A Social Services–Public Health Partnership in Child Protection: a Rural Model

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Synopsis

It is widely recognized that the amelioration of individual and family problems which contribute to child abuse and neglect requires a multidisciplinary effort. Unfortunately, however, these efforts are often sporadic or disjointed. This article is a description of a county social service-public health partnership in rural Minnesota which can serve as a model for other agencies interested in developing more interactive relationships with one another to the benefit of dysfunctional families and vulnerable children.

A respect for one another's professional knowledge base and skills, a shared philosophy of intervention, and supportive agency administrators are the key components that make this model successful. Social workers and public health nurses working together—and in cooperation with still other professionals in the community—can identify and help to resolve those unmet social, psychological, and health needs which often are found in dysfunctional families.

Public health nurses have many talents and a very diverse knowledge base that can be tapped by legally designated social workers who are charged by State statutes with intervening in cases involving physical or sexual abuse or neglect of children. The Brown County, MN, model is an example of a collaborative strategy that can be replicated nationwide.

HISTORICALLY, THE PROTECTION OF vulnerable children and the solution of family problems have been the responsibility of the social services profession.

Increasingly, however, it has become widely recognized that the amelioration of individual and family problems which contribute to child abuse and neglect requires a multidisciplinary effort (*1*). Collectively, social workers, psychologists, psychiatrists, nurses, pediatricians, child development specialists, police officers, attorneys, clergymen, and school counselors are, today, pooling their respective professional expertise to address the complex phenomenon of family violence, including child maltreatment. The development of multidisciplinary child protection teams throughout the United States has galvanized this collective approach to child abuse (*2*).

Yet, in most counties and regions of the United States, the primary agent for intervening in child protection cases remains a legally designated, public social service agency. For example, in States that operate a county social service delivery system, the identified "responsibility agency" for receiving reports of child abuse and neglect and providing protection to vulnerable children is the county welfare department, the county department of children and youth, child and family services, or like-titled county agencies. In States which operate a state-wide social service delivery system, regional offices of the State department of children and families (or like-titled agencies) are the designated agencies ultimately responsible for child protection.

Agency Partnerships

Although county or State social service agencies are ultimately responsible for cases involving child physical and sexual abuse and neglect, it must be understood that these agencies cannot exist in a vacuum among other human service providers if the complex family problems which contribute to child maltreatment are to be fully resolved. This article is a description of the partnership of two rural county agencies that are working together to identify and resolve cases involving child maltreatment.

The county agencies are Family Services and the Public Health Nursing Service. Their model partnership operates in a rural county in southern Minnesota—Brown County, population, 24,000.

The partnership is an interactive, interdependent working relationship between three social workers responsible for child protection in the county and two public health nurses responsible for maternal and child health services. All are county employees.

This working relationship might be considered a "natural one," yet, after reviewing the professional literature, we discovered that this partnership appears to be a novel approach to child protective service delivery. In general, collaboration between social workers and public health nurses is not a new practice concept (*3–5*). However, with few exceptions (*6*), it is an underutilized one in child protective services. Although many child protection social workers are likely to have some contact with public health nurses, perhaps at child protection team meetings, the extent of their cooperative relationship is likely to be sporadic and disjointed.

The partnership that exists in Brown County, by comparison, is on-going, well-understood, and highly interactive. Cooperation begins with case discovery (investigation) and continues through case termination. Facilitating this partnership is the fact that both county departments share the same one-story building. Being "just down the hall" allows workers from either department easy and immediate access to the other. There are frequent unscheduled consultations. Yet, shared facilities alone does not account for the success of the partnership.

Perhaps at the heart of the professional relationship is the mutual respect and willingness that exists between the two disciplines to share their respective expertise. Brown County professionals also share the same philosophy: dysfunctional families in which child abuse and neglect occurs typically have many unmet social, psychological, and physical health needs. Only "teaming" can satisfactorily address and resolve these needs. In addition to meeting clients' needs better, collaboration also serves to meet many of the workers' needs as well. A decade ago, an empirical study that explored social work-public health nursing collaboration revealed that the nurses and social workers who expressed the highest levels of satisfaction in their work had the most frequent professional and informal contacts with members of the counter profession. They apparently had developed patterns of communication and patterns of interprofessional dependence that met their mutual needs (*7*).

The Role of Nurses

Public health nurses in rural counties have extensive knowledge of hundreds of county families seen during routine home visits for newborns, early periodic screenings, immunization clinics, well child visits, school health programs, or other professional activities. Their knowledge shared with the social workers is invaluable in investigations involving child maltreatment. (In Minnesota, by law, nurses are mandated reporters if they suspect child abuse or neglect.) In addition to case discovery, public health nurses are invaluable because of their specialized knowledge about child development and child health. Their knowledge of county and regional medical resources is also invaluable to social workers. This information is especially useful in cases involving special-needs children. Because of their specialized medical knowledge, public health nurses also act as interpreters of medical reports sent to social workers, particularly in those protection cases that required medical intervention.

Given their specialized knowledge of child development, nutrition, and the routine and atypical health needs of children, public health nurses in Brown County routinely cooperate in the treatment plan for families who come into the child protection system, sometimes voluntarily and sometimes by court order. Frequently, case plans specify "parent education" as a need of abusive or neglectful parents. Nurses, often together with agency homemakers, provide this service.

They also serve as liaison between parents and physicians, parents and school staff, and even parents and their social workers. In many instances, public health nurses are perceived as "nonthreatening" by comparison with county social workers "who take your kids away." Nurses' nonthreatening demeanor is often an asset in engaging highly resistant families. In addition, while cases remain open, public health nurses routinely monitor the physical health of vulnerable children (those placed in foster care and those allowed to remain at home). The public health nurses, with specialized training, have also been especially useful in interviewing children who are believed to be victims of sexual abuse (*8*).

