an addiction to the attention, affection, and sympathy derived from having an ill child (APSAC, 2017). This requires intensive work to resolve.

When an anxiety disorder is at the root of the behavior, it is often the anxiety-avoidance cycle that prompts excessive, unnecessary medical interventions. For example, a caregiver may have anxiety about what they are observing in their child, seek medical care to reduce that anxiety (i.e., "avoiding" the anxious feeling of uncertainty), and experience relief when medical tests, interventions, or referrals are undertaken. Over time, this can solidify into a habit where the anxiety-avoidance cycle is reinforced by the response of the medical system to an anxious caregiver.

While the reasoning behind why the caregiver is instigating medical harm is irrelevant to the *diagnosis* of MCA, it will be of particular relevance to the CPS investigator or child welfare worker faced with making determinations about service provision and possible reunification. We recommend the following considerations in terms of service provision and intervention:

- 1. Comprehensive mental health evaluation of instigating caregiver.** One priority of service provision should be a mental health evaluation for the instigating caregiver by a mental health professional experienced in assessing conditions such as Munchausen syndrome by proxy, factitious disorder imposed on another, and MCA. Because expertise in this area is relatively rare, a mental health professional who is skilled in evaluating personality disorders and is open to learning more about the psychopathologic origins of MCA while maintaining open communication with CPS (to ensure child safety) is sufficient.

In addition to diagnosing and treating any unmet mental health needs, the provider should assess the caregiver's parenting skills, coping skills, any learning or cognitive disabilities, and the quality of the social support structure around the caregiver. Instigating caregivers are often skilled in co-opting evaluators. To limit this, the mental health evaluator should be provided with objective evidence of harm to the child. It is important to remember that the evaluation is done to assess pathways and barriers to potential reunification, and not to prove or disprove that MCA has occurred. A normal psychologic or psychiatric evaluation does not mean MCA has not occurred.

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- 2. Protocol for treatment of instigating caregivers.** The “ACCEPTS” model is one published protocol that provides guidance on the treatment of caregivers who have instigated MCA (Bursch, 2018; Sanders & Bursch, 2020). This protocol may be shared with the mental health provider consulting on the case. The key components of the ACCEPTS model as described by Drs. Sanders and Bursch are as follows:
- **AC: Acknowledgement.** It is important that the instigating caregiver is able to acknowledge and take responsibility for their behaviors that placed the child at risk and/or caused harm.
 - **C: Coping.** It is important that the instigating caregiver has developed and can implement skills to cope with their own stress and emotional needs.
 - **E: Empathy.** It is important that the instigating caregiver demonstrates ability to empathize with the child, including an appropriate cognitive and emotional response to the past harm caused through MCA.
 - **P: Parenting.** It is important that the instigating caregiver demonstrates effective parenting skills, including the ability to put the needs of the child before their own needs.
 - **T: Taking charge.** It is important that the instigating caregiver take charge of their own recovery and stability, including proactive plans for how to prevent relapses.
 - **S: Support.** It is important that a structure is built around the instigating caregiver for ongoing support and monitoring of potential relapses into MCA.
- 3. Multi-disciplinary team collaboration.** Given the context of deception inherent to MCA, it is difficult for any individual managing a case or mental health provider evaluating the caregiver to remain objective and avoid becoming misled by the caregiver’s false narrative. Continuing to work as part of a multi-disciplinary team and

always returning to the objective medical data to answer questions about the child’s illnesses (or lack thereof) is critical for these cases.

As formal intervention occurs through the child protection system, the case may be transferred to a child welfare worker, who was not a part of the initial investigative team. It is imperative that ongoing communication occur between the medical provider(s) and the child welfare worker to ensure they understand the risk of harm, and to reduce triangulation between the family and the systems involved. In addition, the mental health provider evaluating the instigating caregiver should provide guidance to the CPS investigator or child welfare worker regarding which services may be most appropriate for rehabilitation, and the anticipated likelihood (or lack thereof) of successful reunification.

Considerations for Reunification

MCA has a high rate of relapse after reunification. This is particularly true in cases driven by factitious disorder imposed on another (Bursch, 2018) as opposed to caregiver anxiety. Reunification, if sought, should proceed slowly and carefully (Flaherty et al., 2013). Child welfare workers should expect involvement with the family to last months to years to facilitate interventions that may create a safe environment for the child. Perpetrators’ insight into their tendency to fabricate often comes slowly, and they must learn to recognize and avoid their impulses to harm the child via fabrications. This means identification of the psychopathology or motivation at the core of the behavior, and the development of alternative coping skills is imperative. Many perpetrators will never improve sufficiently to be safe around the child.

- 1. Re-initiation of the instigating caregiver’s involvement in the child’s healthcare.** If reunification is planned, the instigating caregiver’s participation in the child’s healthcare should be re-initiated slowly and with careful monitoring. An unbiased third party (often the CPS investigator or child welfare worker)

should attend appointments with the child and caregiver and take notes. Medical records from these visits should be obtained and placed in the child's case file. Close attention should be paid to whether exaggeration or fabrication of the child's symptoms is occurring, and whether the caregiver is asking for specific medical tests or referrals not otherwise suggested by the medical provider. These are indicators that the caregiver has not fully rehabilitated to the point that they can safely participate in the child's healthcare.

Medical care should be sought from a single primary care provider who is aware of the concern for MCA and the risk of overmedicalization. The provider should be able to set boundaries and decline a caregiver's requests for unnecessary interventions. All subspecialty referrals should be placed by this provider, who should be in close communication with subspecialists both before and after subspecialty visits to ensure recommendations are made based on objective findings rather than subjective history.

- 2. Ongoing multi-disciplinary team collaboration.** It will be helpful throughout the case for a protective multi-disciplinary team to meet routinely including CPS, law enforcement, the child's primary care provider, the instigating caregiver's therapist, foster caregivers, and visitation supervisors. This will allow for open communication about the barriers to, and prospects for, reunification.

As the instigating caregiver progresses through the "ACCEPTS" model, and if deemed appropriate by the protective multi-disciplinary team, it may be helpful for the instigating caregiver to have a conversation with the child about their behaviors that led to harm for the child (APSAC, 2017). The instigating caregiver should reassure the child that they are loved regardless of their health or ill status.

- 3. Building a safety net.** If reunification is to occur, a protective community including the patient's primary care provider, family members, and friends should be built who all understand the risk of harm from MCA. This protective community should be educated about the motivation behind the instigating caregiver's overmedicalization of the child, and alternative coping skills that have been developed to prevent recurrence. This community should also be advised to remain alert for any signs that the instigating caregiver's description of the child's symptoms is exaggerated, fabricated, or falsified, and to re-engage CPS if there is concern for recurrence of medical harm via MCA. They should be provided with the number for CPS intake and the names of the previous CPS investigator and child welfare worker, both of whom should be consulted in the screening process and should have priority assignment if the intake screens in.



Conclusion

Medical child abuse is a complex entity that can take years to develop, years to accurately diagnose, and years to de-escalate. By the time a report reaches CPS, the pattern of healthcare manipulation and fragmentation is often so developed that de-escalation is beyond the scope and capabilities of the healthcare system, and protective intervention is required. When a CPS case worker can partner with the medical team to summarize and translate their concerns into non-medical jargon, citing concrete and tangible examples of risk and harm, a stronger case can be made for a protective response in investigative and legal settings. A trial separation from the instigating caregiver may allow for objective and reliable observations of the child's true medical needs as excessive medications and interventions are gradually weaned. Concurrently, an evaluation of the instigating caregiver for unmet mental health needs, psychopathology, and motivation behind the healthcare-seeking behavior is critical if reunification is to be considered. Reunification, when sought, should proceed slowly and carefully with monitoring of milestones indicating that the instigating caregiver may be ready to safely participate in the child's healthcare. A protective community should be established that can recognize patterns of MCA and report concerns should they arise again.