The many roles that public health nurses play in ameliorating child abuse and neglect in rural areas, and their collaboration with other human service providers, is illustrated in a Brown County case history.

A Case History

The W. Family was first brought to the attention of the Public Health Nursing Service through a rural school district. School officials complained that the

school-age children in the large, isolated farm family were dirty, had strong body odor, suffered from suspected impetigo lesions, and that the oldest, latency-aged boy had encopresis. The children reportedly also had learning disabilities.

Despite her initial hostile reception from the parents, the public health nurse was able to convince the mother that she could help her get the children's sores healed and prevent still other diseases. Through her contacts with the local physician, the nurse was instrumental in quickly remedying the impetigo problem. Personal hygiene of the children was addressed during each home visit with both the parents and their children, and this resulted in noticeable improvement in their physical care over time. After no medical cause could be found for the older child's encopresis, the public health nurse referred the child to the school district's consulting psychologist. He initiated a behavior modification program with the child which proved successful.

In time, both the children and their parents welcomed the public health nurse's home visits. The nurse observed, "both the parents and the children seemed starved for attention." In the course of her visits, the nurse provided information about health, child development, parenting, housekeeping, and self-esteem and discussed other services available in the county.

In particular, she promoted the services of a child development specialist who, she told the parents, could help them to stimulate kindergarten-preparedness in their younger children. The development specialist was subsequently invited to the home, was accepted by the family, and began making weekly home visits. Testing the preschool children, she found they were deficient in their emotional, social, physical, and mental development, and she initiated activities to enhance their development in these areas.

Recognizing the need for still other services, the public health nurse met with a county family services' social worker to advocate social services, including homemaker service. Together, the social worker and public health nurse arranged for financial, medical, and social services, and more educational services for the family, including Head Start. Eventually, a social services' homemaker won the trust of the family and made significant progress in helping the family to bring some order to their chaotic and unsanitary housekeeping. She also promoted better parent-child communications.

It was the homemaker who was told by the mother that her early adolescent daughter was being sexually abused by her husband, the child's stepfather. With this disclosure, the social worker arranged for the public health nurse to assist in interviewing the girl, accompanying her for a physical examination and, in general, maximizing reassurance and support for her. In the course of this activity, other members of the county child protection team—a sheriff's deputy and the county attorney—were instrumental in minimizing system-induced trauma to the victim.

Mr. W. was found guilty and began treatment for his sex offenses while imprisoned. The county social worker arranged for a psychotherapeutic treatment program for the victim, her mother, and other members of the family. They have since completed this treatment, but limited, supportive social and nursing service continues with this family, 4 years after case opening.

This case is not atypical of multiple service delivery to dysfunctional families in which neglect or abuse, or both, is found in progressive rural counties like Brown. Consistently, the focus of intervention by human service providers is how they can best help their mutual clients, working in concert, to resolve the problems which contributed to child abuse and neglect.

Given their legal mandate, county social workers act as case managers in child maltreatment cases. They negotiate services for families and coordinate the activities of the entire professional team engaged with a family. Interestingly, however, if cases are not designated as substantiated child maltreatment cases, the service provider most involved with a family—public health nurse, school social worker, mental health clinician, clergyman—will act as case manager and will invite collaboration with other human service professionals in the course of county child protection team meetings. Biweekly, multidiscipline team meetings serve as the forum for case reviews. (Minnesota law provides for the exchange of confidential information at these meetings. In fact, an oath of confidentiality is a requirement for membership on the team.)

Administrative Cooperation

Finally, the cooperative spirit between the two department administrators is also of critical importance to the success of the social service-public health partnership. Both administrators allow their staff unencumbered access to the other. Both administrators have been convinced of the utility of this model partnership in child protection, understanding that the expertise which each discipline brings to the case is crucial in ameliorating the

stresses contributing to the abuse and neglect of county children. While the Brown County partnership rests on an informal agreement between the agency administrators to encourage the collaboration discussed in this paper, in large urban counties bureaucracy may demand more formalized agreements for collaborative activity. Bureaucracy, however, should not deter professionals from collaboration.

The Brown County partnership can serve as a model for other social service and public health nursing service agencies. The shared expertise of these disciplines—characterized in the relationship between departments in Brown County—can meet the needs of vulnerable children and their families everywere.

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Hansen's Disease in Native-Born Citizens of the United States

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Synopsis

This paper presents a statistical analysis of data on 1,309 Hansen's disease (HD) patients born in the continental United States during the 50 year period 1932–81. Fifty-six percent of them were born in Texas. The cases of 66 percent were classed as multibacillary, 31 percent were considered paucibacillary, and the type was unknown for 3 percent. Blacks and whites appeared to be equally susceptible to Hansen's disease. Thirty percent had a history of contact with Hansen's disease.

The age at diagnosis has increased an average of 2.7 years per decade, and the increase has accelerated in the last two decades. If the present trend continues, Hansen's disease among native-born citizens of the United States will ultimately disappear.

HANSEN'S DISEASE HAS BEEN KNOWN in the United States since 1758 when it was reported in Florida. It is thought to have been introduced into the Americas by early Spanish explorers and later by the slave trade from Africa and by other groups, such as the French in South Louisiana (*1*). These groups not only introduced the disease but also necessarily introduced a susceptible population, since Hansen's disease has never been reported in a full blooded American Indian (*2*). The disease was