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Appendix

Date: [MM/DD/YYYY]

Re: [Patient full name], DOB: [MM/DD/YYYY]

To whom it may concern:

This is a letter summarizing concerns of medical child abuse leading to Child Protective Services intake for [Patient full name].

Medical child abuse is defined as “unnecessary and harmful or potentially harmful medical care at the instigation of a caretaker.” It is sometimes referred to as Munchausen Syndrome by Proxy, but unlike Munchausen Syndrome by Proxy, the definition of medical child abuse focuses on the *harm to the child* rather than the motivation or diagnosis of the abuser. Medical child abuse can involve exaggeration, misrepresentation, fabrication, falsification, or induction of illness in a child.

[Patient]’s Medical History

[Provide a brief summary of the patient’s medical history]

Involvement of Reporting Provider

[Provide a brief description of how the reporting provider came to know the patient, and how concerns culminated in a mandated report]

[Include the following 3 sections as applicable, with a bulleted list of examples specific to the patient]

Concerning Pattern of Healthcare Seeking

Perpetrators of medical child abuse often fragment medical care between different providers and undergo frequent care transitions. There is often overutilization of inappropriate medical care, and underutilization of appropriate medical care, as observed in [Patient]'s case:

- *[Examples may include, but are not limited to: seeking care from many different hospitals and clinics, resisting the release of records from one institution to another, or seeing multiple subspecialists within the same specialty. It can be helpful to provide a complete list of all the hospitals and clinics where the patient has been seen]*

Exaggeration, Fabrication, Misrepresentation, or Induction of Illness

Medical child abuse involves exaggeration, fabrication, misrepresentation, or induction of illness. The following are examples of this in [Patient]'s case:

- *[Examples may include, but are not limited to: exaggerating symptoms, reporting symptoms that have never been observed by another person, misrepresenting the medical opinions of other doctors, reporting diagnoses that have not been confirmed, or inducing illness such as through suffocation or poisoning]*

Harm to [Patient]

The inappropriate utilization of healthcare by [suspected perpetrator] has potential for serious harm. The following are examples of harm or risk of harm in [patient]'s case:

- *[Examples may include, but are not limited to: unnecessary medical exams, labs, imaging, radiation exposure, medication side effects, procedures, surgeries, risks of anesthesia, missed school, educational neglect, unsought psychiatric or psychologic care, medical neglect, removal from social activities that are important for child's development, and being placed in the psychological sick role]*

Summary of Concerns

In summary, it is my medical opinion that [patient] is a victim of medical child abuse by [suspected perpetrator]. This type of abuse is often difficult to recognize because the perpetrator gives an impression of caring and advocating for the child. However, the pattern of overutilization of inappropriate healthcare services and underutilization of appropriate healthcare services leads to undue medical harm to the child. Medical child abuse can have long-term physical and psychological repercussions. It can lead to unnecessary surgeries and can cause death. Thank you for your close review of this case and I welcome you to contact [me/us] with any questions.

Sincerely,

[Signatures and contact information for medical provider(s) making report]

Myth-Busting: Supporting Young Children With Intellectual and Developmental Disabilities Who Have Experienced Maltreatment

*Mia Chudzik, MEd; Catherine Corr, PhD;
Michaelene M. Ostrosky, PhD*

Abstract

Estimates of the prevalence of children with disabilities in the child welfare system vary, as only a handful of researchers have investigated this topic. Yet, research has shown that children with disabilities are more likely to experience maltreatment compared to children without disabilities. While *all* children with disabilities are at greater risk of experiencing maltreatment, those with intellectual and developmental disabilities (IDD) may be at a higher risk. In this article, we summarize the data on maltreatment and its intersection with data on children with disabilities. We then discuss six common myths around children with IDD and offer alternative ideas and viewpoints. Addressing these misconceptions will help child welfare professionals better understand and support children with IDD.

Keywords: maltreatment, disabilities, children, intellectual disability

What Is a Disability?

Over three million children ages birth to 18 in the United States have a disability (Young & Crankshaw, 2021). While there are multiple ways to define disability, the Individuals with Disabilities Education Act (2004) defines a disabled individual as one who:

“(1) has an intellectual disability, hearing impairment (including deafness), speech or language impairment, visual impairment (including blindness), serious emotional disturbance, orthopedic impairment, autism, traumatic brain injury, other health impairments, or specific learning disabilities and (2) who, by reason thereof, needs special education and related services.”

A disability can impact a variety of developmental domains including communication, motor, cognition, and social-emotional skills (Young & Crankshaw, 2021). However, children with disabilities have many strengths as well as areas in which they need specialized support.

Some children are born with an identifiable disability, such as Down syndrome, whereas others may be diagnosed with a disability later in life such as attention deficit hyperactivity disorder (ADHD), a learning disability, or autism. Other children may develop a disability because of an illness, injury, or as a result of maltreatment such as a traumatic brain injury. Some children have a disability that impacts specific developmental domains such as physical development or cognitive development, while others may have more global delays. Some children may be diagnosed with a developmental delay, which refers to a significant variation in developmental milestones for one's age, such as walking, talking, and eating. While a developmental delay may not be permanent, as in the case of a child who may not be walking at 16 months

of age and starts to walk at 22 months, this diagnosis is commonly used for young children so they may access and receive supports such as speech-language therapy, physical therapy, occupational therapy, or developmental therapy (Batshaw et al., 2019).

One type of disability is an intellectual and developmental disability (IDD). This term is often used to describe a disability that is usually present at birth and affects an individual's physical, intellectual, and/or emotional development (Batshaw et al., 2019). An IDD can impact a child's ability to learn, reason, and problem solve. It also can impact adaptive behavior, which includes everyday social and life skills such as interacting with peers, dressing, toileting, and eating. While all children with disabilities are at a greater risk of experiencing maltreatment compared to children without disabilities (Jones et al., 2012; Sullivan & Knutson, 2000; Zetlin, 2006), those with significant support needs, such as children with IDD, may be at a higher risk (Child Welfare Information Gateway, 2018; Jones et al., 2012; Lightfoot, 2014).

Prevalence of Maltreatment Among Young Children With Disabilities

Estimates of the prevalence of young children with disabilities in the child welfare system vary for a few reasons. First, child welfare systems were not required to report information about a child's disability status until the 2010 reauthorization of the Child Abuse Prevention and Treatment Act (CAPTA) (Lightfoot, 2014). This reauthorization required that state child welfare agencies report the number of children under age three involved in a substantiated case who are eligible for early intervention services (i.e., special education) and the number of children under three who were referred for services. However, the child welfare system does not require the documentation of information regarding types of disabilities or the number of children with disabilities who are older than age three when they enter the child welfare system (Child Welfare Information Gateway, 2018). Moreover, while it is the responsibility of professionals in the child welfare

system to report data on disability, they often lack training focused on disability and special education services (Lightfoot & LaLiberte, 2006; Orelove et al., 2000). Specific challenges that these professionals may face include feeling unprepared to communicate with children with disabilities (Shannon & Tappan, 2011a) and being unable to identify a disability in children (Manders & Stoneman, 2009). Therefore, current estimates are likely conservative in terms of the number of children with disabilities within the child welfare system. This is problematic because when children with disabilities are not accurately identified and served within the child welfare system, they and their families are negatively impacted.

Child welfare professionals may be underprepared to support young children with IDD for a few reasons. First, despite understanding the importance of collaboration between child welfare and disability systems, there are often systemic barriers that make this collaboration difficult (Allen et al., 2012; Corr & Santos, 2017a, 2017b). The siloed nature of these systems can make it difficult to fully understand what each system does and how they could collaborate (Corr & Santos, 2017a, 2017b; LaLiberte & Lightfoot, 2013). Additionally, child welfare professionals have reported that they do not receive adequate training about disability and special education services (LaLiberte, 2013; Miller, 2018).

Despite these difficulties, some researchers have examined the prevalence of children with disabilities in the child welfare system. For instance, Sullivan and Knutson (2000) found that children with disabilities were 3.4 times more likely to experience maltreatment than children without disabilities. Similarly, Jones and colleagues (2012) reported that children with disabilities were 3.68 times as likely to experience maltreatment. Additionally, according to the U.S. Department of Health and Human Services (HHS), 14.1% of children who experienced maltreatment in 2015 had a disability (U.S. HHS, 2015). These findings, though limited in number, and somewhat variable, are startling and are a cause for concern and focused attention.

Young Children With Intellectual and Developmental Disabilities

Why Children With Disabilities Are More Likely to Experience Maltreatment

Many factors may contribute to the higher prevalence of children with disabilities experiencing maltreatment. Children who rely on caregivers to have their daily needs met (i.e., feeding, dressing, bathing) may experience a lack of independence and privacy (Hibbard et al., 2007; Zablotzky et al., 2019). Compounding this, some of these children may have a limited ability to protect themselves, to communicate, or to understand what maltreatment is or whether they are experiencing it (Lightfoot, 2014). Additionally, added stress in caregivers' lives due to social isolation, children's intensive needs, and children's challenging behaviors may contribute to high rates of maltreatment (Shannon & Tappan, 2011b; Sobsey, 1994). Finally, it may be hard for caregivers to determine whether a behavior such as hitting, crying, or social withdrawal are due to a child's developmental age, disability, or maltreatment, causing them to overlook possible signs of distress (Lightfoot, 2014).

In addition to children with disabilities being more likely to experience maltreatment compared to children without disabilities, the risk and prevalence of maltreatment varies based on the type of disability. Consider, for example, a child with an IDD who has a communication delay or communicates in an alternative way, such as by using an augmentative or alternative communication system. If this child experiences abuse or neglect, they may not be able to alert a trusted adult to this, and adults who support this child may feel unprepared to determine how to best support them. Additionally, children born with congenital disorders that may lead to medical complications such as Down syndrome or spina bifida are at an increased risk of experiencing maltreatment in the first month of life (Van Horne et al., 2015). This type of maltreatment may occur when medical care is withheld by a caregiver, such as when a child born with a heart defect is denied surgery.

Due to the increased risk of children with disabilities experiencing maltreatment, it is important that child welfare professionals are cognizant of the relationship between disability and maltreatment. Professionals also need to have the knowledge, skills, and confidence to support young children with IDD in the child welfare system.

Myth Busting

Previous research has highlighted the need to better support children with disabilities who have experienced maltreatment. Despite this perceived importance, child welfare professionals report feeling unprepared to do so (Corr & Santos, 2017a; Orelove et al., 2000; Shannon & Tappan, 2011a, 2011b). Below, we discuss six common myths about children with IDD and offer alternative ideas and ways of thinking.

Myth: Children with disabilities are best understood through the medical model.

Reality: Using the social model can help promote better understanding of children with disabilities.

The medical model focuses on disability as an impairment that is impacting the individual (Ladau, 2021). This model can be problematic when working with children with disabilities, as it puts the onus on the individual. A different way to view disability is through the social model. According to this model, individuals are not disabled by their impairments or medical conditions, but by systems, attitudes, and environments that create barriers to access and participation (Cole, 2007; Ladau, 2021). This is generally in opposition to the medical model of disability, which places the blame for a child's inability to "do something" on the individual and their disability (Ladau, 2021). Viewing disability through the social model may help child welfare

professionals better understand how to best support children with IDD, as it encourages looking at physical and social environments and assessing how they can be changed to support the child as opposed to focusing on fixing the child. For example, if a child in a wheelchair attempted to enter a building that only had stairs, the medical model would focus on the child's disability (i.e., the child cannot walk up the stairs). The social model would recognize that the problem stems from the fact that the building is not accessible.

It is also important to note that while children with disabilities are at an increased risk of experiencing maltreatment, it is not the disability itself that causes this increased risk, but instead society's response, or lack of response, to disability through discrimination, a lack of support, and barriers to accessing services (Lightfoot, 2014; Shannon & Tappan, 2011a).

Myth: Child welfare professionals need to work on their own to support a child with IDD.

Reality: There are other professionals who can support child welfare professionals in their work with children with IDD.

The importance of collaboration between the child welfare system and disability-related systems, such as early intervention (Corr & Santos, 2017a, 2017b; Dicker & Gordon, 2006; Shannon, 2021) and the special education school system (Zetlin, 2006), has been established. Cross-system collaboration is needed because no one system can meet the complex needs of families and young children with disabilities who have experienced maltreatment (Corr & Santos, 2017a). For very young children ages birth to three served in the early intervention system, reading their Individualized Family Service Plan (IFSP) and talking with the early intervention team can be helpful. A child's IFSP will contain information about

goals for the family and child that can be worked on in the child's natural environment, such as at home or at the park. The child's service coordinator should be able to share information and help professionals within the child welfare system learn more about an individual child's strengths and needs. Children over the age of three typically are served through the special education system in their local public schools. A child's special education teacher can provide valuable insights into the child's strengths and strategies that are used to support the child, as well as answer questions. Additionally, looking at the child's Individualized Education Program (IEP) can provide further insight into supports the child receives at school. Strong collaborative relationships can improve access to and the quality of services that children with disabilities who have experienced maltreatment receive (Corr & Santos, 2017a; Dicker & Gordon, 2006). See Table 1 for additional information about IFSPs and IEPs.

Myth: The only way children can communicate is verbally.

Reality: Children with IDD communicate in a variety of ways.

Children communicate in many ways in addition to talking. For instance, eye gaze, vocalizations, picture systems, and sign language are common and effective ways to communicate. Children with IDD may communicate in other ways as well. Some children may use an Augmentative and Alternative Communication (AAC) device, such as a picture system or a computer to communicate. While child welfare professionals do not need to be experts in all forms of communication, it is important to know what a child's primary form of communication is and to recognize and respect that it is a valid form of communication. If interested, child welfare professionals can enlist the help of someone who is able to communicate with the child using that

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communication system or someone who has more knowledge of the communication system, such as the child’s caregiver, special education teacher, or speech language pathologist. The child’s IFSP or IEP should include additional information about their communication style.

Myth: It is impossible to take a strengths-based approach with children with IDD.

Reality: Using a strengths-based approach is the best way to support children with IDD.

When taking a strengths-based approach, professionals focus on identifying the developmental competencies of the child, rather than simply noting what the child cannot do (Brunzell et al., 2016; Burdick & Corr, 2021). For example, rather than seeing a child as “nonverbal,” it is important to focus on how and when the child makes their needs and wants known through eye gaze, vocalizations, shaking their head, or other forms of communication. Identifying a child as nonverbal is not helpful because it only focuses on what the child cannot do—not the ways in which they can and do communicate. By using a strengths-based approach, professionals can better understand and support children with IDD. Using a strengths-based approach as a child welfare professional can be beneficial because it helps provide a better understanding of the child and can set the stage for fostering strong relationships with them.

Myth: Child welfare professionals have to learn to support the child they are working with on their own.

Reality: Using a family-centered approach can help child welfare professionals learn from those who know the child best.

As a child welfare professional, it may feel as if you are on your own when trying to support a child with IDD. However, taking a family-centered approach may be helpful. A family-centered approach focuses on supporting the family as a whole, honoring their strengths, and promoting their active engagement (Child Welfare Information Gateway, 2018; Dunst & Espe-Sherwindt, 2016). In this capacity, “family” can mean more than just biological parents. It also can include childcare providers, relatives, foster parents, or anyone else who provides care for the child. Taking a family-centered approach when working with children with IDD is important, as these caregivers are the most knowledgeable about the child, their strengths, and their needs (Dunst & Espe-Sherwindt, 2016). One key component of family-centered practices includes building relationships with everyone who provides care for a child, including foster parents or childcare providers. This can be done by finding out who the child is close with, contacting them, and asking questions to learn more about the child and how to best support them. These individuals typically have valuable insights about the child and can help child welfare professionals gain a better understanding of the child’s strengths and needs.

Myth: The preferences and priorities of children with IDD do not matter.

Reality: Children with IDD have their own thoughts, experiences, and preferences.

Children with IDD have their own individual thoughts, experiences, and preferences. One way to think about this idea is by understanding the concept of self-determination, which refers to a child’s ability to act as the primary causal agent in their life (Wehmeyer, 1996). Supporting children’s self-determination requires professionals to recognize them as full people and honor their voices, choices, and preferences. For children with IDD, this might take the form of recognizing and supporting their use of assistive technology or allowing them to

share their opinions and thoughts on a topic. A child’s IFSP or IEP can help with this, as these support plans include information about a child’s present levels of development, their strengths, and modifications that will help them succeed. Reading this document can provide insights into the child’s preferences and priorities. Additionally, a child’s special education teacher or early intervention provider can provide more information on this, based on their interactions and work with the child and their family.

Conclusion

Research has shown that children with disabilities are at an increased risk of experiencing maltreatment. Because of this, it is important that child welfare professionals consider how to best support these children. Table 2 includes information on some professional organizations and resources focused on disability and special education; child welfare professionals can peruse these to learn more about supporting young children with IDD. Additionally, while child welfare professionals may not have received training related to disability, there are other professionals they can collaborate with to gain more information and support. Special education professionals, such as early intervention providers or classroom teachers, can provide useful insights into children’s strengths and strategies for supporting them. Childcare providers or other caregivers also can provide support and serve as important resources. Finally, it is important to view children with IDD through a strengths-based lens and assume competence. This can be done by viewing disability through the social model and focusing on what children can do. By using these strategies, child welfare professionals can better support children with IDD who have experienced maltreatment.

Table 1
Information about IEPs and IFSPs

Adapted from the Pacer Center

Individualized Family Service Plan (IFSP)	Individualized Education Program (IEP)
Used in early intervention for children ages birth to three and their families	Used in special education for children ages three to 21
Services are provided in the natural environment (home, childcare)	Services are provided in school
Goals focus on child and family needs	Goals focus on educational needs of the child
Includes information on the child’s present level of development, goals for the child and family, and services the child and family will receive to help them achieve the goals	Includes the special education services (speech therapy, physical therapy, occupational therapy), related services, and modifications the child will receive in school
Team members include caregivers, service coordinator, and other professionals that are providing services (speech-language pathologist, physical therapist, occupational therapist)	Team members include caregivers, general education teachers, special education teachers, and other professionals who are providing services (social work, speech-language pathologist)

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Table 2
Disability Organizations and Resources

Resource	Website	Description
Division for Early Childhood (DEC)	https://www.dec-sped.org/	The Division for Early Childhood (DEC) is an organization for those that work with or on behalf of young children with disabilities.
Division on Autism and Developmental Disabilities (DADD)	http://www.daddcec.com/	The Division on Autism and Developmental Disabilities (DADD) is an organization of individuals committed to enhancing the quality of life of individuals with IDD.
Center for Parent Information and Resources	https://www.parentcenterhub.org	This website provides additional information about IEPs and IFSPs in a jargon-free manner.

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